

Child and Youth Care Professionals' Mental Health Literacy Practices in their
Encounters with Suicidal Adolescents: A Grounded Theory Study

by

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B.A., Carleton University, 1995
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of the Requirements for the Degree of

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Supervisory Committee

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Dr. Margie I. Mayfield, Departmental Member (Department of Curriculum and Instruction)

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Abstract

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As suicide is a leading cause of death for young people, child and youth care professionals are likely to encounter adolescents who are contemplating ending their lives. Recognizing and responding to the needs of a suicidal adolescent is challenging for the professional as they attempt to balance their relationship with the young person while simultaneously following customary rules of engaging in situations involving suicide. The need for theory to deepen understanding of child and youth care professionals' mental health literacy practices with suicidal adolescents led to this grounded theory study. Derived from interviews with 19 participants including child and youth care professionals, supervisors at youth-serving agencies, educators in schools of child and youth care, and textual analysis of policies, assessment tools, and curricula, the Balancing Perimeter and Proximity process was identified as the core category in the analysis. The Balancing process suggests professionals' mental health literacy practices fluctuate between circling care and circling defensively. Circling defensively refers to the professional taking up literacy practices that establish a perimeter of protection; whereas literacy practices within circling care position the professional in relational proximity where they connect and attend to the adolescent holistically. The theory extends current conceptualizations of mental health literacy, and contextualizes professionals' practice in identifying the conditions influencing the Balancing process, thereby providing an understanding for how existing structures (e.g., suicide education, agency policies) influence child and youth care professionals' mental health literacy practices with suicidal adolescents.

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Dedication

To my grandmothers...

For showing me there is strength in womynhood;

For modelling how to laugh and be silly;

For demonstrating there are times to be quiet, and times to be blunt.

Inez Clara MacLeod 1919-2009

Ella Frances Ranahan 1918-2010

Chapter 1

Introduction

My sister's friend Louise¹ attempted suicide in my early adolescence. Louise was creative, artistic, and shared my admiration for the melancholy melodies of *Depeche Mode* and wearing black. I learned from this event about the stigma associated with suicidality when my sister's friendship with Louise was no longer welcomed much less encouraged by my parents.

My encounter with Debbie followed Louise. Debbie was a beautiful blonde with great skin, plenty of friends and a boyfriend envied by all the young adolescent females who knew her. Debbie taught me that suicidality does not always present itself in those who are unpopular or on the margins. Debbie killed herself by carbon monoxide poisoning in her parents' garage.

In my later adolescence I encountered Amy who befriended me at my new high school. Not long into our friendship, Amy called me to say she had tried to kill herself by swallowing pills and was now at the adolescent psychiatric unit at the hospital. My subsequent hospital visit was my first introduction to the mental health system of care. I vividly recall the large, locked metal door that secured the entrance into the psychiatric ward. I learned from Amy that care for suicidal persons occurs behind secured doors.

My experiences with suicidality shifted in adulthood to be located primarily within my professional practice. Billy was 15 years of age when I met him. He was afflicted with a head injury and struggled with controlling his impulses and anger. Billy tried repeatedly to hang himself from the closet rod in his bedroom. Thankfully he was

¹ All names and identifying information have been changed to protect confidentiality and anonymity.

too heavy for the closet rod to hold his weight. I learned from Billy that sometimes suicide could be an expression of intense pain and frustration in the midst of not seeing any other options. Billy also taught me that if I listened and heard about his frustrations, he felt connected, his pain lessened, and he no longer wanted to die.

Patsy was a vibrant and creative young woman who was loved by everyone on staff. I had known Patsy for a very short time at the residential facility where I worked. On my day off I received a call at home from my manager who informed me that Patsy had killed herself. I attended Patsy's funeral with my coworkers and met, for the first time, some of her family. My manager conducted debriefing sessions with all the staff and smudged² the residence. Several of my colleagues took years to heal from Patsy's death and some workers blamed themselves for not recognizing that Patsy was suicidal. I learned from Patsy the devastating wave of pain and experience of guilt that can occur when someone dies by suicide for those that are left behind.

I encountered Martha who was a mother of an adolescent enrolled in a group I was co-facilitating. Circumstances led to my giving the adolescent and her mom a ride home one evening. On the way, Martha repeatedly stated in our conversation that she wanted to "go home". She was upset and crying. I intuitively felt that Martha was trying to communicate something more to me beyond her desire to "go home." I asked her if she was thinking of suicide, to which she responded "yes". I learned from Martha that some people who are experiencing suicidality might have difficulty explicitly communicating such thoughts to others. Martha also taught me that there are multiple ways of knowing suicidality is present.

² Smudging refers to a First Nations cleansing practice whereby herbs, such as sage, are burned, and the smoke is brushed over the body or spread throughout the room

The stories of encounters with suicidal persons I have shared above position me as having an insider perspective on suicidality and the literacies (e.g., recognizing presence of suicidality, knowing approaches to suicide prevention and intervention) that may be asked of the professional in the context of such interactions. As a reflexive researcher, I begin with an understanding that I “cannot help but come to almost any research project already knowing in some ways, already inflected, already affected, already infected” (Clarke, 2005, p. 12). That is, I am inflected, infected and affected by Louise, Debbie, Amy, Billy, Patsy, and Martha.

Suicidality amongst adolescents is a highly relevant concern for child and youth care professionals. Suicide is a leading cause of death for adolescents worldwide (Pelkonen & Marttunen, 2003) and out of the one million people who die annually by suicide, approximately 100,000 of those deaths are adolescents (World Health Organization, 2011). For children and adolescents ages 10-19 in Canada, suicide ranks as the second most common cause of death after accidents (Shaw, Fernandes, & Rao, 2005). Data from high-income countries such as Canada indicate mortality from suicide has increased over the past 50 years among adolescents and young adults (Viner, et al., 2011). In the year 2007, 508 young people between the ages of 10-24 died by suicide, which represented an increase of 60 additional deaths over 2006 rates (Statistics Canada, 2010). Clearly, many adolescents’ lives are being cut short by suicide.

Beyond youth who die by suicide, many adolescents are also actively contemplating ending their lives. For example, in British Columbia, Canada, 12% of adolescents aged 12-18 years considered suicide and 5% of adolescents in the province actually attempted suicide (Smith, Stewart, Peled, Poon, Saewyc, & the McCreary Centre

Society, 2009). Suicidality increases with age in adolescence with younger adolescents considering death by suicide to a lesser extent. For example, Peter, Roberts, and Buzdugan (2008) found 8% of adolescents between 12 and 15 years of age reported they considered suicide in the past year. Peter and colleagues' findings are similar to an earlier study by Affi, Cox and Katz (2007) focused on Canadian adolescents, ages 12 to 13 years. Affi and colleagues found 8.4% of females and 4.6% of males had considered suicide. That is, out of the 525,820 young people in British Columbia, Canada between the ages of 10 and 19 (BC Stats, 2010), there are approximately 63, 098 (12%) who have considered suicide.

The encounter with an adolescent contemplating ending their lives is the site of interest and curiosity for my study. Adolescents wrestling with their own mortality and considering when death may, or could, occur may not sound inviting to some, and yet it is a subject of great importance. I find the complexities of the pain, anger, confusion, isolation and the vast array of emotional turmoil and life circumstances that lead to suicidality intriguing. Edwin Shneidman, the father of suicidology (Leenaars, 2010), crystallized the complexities of suicidality that fascinate me in his interview with Thomas Curwen (2009) of the *Los Angeles Times*:

“Suicide is a complex malaise,” Shneidman said. “Sociologists have shown that suicide rates vary with factors like war and unemployment; psychoanalysts argue that it is rage toward a loved one that is directed inward; psychiatrists see it as a biochemical imbalance. No one approach holds the answer: It’s all that and more.” (para. 7)

Professionals who encounter suicidal persons are faced with a complex challenge with no clear answer. A wealth of literature has accumulated exploring the experiences of nurses (e.g., Bohan & Doyle, 2008; Carlen & Bengtsson, 2007), counsellors (e.g., Reeves & Mintz, 2001), or psychologists (e.g., Webb, 2011) in suicide encounters. With the heart of child and youth care practice described as a relational and personal connection with children, youth, and families (see for example Fewster, 1990a; Krueger, 2009), how, then, do these professionals explain their experience and actions in suicidal situations with adolescents with whom they are in relationship?

White (1997) maintains that “by virtue of their proximity to potentially vulnerable youth across a wide array of settings”, child and youth care professionals can participate in preventing suicide (p. 48). They provide services and care for young people across a range of settings including, but not limited to, schools, health care, social care services, addictions services, child welfare organizations, or outreach centres. When experiencing suicidality, adolescents are more likely to access services from social workers, counsellors, teachers, or friends for help, rather than using specialized mental health resources (Cheung & Dewa, 2007; Smith et al., 2009). There is a disconnection, then, between suicidal adolescents help seeking preferences and the current mental health system of care. Thus, if child and youth care professionals can participate in suicide prevention and intervention, there is an opportunity and a need to examine how child and youth care professionals currently respond to suicidal adolescents.

The Research Context and Question

The research question emerges from my experiences as a child and youth care professional and educator over the past sixteen years. Having worked in a variety of

settings with children, youth and families, I have been involved in several suicide situations including adolescents who were considering suicide, attempted suicide, and died by suicide. On occasion, I have also encountered children and youth whose parents were experiencing suicidality. I have personally experienced a range of emotions and questions in situations involving suicide, and observed similar responses in my colleagues as well. There have been multiple practice moments in which I have felt unprepared for encounters with suicidal adolescents despite my graduate-level qualifications in child and youth care . Now, as an educator in child and youth care and an Applied Suicide Intervention Skills Trainer (ASIST), I attempt to delineate the intricate challenges of such encounters in my education of students. Though as a teacher and trainer I have been swayed by current approaches to suicide education and practice that emphasize “assessment” and I admittedly have engaged in discourses of “risk” by encouraging the use of standardized assessment questions and labelling suicidal persons into categories (e.g., high, medium, or low risk), my curiosity pulls endlessly to explain the inner workings of professionals’ practice with suicidal adolescents so we might become better informed educators and child and youth care professionals.

My research is relevant and optimally timed in the development of child and youth care pre-service education. The North American Certification Project is underway (Curry, Eckles, Stuart, & Qaqish, 2010), with Alberta, Canada leading the way in formal testing and certification of child and youth care professionals (Stuart, 2010a). Schools of child and youth care are now offering courses in mental health. For example, the child and youth care program at Vancouver Island University in Nanaimo, Canada offers an elective course in child and youth mental health on a bi-annual basis (Leanne Rose,

August 27, 2011, personal communication). Students enrolled in the child and youth care counsellor diploma program at Douglas College in Vancouver, Canada are now required to complete a course in mental health in childhood and adolescence (Douglas College, 2011). As mental health content and suicide education evolves within pre-service child and youth care education, mental health literacy may provide a framework for future curriculum development.

Current conceptualizations of mental health literacy include “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, para.1). I have argued elsewhere (Ranahan, 2010), that mental health literacy, as defined above, is relevant to child and youth care education and practice in several ways. First, labelling of mental disorders may improve child and youth care professionals’ communication with other service providers. Secondly, professionals recognizing possible symptoms of a mental health concern for a child or adolescent may lead to early intervention and improved outcomes. Thirdly, child and youth care professionals can play a role in the management of the concern by supporting children and adolescents to obtain further help. However, it is unknown how child and youth care professionals in practice take up mental health literacy, or what additional knowledge professionals draw upon that could extend current conceptualizations of mental health literacy. With mental health content emerging in schools of child and youth care, research focused specifically on mental health literacy for child and youth care professionals is important.

Rationale for Inquiry

There is a significant gap in the literature on child and youth care professionals' practices with suicidal adolescents. Evidence of the heightened suicide risk amongst specific adolescent populations likely to receive service from child and youth care professionals is well documented. For example, young people are at a greater risk of suicidality if they have experienced child maltreatment (Thompson, et al., 2005), or sexual abuse (Plunkett, O'Toole, Swanston, Oates, Shrimpton, & Parkinson, 2001), are street-involved (Kidd & Carroll, 2007; Votta & Manion, 2004), or struggling with addictions (Affi et al., 2007; Dunn, Goodrow, Givens, & Austin, 2008; Wu, Hoven, Liu, Cohen, Fuller, & Shaffer, 2004). Knowledge of how particular practices are taken up by professionals and the conditions that intersect with such practices are greatly needed as our deepened understanding will enhance child and youth care professionals' practice, inform pre- and in-service education, and ultimately, improve care for suicidal adolescents.

Research Question

The research question that guides this inquiry asks: How do child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents? I chose to use a grounded theory methodology to investigate this topic.

Purpose of Study

My study explored child and youth care professionals' mental health literacy practices during encounters with suicidal adolescents, and concludes in the production of a theoretical model representing the experiences and voices of participants who have had such encounters. I aimed to generate a substantive theory that examined a specific

substantive area: child and youth care professionals' realization of mental health literacy practices with suicidal adolescents. The goal of my research was to understand the process of child and youth care professionals' practices with suicidal adolescents, and in doing so, enhance current pre-service education pertaining to suicide in schools of child and youth care. I identified child and youth care professionals, educated in schools of child and youth care, as a unique population that has yet to be considered in the existing mental health literacy research, and has not appeared as a group of interest within the current body of research exploring professionals' practice with suicidal adolescents. Further, I chose a qualitative approach that allowed me to construct a theoretical explanation of mental health literacy as a social process, rather than an individual attribute. My study is innovative and provides new insights into mental health literacy and child and youth care professionals' practices with suicidal adolescents.

An Overview of Child and Youth Care Practice

To situate the population of interest for my study, in the following section I provide a brief overview of child and youth care beginning with the development of the field and current pre- and in-service education. I also describe features of child and youth care practice with children, youth and families including the development of therapeutic relationships, attention to professionals' self-awareness, joining with children and youth in everyday life events, and developmental and ecological perspectives on care. I present the features as common themes evident in child and youth care literature and pre-service education programs while simultaneously recognizing the field continues to evolve (Gharabaghi & Krueger, 2010; Little, 2011) and early ideas are being revisited and contested. As child and youth care is an emerging profession, White (2011) posits that

final or absolute descriptions of the field should be resisted. Further, the child and youth care profession may be viewed as a social construction subject to “shifting identities and redefinition across time” (Alsbury, 2011, p. 133). Thus the following overview of child and youth care may be viewed as my interpretation of the field based upon the construction of my identity as a child and youth care professional and educator, my engagement with child and youth care literature and participation in collegial discussions, and a reflection of this moment in time.

Origins and Development of Child and Youth Care

According to Charles and Garfat (2009), the origins of child and youth care in North America began with the deinstitutionalization movement in the 1950s. Between the 1950s and 1970s, large rural institutions were replaced by smaller specialized treatment facilities located in urban areas (Charles & Garfat). The smaller facilities required professionals with specialized skills and knowledge, rather than lay staff that previously worked in institutional settings, and consequently, formal pre-service education programs slowly started to be established (Charles & Garfat). Over the past two decades, Charles and Garfat state that there has been a shift from a focus solely on residential care to community-based practice. As a result, defining the field and the skills and competencies required to work within it has been an evolutionary process (Charles & Garfat). The definition provided by Council of Canadian Child and Youth Care Associations (2009) illustrates the broad scope of practice and requisite skills required of child and youth care professionals:

Child and youth care practitioners work with children, youth and families with complex needs. They can be found in a variety of settings such as group homes

and residential treatment centres, hospitals and community mental health clinics, community-based outreach and school-based programs, parent education and family support programs, as well as in private practice and juvenile justice programs. Child and youth care workers specialize in the development and implementation of therapeutic programs and planned environments and the utilization of daily life events to facilitate change. At the core of all effective child and youth care practice is a focus on the therapeutic relationship; the application of theory and research about human growth and development to promote the optimal physical, psycho-social, spiritual, cognitive, and emotional development of young people towards a healthy and productive adulthood; and a focus on strengths and assets rather than pathology. (para. 2)

As the field continues to be defined and redefined, efforts to create a professional certification program and articulate competencies for child and youth care professionals have occurred over the past two decades (Curry et al., 2010). The identified competencies for child and youth care practice were intended to transcend the specific setting, population, and age of the child or adolescent to unite “child and youth services into one profession, founded on a common knowledge and skill practice base” (Curry et al., 2010, p. 60). Child and youth care competencies were organized into five domains including: (1) professionalism, (2) cultural and human diversity, (3) applied human development, (4) relationship and communication, and (5) developmental practice methods (Eckles et al., 2009). These competencies have provided the basis for planning and organizing curriculum within child and youth care pre-service programs in British Columbia (Ferguson, 2008).

Over the past twenty years, efforts to professionalize child and youth care have included the formation of national and provincial child and youth care associations; developing and adopting a code of ethics; and the accumulation of a body of knowledge comprised of several academic journals and texts (Krueger, 2002). The movement towards professionalization is motivated by concerns of quality of care, differentiation of child and youth care practice from other allied professions, and challenging working conditions including low pay and limited opportunities for promotion (Beker, 2001). The field continues to have challenges in gaining recognition and acknowledgement as a profession, struggles with high turnover of staff, and funding cuts to children's services (Charles & Garfat, 2009; Krueger, 2002).

Pre- and In-service Child and Youth Care Education

Pre-service programs, opportunities for in-service education, and provision of supervision all have the potential to influence and shape child and youth care professionals' practice with suicidal adolescents. The foundation of child and youth care pre-service education was derived from the experiences within allied disciplines (Ferguson, 2008), and premised upon interconnectedness and holistic perspectives (Beker & Maier, 1981). Curriculum within pre-service programs in child and youth care have historically emphasized the therapeutic relationship and interpersonal communication, small group facilitation and leadership, diversity, lifespan development, planned change and interventions, and professionals' self awareness (Anglin, 1995; Mann-Feder & Litner, 2004; Phelan, 2005). Students within child and youth care programs take courses such as interviewing skills, child development, and law and social services, and have the opportunity to graduate with a specialization in child welfare (Stuart, 2010b).

Opportunities now exist for students in schools of child and youth care to complete both undergraduate and graduate degrees including a PhD at the University of Victoria in Victoria, Canada (Ferguson). In western Canada, there are four pre-service programs in child and youth care that offer a bachelor's degree, and over ten colleges offering 2-year diploma programs (Stuart & Hare, 2004). New pre-service programs continue to be developed in Canada. For example, Concordia University in Montreal, Canada has created a bachelor's level specialization in Youth Work and Family Relations within the Department of Applied Human Sciences and is provincially recognized for child and youth care work (Mann-Feder & Litner). Ryerson University in Toronto, Canada offers an undergraduate degree program in child and youth care, and efforts are underway to develop a masters' option (Stuart & Hare).

Field placements during pre-service programs are considered a vital component of child and youth care education (Forkan & McElwee, 2002; Smith & Morgaine, 2004). Placements offer experiential learning opportunities for students to apply learning to practical, real world situations. Seminars that coincide with students' engagement in field placements encourage students to reflect on their experiences, develop their professional identity, and connect their experiences with course content (Smith & Morgaine).

Child and youth care pre-service education programs have grown substantially over the past three decades; however Phelan, (2005) criticizes the direction of some schools of child and youth care. Phelan notes many pre-service programs continue to adopt textbooks and materials from allied professions, such as the use of social work texts for courses in child and youth care theory. Phelan suggests further that faculty without a background in child and youth care need to clarify for themselves what defines

the discipline and become acquainted with the vast array of literature specific to child and youth care theory and practice. Phelan posits that without an alliance to child and youth care sources of knowledge, child and youth care pre-service programs “will continue to be seen as a subset of other disciplines and a patchwork quilt of other approaches” (p. 349).

While Phelan’s criticisms may be well-placed for some pre-service programs, there are schools that are focused on distinguishing child and youth care education as unique and well-defined. For example, the Youth Work Learning Centre at the University of Wisconsin, Milwaukee is the primary source of education and research for child and youth care professionals in the state of Wisconsin (Krueger, 2005). Faculty at the Youth Work Learning Center possess academic qualifications and practice experience in child and youth care and have created partnerships with organizations, professionals, administrators, and policy-makers within the field in the ongoing development of the school. Additionally, faculty rely upon, and contribute to, child and youth care-specific academic journals including the *Child and Youth Care Forum*, *Journal of Child and Youth Care Work*, and *Relational Child and Youth Care Practice*.

In-service education for child and youth care professionals varies across practice settings and is found by some scholars to be insufficiently supported at the organizational level. For example, Gharabaghi (2010) examined the in-service training and professional development opportunities for professionals in Ontario, Canada and found some agencies did not provide employees with professional development opportunities beyond provincially mandated programs, such as First Aid/CPR certification, during the period of review. Some agencies who participated in the study provided one-time in-service

education on cultural competency/diversity training, sexual orientation/identity issues, or information management and data base training. In-service opportunities related to developing therapeutic alliances with children, adolescents and families were noted by Gharabaghi as “infrequent” within mental health (p. 99) and child welfare settings (p. 102) , and “frequent” within residential group care settings (p. 104). Suicide prevention and intervention in-service education was offered more frequently to child and youth care professionals located within residential group care programs. While Gharabaghi did not clearly define the level of frequency in terms of the number of hours of in-service education child and youth care professionals completed, it is clear there are limited opportunities for professionals to enhance their practice with children, youth and families through in-service education beyond the provincially mandated requirements.

Therapeutic Relationships and Self-Awareness

Child and youth care practice has been characterized by the development of therapeutic relationships with children, youth, and families (Anglin, 1999), with particular attention to professionals’ self-awareness (Fewster, 1990a). Practice itself has been reframed as “relational practice” (Bellefeuille & Jamieson, 2008, p. 38) or “the co-created space between us” (Garfat & Fulcher, 2011, p. 8). Within such space, child and youth care professionals are required to be *present*. Presence, as Krueger (1994) explains, is comprised of “being real or bringing a desire to know and to continually discover oneself to the mutual boundaries where relationships are formed” (p. 224). It includes *being there* to be committed and counted upon by the children and youth being served (Krueger, 1994). Within the interactional process, child and youth care professionals are most effective if they are self aware and engaged with children and youth (Krueger,

2011). If the personal relationship is at the center of child and youth care, professionals' selves must be fully invested in their relationships (Fewster, 1990a). Fewster (1990a; 1990b) explains the personal in relationship is a style of connecting in practice and a commitment to self-discovery by the professional, rather than a focus on self-disclosure to others. The relationship transforms and is transforming for both professional and the child or adolescent.

The focus in child and youth care on therapeutic relationships located at the individual level has received recent criticism. Newbury (2011) suggests that when child and youth care professionals practice exclusively at the individual level there is a risk of perpetuating oppressive conditions faced by children, youth, and families such that young people are positioned as in need of help, and professionals are the helpers. Rather, Skott-Myhre and Skott-Myhre (2011) posit that child and youth care may be viewed as political praxis whereby professionals collectively join with youth and families to "challenge the existing dominant social arrangement of society" (p. 44). That is, child and youth care practice is not only comprised of relational engagement with individual children, adolescents, or families; it includes challenging oppression and working collectively towards equitable conditions for all (Newbury, 2009). Child and youth care practice then, may be envisioned more broadly to include challenging policies and practices that marginalize children, youth, and families from participating fully in the community (Stuart, 2004).

Everyday Life Events

Gharabaghi and Krueger (2010) suggest that child and youth care professionals working within the *life space* of children, youth and families is a unifying concept within

the field. Transformative and relational practice with children, adolescents and families is realized through shared activities where connection and belonging are experienced by participants (Steckley, 2011). Shared activities include everyday life events that are viewed by child and youth care professionals as opportunities for learning (Maier, 1981). The child's or adolescent's total learning environment, including home, school, and community may be viewed as the curriculum for teaching and learning social competencies (Small & Fulcher, 2006). Likewise, professionals do not typically base their practice in office settings where children, adolescents and families meet for pre-arranged, scheduled sessions. It is the daily work within a child's or adolescent's environment that is a unique aspect of practice where the focus is on "living and working with" young people (Anglin, 1999, p. 147). Garfat and Fulcher (2011) refer to this flexible nature of child and youth care practice as "counselling on the go" (p. 14). Further, child and youth care practice is influenced by constructivist approaches such that "practice is not something we do *to* young people" but "we indeed do *with* them" (Skott-Myhre & Skott-Myhre, 2011, p. 46). Child and youth care professionals strive to be "in-synch" with the child or adolescent so that the worker and youth feel a sense of togetherness (Krueger, 1994, p. 227). Shared activities, collaborative practice, and togetherness support the development of relationships with children, youth and families.

Ecological and Developmental Perspectives

Early ideas in child and youth care were focused on ecological and developmental perspectives. Development was viewed as a uniquely individualized, yet universal and reciprocal process between the child or adolescent and their context such that pathological development or abnormal behaviours were understood as a developmental

occurrence in response to daily life, coping patterns, or encountering an unmanageable situation (Maier, 1990). Recently, some scholars in child and youth care have challenged developmental theories that are based on universal stages. For example, Pacini-Ketchabaw (2008) suggests that there is “not a universal truth that specifies who children/youth are” (p. 40). The construction of so-called normal developmental pathways locates development solely within individuals and reduces it to a binary category of normal/abnormal (Dean, Harpe, Lee, & Mallett, 2008). Further, Pacini-Ketchabaw (2008; 2011) suggests that developmental theories must be treated as constructions influenced by social and political motives and therefore, child and youth care professionals must challenge conceptualizations of *normal* child and adolescent development.

Pacini-Ketchabaw (2011) posits that child and youth care is concerned with the ecologies of children, youth, and families. Bronfenbrenner’s (1979) ecological model has influenced child and youth care perspectives on human development and change (Kuehne & Leone, 1994). An ecological perspective views development as occurring within the context of the microsystem (e.g., family), the mesosystem (e.g., relationship between school and family contexts), the exosystem (e.g., parent’s workplace), and the macrosystem (e.g., social structures of society). Each system has an influence on the adolescent, and in turn, the adolescent may influence each system. Further, an ecological perspective acknowledges the interactions among systems that can also influence the adolescent, and so on. Change, then, in one system can impart change in another system. For example, child and youth care professionals in a residential program can extend their practice beyond the adolescent-in-residence to additionally working directly within the

adolescent's community including their school, social worker, or probation officer (Radmilovic, 2005).

Child and youth care is an emerging field shaped by the early collaboration of educators and professionals from allied disciplines. The field's struggle for recognition has motivated efforts toward professionalization and certification. Opportunities for pre-service education continue to be developed, however the availability of in-service education varies across settings and contexts. Literature in child and youth care has focused on therapeutic relationships, professionals' self-awareness, joining with young people in their daily lives, and viewing children, youth, and families within an ecological context. While recognizing that there are multiple perspectives in child and youth care, in this section I presented a brief overview of the field including early ideas and more recent perspectives with the aim of locating the population of interest for my study.

Summary and Overview of Chapters

Suicidality is a concern for many adolescents and, consequentially, for others who care for the young person who is considering ending their life. In Chapter One, I set the stage for my inquiry into how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents. As a group, child and youth care professionals' practice is characterized by an emphasis on relationship, self-awareness, and an ecological and developmental understanding of children, youth and families. Such professionals are located within a range of practice settings where they may encounter a suicidal adolescent, thus a theory explaining the process of such encounters would benefit professionals, educators, and adolescents.

The research question I have outlined above may be viewed as multi-layered in regards to population of interest, constructs of literacy and approaches to suicide education, and adolescents' help seeking preferences. For this reason, in Chapter Two, I provide a review of the literature pertaining to critical and social literacy theories, health and mental health literacies, pre- and in-service suicide education, and adolescent help-seeking for health concerns. Each area reviewed provides the reader with understanding of the layers involved in my research question.

In Chapter Three, I present a discussion of my research design and procedures. I locate constructivist grounded theory method within the history and development of grounded theory, and the philosophical foundations therein. I provide a rationale for such an approach to inquiry, followed by a detailed description of my research process.

Chapter Four is the first of three chapters in which I present my research findings. In the first findings chapter, I introduce the theory of the **Balancing Proximity and Perimeter** process, followed by a specific outline the professionals' rules of engaging, or mental health literacy practices taken up during encounters with suicidal adolescents. The second findings chapter, Chapter Five, describes and explains the micro and macro conditions influencing the process and the consequences within. In Chapter Six, I provide a description, visual representation, and vignette illustration of the **Balancing Proximity and Perimeter** process and its respective sub-processes, circling care and circling defensively, that explains how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents.

In Chapter Seven, I situate the theory that I generated from the data in relation to the existing literature. I suggest several implications of the theory for child and youth

care practice, education, and for the mental health literacy field. I identify the limitations of my study along with avenues for future research.

Chapter Two

Literature Review

The purpose of this chapter is to present the preliminary review of the literature in content areas pertaining to child and youth care professionals' mental health literacy practices during their encounters with suicidal adolescents. I begin the chapter with a discussion regarding the use of the literature in a grounded theory study and distinguish between the preliminary literature review conducted at the beginning of a grounded theory study, and the subsequent literature I drew upon to situate my work within the existing literature as reported in future chapters. Following my discussion of the use of the literature, I organize the chapter into three main sections: theoretical constructs, sensitizing concepts, and content areas related to research interests.

To contextualize and orient my study, I review two theoretical constructs for literacy: critical literacy theory and social literacy theory. An examination of theoretical constructs for literacy further delineates my research interest in literacy practices of professionals. Following the overview of critical literacy and social literacy, I outline the current literature on two *sensitizing concepts* (Blumer, 1954): health literacy and mental health literacy. Sensitizing concepts provide a focus for my interviews (Holloway, 1997) and allow the researcher to “identify theoretically relevant phenomena” during analysis (Kelle, 2007, p. 207). As efforts to enhance literacy are often associated with education, the current landscape of pre- and in-service suicide education and common assumptions within contemporary approaches to suicide education are discussed. Child and youth care professionals may participate in suicide education within pre- or in-service programs, thus the literature in this area is helpful in explicating how professionals are prepared for

encounters with suicidal adolescents. Next, to build on the relational and interactional aspects of literacy, I provide an overview of adolescent help seeking including adolescents' preferred formal and informal sources for help. In this chapter, I also weave together the various strands of literacy, suicide education, and adolescent help-seeking as "points of departure" (Charmaz, 2006, p. 17) to explicate what is known and not known about child and youth care professionals' mental health literacy practices in encounters with suicidal adolescents.

Use of the Literature in Grounded Theory Studies

Substantial discussion has arisen amongst grounded theorists regarding the use of existing literature relevant to the research topic (Bryant & Charmaz, 2007a). What is deemed most problematic is the timing of the engagement with existing literature (Dunne, 2011). Typically the function of a literature review is to immerse oneself in the existing literature (Mackay, 2007) in preparation for entering the academic conversation on the topic (Biklen & Casella, 2007). For the student completing a dissertation, literature reviews are generally used to demonstrate to their audience a breadth of understanding of the existing relevant literature, which often results in an extensive reference list (Hayes, 2006). The literature review is considered to be foundational in identifying what knowledge is already known, and what areas require further inquiry (Webster & Watson, 2002). The timing, then, of the literature review generally occurs at the outset of a research project with the aim of advancing knowledge by addressing gaps in what is known. Literature reviews in grounded theory studies differ in both timing and purpose.

Timing

Glaser (1978) suggests that the review of the literature should occur after the theory is sufficiently developed. Postponing the literature review generally is advised by experienced researchers, who possess extensive knowledge of relevant literature and familiarity with the topic at hand (Bryant & Charmaz, 2007a). Stern (2007) suggests there are benefits in undertaking the review after data analysis as then it “completes and enriches the research” (p. 123). The timing of the literature review in grounded theory studies has raised questions and caused confusion (Covan, 2007). On the one hand, completing an exhaustive literature review beforehand can lead to unintended adherence to established ideas and authorities on the topic (Selden, 2005). The researcher may then force the data into preconceived ideas reviewed in the literature before data collection and analysis, rather than the theory being generated directly from the data. However, reviewing the academic literature prior to data collection can be useful in remaining current and in enriching interviews with participants (Wiener, 2007). Attempting to balance the conflicting ideas of when the literature review should be conducted can cause confusion especially for the novice researcher. The question of timing is also perhaps better answered by separating the preliminary or orientating literature review from engaging with the literature post-analysis to make connections between the new theory and the existing knowledge. Thus, it is helpful to consider the purpose of each literature review in grounded theory studies.

Purpose

The initial or preliminary literature review in a grounded theory study is conducted for the purposes of orienting the researcher to the topic, not as a defining

framework (Urquhart, 2007). Wide engagement and familiarity with ideas in the literature is required for theoretical sensitivity (Bryant & Charmaz, 2007a; Dey, 2007). Theoretical sensitivity allows the researcher to conceptualize and formalize the developing theory (Glaser & Strauss, 1967). Beginning the study with sensitizing concepts, or general research interests, knowledge, and concepts, provides the researcher with “ideas to pursue and sensitize you to ask particular kinds of questions about your topic” (Charmaz, 2006, p. 16). Thus the preliminary literature review orients and sensitizes me to the topic of child and youth care professionals’ mental health literacy practices during encounters with suicidal adolescents, but does not define what I am analyzing in the data.

The literature review conducted after the theory is generated from the data has a different purpose than the orientating literature review. In grounded theory studies, the researcher does not set out to verify preconceived ideas, but endeavours to situate the generated theory within the existing literature. As Stern (2007) suggests, “[r]ather than verification, your job is to demonstrate how your work adds a new dimension, an element that heretofore was unknown” (p. 123). Situating the theory within the academic conversation also contributes to evaluating the validity of the study. Validity in grounded theory studies is characterized by “the degree to which our theoretical claims are consistent with well-established knowledge in the field” (Dey, 2007, p. 177). Charmaz (2006) suggests weaving and positioning the new grounded theory in relation to other theories, clarifying the contribution of the study, and making connections between the new grounded theory and earlier studies at this later time.

Based on the above description of the use of literature reviews in grounded theory research, in this chapter I provide a preliminary look at the relevant literature pertaining to child and youth care professionals' mental health literacy practices in encounters with suicidal adolescents. In Chapter Seven, I review additional literature to situate my theory. The following section begins with an orientation to theoretical constructs for literacy.

Theoretical Constructs for Literacy

Literacy has been defined by Kirsch (2001) as “an advancing set of skills, knowledge, and strategies that individuals build on throughout their lives in various contexts and through interaction with their peers and with the larger communities in which they participate” (p. 4). Literacy is a social achievement and an outcome of cultural transmission as individuals shape, and are shaped by, participation in social activities (Scribner, 1984). Literacy then, is more than just reading and writing and “encompasses any form of communication” (Wood, 2002). From this *pluralistic* view of literacies (Hull, Mikulecky, St. Clair, & Kerka, 2003), literacy “moves beyond a singular, psychological, fixed, skill-focused view to a view of literacy as inherently situated in personal, historical, cultural, and social contexts” (Cervetti, Damico, & Pearson, 2006, p. 380). Menezes de Souza (2007) described the shift away from traditional notions of literacy located within individuals:

If, as various theorists have already discussed, literacy is no longer seen as a technology or a set of cognitive skills to be developed in individual minds, but as a socio-culturally situated practice involving the ongoing negotiation of meaning in continuously contested sites of meaning construction, then all literacy in a certain sense ought to be “critical” (i.e., arising from crises of various sorts). (p. 4)

Situating literacy within these contexts illuminates literacy as a “political phenomenon... [which] must be analyzed within the context of a theory of power relations and an understanding of social and cultural reproduction and production” (Freire & Macedo, 1987, p. 142). The following section provides an overview of critical literacy and social literacy theoretical constructs. Based on these theories of literacy, mental health literacy can be viewed as a social construction and a social practice (Menezes de Souza, 2007) that is linked to economic and political interests.

Critical Literacy Theory

A process of empowerment, awareness leading to transformation and social action, characterizes critical literacy. Empowerment, within critical literacy theory, recognizes the role of teachers and learners and attempts to shift the power and redefine these roles. Awareness and transformation invites learners to adopt a critical questioning stance, which leads to thinking being transformed. As their thinking changes, people experience a duty to respond with social action. Each part of this process is described further in this section.

Empowerment. Empowerment begins with shifting the roles of teachers and learners where “teachers learn and learners teach” (McDaniel, 2004, p. 474). Redefining the roles of teacher and learner requires teachers to relinquish their power (McDaniel, 2004), and encourage students to adopt a critical stance. Teachers, then, collaborate with students as learners share their experiences and knowledge. Teachers and learners are actively engaged with each other (Gee, 2007). As they redefine their roles, engage, and collaborate, knowledge is co-created in the in-between, rather than transmitted from teacher to learner (Gee, 2007). The production of knowledge then, “is a relational act”

(Giroux, 1987, p. 15). Changing the nature of the teacher-learner relationship as described here, moves beyond traditional approaches or “banking” models of education (Mayo, 2004, p. 44) where teachers are viewed as experts and dispense knowledge to passive receivers. When roles are altered, students are able “to develop the capacity to speak up, to negotiate, and to be able to engage critically with the conditions of their working lives” (New London Group, 2000, p. 13). Teachers become “designers of learning processes and environments” (New London Group, 2000, p. 19) where students are able to develop their sense of agency, self-sufficiency, and thus can confidently make decisions (McDaniel, 2004). Empowerment, then, grows from a designed process and environment in which students develop agency, self-sufficiency and confidence.

Shifting roles and changing the nature of the teacher-learner relationship is not without its challenges. Relinquishing power requires teachers to be aware of their assumptions and beliefs about self and others. They may experience resistance from those who wish to maintain the status quo (McDaniel, 2004). For example, based on their prior learning experiences, learners may come with an expectation of ‘being taught’ and adopt a passive stance as receiver of knowledge. Learners may resist questioning those who they view as authority figures and refuse collaboration with the teacher. Teachers may experience resistance from colleagues who wish to maintain power and their position as expert. Blind compliance may be valued, while questioning and critique may be met with disapproval (McDaniel). However, critique, or adopting a critical stance, empowers learners (and teachers) to participate fully in society (Giroux, 1987). Through analyzing their own experiences including their relationship with authority, the designed learning process and environment “...provides them with the opportunity to give meaning and

expression to their own needs and voices as part of a project of self and social empowerment” (Giroux, p. 7).

Awareness and transformation. Empowerment leads to awareness, and awareness leads to transformation. Through teachers shifting their roles, and the roles of learners by inviting learners to adopt a critical stance, rather than blind compliance, learners gain consciousness of the power and place of literacy within their own lives. Shannon (1995) illuminates the impact of critical literacy on our awareness in the following statement:

Critical perspectives push the definition of literacy beyond traditional decoding or encoding of words in order to reproduce the meaning of text or society until it becomes a means for understanding one’s own history and culture, to recognize connections between one’s life, and the lives of others and society are possible as well as desirable, and to act on this new knowledge in order to foster equal and just participation in all the decisions that affect and control our lives. (p. 83)

By adopting a critical perspective, learners gain awareness of their own history, their culture, and connect self-understanding to others and society as a whole. Freire and Macedo (1987) refer to such awareness as conscientization or “critical consciousness” (p. xiii). Critically conscious learners engage in “deepening awareness both of the sociocultural reality that shapes their lives and of their capacity to transform that reality” (Freire, 1970/2000, p. 65). Awareness, then, leads to transformation as learners are able to conceive of change and possibilities become known.

An example of the link between awareness and transformation within critical literacy theory is consideration of language. Language actively constructs and organizes

experiences (Giroux, 1987), is the means to which we make meaning, and communicate this meaning to others (Freire & Macedo, 1987). Through critical consciousness, language can be transformed so new meanings are constructed and communicated. To illustrate further, Maddux (2008) maintains that current perceptions of mental health are often centered on communicating an illness ideology and that the language of mental illness (e.g., symptom, disorder, pathology, diagnosis, co-morbidity, treatment) focuses on communicating the meaning of mental health as ‘disorder’, ‘dysfunction’ and ‘disease’, rather than on health or wellness. Street (1995) suggests adopting a critical stance when considering a dominant or standardized language by asking the following questions: “How did it become dominant, how does it reproduce itself, how does it connect with other, marginalized languages?” (p. 135). Questioning can lead to constructing mental health language differently (e.g., health, wellness, community, culture, confidence, control), and alternate meanings may be communicated (Stewart, Riecken, Scott, Tanaka, & Riecken, 2008). Awareness of the meanings communicated through language thus opens up possibilities for transformation.

Pedagogy, within critical literacy theory, is centered on transforming thinking, rather than teaching technical skills (McDaniel, 2004). Learners are encouraged to adopt a critical stance and question and examine the assumptions and messages within a text (McDaniel). Critical literacy, then, includes reflection for the purpose of transformation (Mayo, 2004). The process of empowerment, awareness, and transforming thinking invites and enables opportunities for action.

Social action. As learners are empowered to question, participate and value their own experiences and knowledge they become conscious of the conditions of their lives.

Thinking is transformed and learners are called to social action. Critical literacy theory includes “learning how to interpret and act on the world in socially just ways” (Kendrick, Rogers, Smythe, & Anderson, 2005, p. 2). Action consists of addressing inequities, promoting justice, and challenging the status quo (Shor, 1999). It is not enough to question, examine, and transform oneself. Critical literacy theory involves a duty to work towards change (McDaniel, 2004). That is, critical literacy becomes an “ethical and political project” (Giroux, 1987), where people are connected, transformed, engaged, and actively pursuing social change.

Social Literacy Theory

Social literacy theory is concerned with moving beyond traditional views of literacy where literacy is measured in individuals, and acquired through schooling. Creativity and innovation are emphasized (New London Group, 2000), as literacy is viewed as complex social practice (Ivanic, 2009). Beginning with an overview of traditional views of literacy, the following section further defines and explores social literacy theory.

Traditional views of literacy. Giroux (1987) posits that, traditionally, literacy has been reduced to a function tied to economic interests and efforts are focused on initiating the underprivileged and minorities into the dominant ideology of literacy. Notions of literacy have focused on reading and writing abilities of individuals (Norton, 2007), essentially locating literacy within individual persons and distinguishing people as being literate or illiterate. In the dominant, traditional perspective, literate people are viewed as intelligent and civilized (Gee, 2007), whereas illiterate people are unskilled (Street, 2009).

Gee (2007) refers to the traditional perspective on literacy as the “literacy myth” (p. 51), whereas Street (1995) identifies this view as the “autonomous model of literacy” (p. 114). Literacy, as an attribute of autonomous individuals, is a myth such that literacy is not static or measurable, nor does it have a universal essence that can be captured (Scribner, 1984).

Ideological model of literacy. Street (1995) expands the notions of literacy beyond the autonomous or traditional view by locating literacy within a social context. Literacy, Street argues, is embedded within “relations of hierarchy, authority and control” (p. 114) and cannot be separated or viewed outside of the context in which it is used. Furthermore, literacy has no effect or meaning when distanced from the specific context (Gee, 2007). Just as “human knowledge is embedded in social, cultural and material contexts” (New London Group, 2000, p. 30), literacy is heavily influenced by, and created within a social, cultural, historical, and institutional context. Thus an ideological model of literacy takes into account the variances of literacy from one context to another and the uses and meanings people bring into the context (Street, 2009). Literacy is also rooted in activities and actions (Prinsloo & Baynham, 2008). The context, the actors and their actions, and the activities in which they engage, all contribute to a view of literacy as a social practice.

Beyond locating literacy within context, social literacy theory expands the singular aspect of the traditional notion of literacy by taking into account multiple literacies (Gee, 2007). For example, Ivanic (2009) identifies several literacies required for college students including “literacies for being a student...; literacies for learning of knowledge, understanding and capabilities; literacies for assessment; literacies related to

an imagined future” (p. 104). That is, college students engage in multiple literacies within varied contexts all influenced by the uses and meanings they bring and what actions and activities they undertake. Within social literacy theory, recognizing multiple literacies is not simply labelling a specific skill set or list of competencies (e.g., emotional literacy). Street (2009) suggests labelling specific literacies in this way follows the traditional, reductionist approach and ignores the conception of literacy as social practices embedded within particular contexts. Furthermore, identifying a specific literacy inevitably leads to corresponding identification of people who are deemed illiterate. Pluralizing literacy instead is intended to take into account “the complexity of meaning making” by persons within the surrounding conditions of power relations, identities, or cultural practices (Street, 2009, p. 26). For example, specifying mental health literacy as, in part, knowledge of mental health resources available for suicidal adolescents, potentially ignores the social and political contexts that influence the availability of resources. A child and youth care professional may be geographically located within an area where mental health services are solely accessible to adults and adolescents are expected to leave the community for psychiatric care. In such circumstances, literacy in mental health may require professionals to extend existing notions of mental health resources to include multiple perspectives and approaches.

Acquisition and apprenticeship. The traditional autonomous perspective on literacy has influenced educational approaches to address the perceived needs of the illiterate. Advocates viewed literacy as the ability to read and write, thus efforts to enhance literacy were centered on individuals’ mental states and mental processing (Gee, 2010), devoid of context, as a set of neutral competencies (Street, 1995). According to

Street, schooled literacy reigns in the Western world where literacy is measurable, and too often power is associated with the level of literacy acquired, whereas literacies deemed inferior to schooled-literacy, are invisible, marginalized, and devalued (Street, 1995).

In contrast with schooled-literacy, Street asserts that literacy acquisition, within social literacy theory, is a process whereby learners move beyond reading and writing, to engage critically with the content and material. Learning is viewed as a process of engagement, adoption of a critical stance, and is actively connected to experience (New London Group, 2000).

Social literacy theory additionally is concerned with changing traditional approaches to literacy acquisition to pedagogical relationships consisting of mentoring and training for the purpose of full participation (New London Group, 2000). Cope and Kalantzis (2000) suggest there are four components of social literacy pedagogy:

Situated Practice, which draws on the experiences of meaning-making in lifeworlds, the public realm and workplaces; Overt Instruction, through which students develop an explicit metalanguage of Design; Critical Framing, which interprets the social context and purpose of Designs of meaning; and Transformed Practice, in which students become meaning-makers, become designers of social futures. (p. 7)

Emphasis is on innovation and creativity (New London Group, 2000), instead of replicating a standard, monocultural form. Shifting from schooled notions of literacy, literacy apprenticeship replaces literacy acquisition whereby experiences are shared, valued, and built upon (Gee, 2010).

Literacy events and literacy practices. Social literacy theorists Heath (1982) and Street (1984) articulated the concepts of *literacy events* and *literacy practices* as a way of investigating and analyzing literacy. Heath defined literacy events as “occasions in which written language is integral to the nature of participants’ interactions and their interpretive processes and strategies” (p. 50). For example, Heath suggests that activities such as reading cereal boxes or interpreting instructions are literacy events. Literacy events are characterized by socially established rules for reading, verbalizing, and sharing knowledge. For example, a child and youth care professional may read an agency policy document that outlines instructions for how they are to respond to a suicidal adolescent. How information is prioritized, located, or emphasized in the instructions, conveys to the professional what is the priority, what is important to notice, and what actions are expected of them.

Literacy practices refer to the specific activities participants enact during a literacy event (Street, 1984). Simply stated, “literacy practices are what people do with literacy” (Barton & Hamilton, 2000, p. 7), from reading a policy document to organizing a labour strike. The activities or practices are framed by the understanding and meaning each participant ascribes to the event. Literacy practices within a sociocultural context include relations of power contained inside contexts of social inequality (Prinsloo & Baynham, 2008). Different ways of knowing, the use of technologies and tools, and the beliefs and values of participants are all integrated into literacy practices (Gee, 2010). Underlying assumptions regarding literacy practices within social literacy theory include the following:

- Literacy is best understood as a set of social practices; these can be inferred from events which are mediated by written texts;
- Literacy practices are patterned by social institutions and power relationships, and some literacies are more dominant, visible and influential than others;
- Literacy practices are purposeful and embedded in broader social goals and cultural practices;
- Literacy practices change and new ones are frequently acquired through processes of informal learning and sense making. (Barton & Hamilton, 2000, p. 8)

In addition to the assumptions above, literacy events are mediated by visual and spoken texts, and, more recently, texts in electronic form. Delineating the concepts of literacy events and literacy practices opens up opportunities for researchers to examine how literacy is realized during events and shaped by the sociocultural context (Prinsloo & Baynham, 2008). That is, researchers interested in literacy are not measuring skills located within individual participants, but studying complex social practices (Street, 2009; Kendrick, Rogers, Smythe, & Anderson, 2005). Events and practices are made up of multiple ingredients (e.g., participants' interpretations, conditions influencing the sociocultural context) as well as configurations and combinations of ingredients (Ivanic, 2009). Research on literacy events attempts to identify the ingredients, and varied configurations of the ingredients, within literacy practices (Ivanic).

Implications of Critical Literacy and Social Literacy Theoretical Constructs

The theoretical constructs of critical literacy and social literacy provide the foundation for my investigation into child and youth care professionals' mental health literacy practices during encounters with suicidal adolescents. As noted in Chapter One, I

am concerned with how these professionals realize mental health literacy practices during encounters. While the encounter with a suicidal adolescent is viewed here as a literacy event, mental health literacy practices refer to the professionals' reading and writing of text (e.g., reading agency policy, documenting suicide assessment tool) and communicative practices (e.g., verbal reports to colleagues), and the professionals' perceptions, understandings, meanings, and knowledges they hold during the encounter (e.g., perceptions of risk, intuitive knowing).

Additionally, critical literacy theory and social literacy theory provide a way of considering how mental health literacy practices are influenced by the process of empowerment, awareness, transformation and social action within a sociocultural context. The meanings of mental health literacy, and its related practices, are relationally and contextually produced at the intersection of child and youth care professional and adolescent. Literacy is now understood as "a myriad of discursive forms and cultural competencies that construct and make available the various relations and experiences that exist between learners and the world" (Giroux, 1987, p. 6). Thus language such as labelling of mental health concerns may limit and make available particular literacy practices while limiting other possible practices during encounters with suicidal adolescents.

Furthermore, critical literacy and social literacy theories clarify literacy as a social practice. That is, how literacy is used, acquired, or learned and the meaning of being mental health *literate* are determined by the sociocultural context (Kendrick et al., 2005). Mental health literacy, then, is immeasurable and indeterminate outside of the interactional context. As a complex social practice, mental health literacy must be

investigated in my study as a relational encounter between child and youth care professional and adolescent, and between participant and researcher. The aforementioned implications pave the way for additional discussion of health literacy and mental health literacy as sensitizing concepts for my study.

Sensitizing Concepts

Grounded theorists enter the study with particular research interests that bring particular concepts into the study (Charmaz, 2006). Researchers are able to identify categories in the data and make sense of participants' experiences based on their cognitive frame of reference (Dey, 2007). The co-originator of grounded theory, Anselm Strauss, suggested the researcher's perspective or frame of reference is not viewed as the only useful one or that it should dominate the study (Kearney, 2007). Concepts and ideas that the researcher brings into the grounded theory study are named *sensitizing concepts*. Charmaz (2006) refers to sensitizing concepts as "points of departure for developing, rather than limiting, our ideas" (p. 17). Researchers start with sensitizing concepts as tools to develop ideas, and then set them aside if they prove to be irrelevant during data analysis (Charmaz, 2006). That is, concepts identified at the outset are not operationalized or tested in the research. Leads in the data are followed based on what research participants define as important (Charmaz, 2006). Health literacy and mental health literacy are two sensitizing concepts I entered my study with and used as points of departure in analyzing my data. In the following section I define health literacy, and by extension, mental health literacy. I additionally provide an overview of mental health literacy research in regards to populations of interest and common research design.

Health Literacy

The concept of *health literacy* has undergone numerous developments, additions, and transformations since its initial conception by Simonds in 1974 (Rootman, Frankish, & Kaszap, 2007). According to Rootman and colleagues (2007), Simonds' use of the term was in respect to creating minimum standards for elementary and secondary students' health literacy in health education. Following an autonomous view of literacy (Street, 1984), early definitions of health literacy focused specifically on individuals applying literacy skills (e.g., reading and writing) to health related materials. Health literacy has since been reconceptualized more broadly to include access to health information, interactive literacy (e.g., development of personal skills within a supportive environment), and critical health literacy (e.g., cognitive and skills development which support social and political action to address multiple determinants of health) (Nutbeam, 2000). The Canadian Public Health Association (CPHA) Expert Panel on Health Literacy defines health literacy as "...the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life course" (Rootman & Gordon-El-Bihbety, 2008, p. 9). This definition expands earlier conceptualizations of health literacy. That is, the individual is situated within a larger health-care system and societal context, a "variety of settings" which influence and contribute to an individual's ability and willingness to understand, communicate, evaluate, or access health information (Rootman et al., 2007; Wharf-Higgins, Begoray, & MacDonald, 2009). Health literacy is also viewed as a "reciprocal function of the health context and individual" (Nielsen-Bohlman, Panzer, & Kindig, 2004, p. 66). Access to information is mediated by contextual concerns such as the

communication skills of professionals and the type of supports provided (Rootman & Gordon-El-Bihbety), alongside the “degree of fit” between the individual’s skills and the health care system demands (Rootman, 2009).

Expanding perspectives on health literacy also include the idea of developmental mediation. Mancuso (2008) defined health literacy as a “process that evolves over one’s lifetime and encompasses the attributes of capacity, comprehension, and communication” (p. 250). Furthermore, Mancuso proposed a concept model of health literacy that signified the embedded competencies that are needed to attain health literacy (e.g., interactive competence, cultural competence). Freedman and colleagues (2009) also highlight the interactive nature of health literacy between individual and the community in suggesting health literacy encompasses two components: individual-level health literacy (as demonstrated in existing definitions), and *public health literacy*. Freedman et al. define public health literacy as “the degree to which individuals and groups can obtain, process, understand, evaluate, and act upon information needed to make public health decisions that benefit the community” (p. 448).

Conceptualizations of health literacy are expanding and offer new understanding of the *shared function* of health literacy (Gazmararian & Parker, 2005; Nielsen-Bohlman et al., 2004) and the interactive competence needed for a person to be health literate (Mancuso, 2008). Recent perspectives clarify health literacy as the “dynamic state of an individual during a health care encounter. An individual’s health literacy may vary depending upon the medical problem being treated, the health care provider, and the system providing the care” (Baker, 2006, p. 878). Health literacy includes a “relational” aspect (Kickbusch, 2001, p. 294), and is dependent on the “degree of fit” between the

individual's health literacy and the demands of the health care provider and larger health care system (Rootman, 2009). Furthermore, health literacy is based on the individuals' skills, within the context of the health-care system, the education system, and social and cultural factors (Nielsen-Bohlman et al., 2004). As the concepts of health literacy and mental health literacy continue to evolve, researchers need to consider the *relational* aspects of mental health literacy, such as between child and youth care professionals and suicidal adolescents. Deepening our understanding then of how child and youth care professionals realize mental health literacy practices in their encounters with suicidal adolescents encompasses emerging perspectives on health literacy as relational, dynamic, and contextual.

Mental Health Literacy

Expanding on the notion of health literacy, Jorm et al. (1997) introduced and initially defined *mental health literacy* as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (p. 182). Beyond knowledge and beliefs about mental disorders, Jorm and colleagues identified “knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking” as part of mental health literacy (p. 182). Mental health literacy has not undergone the conceptual evolution and development to the same degree witnessed in the field of health literacy, although some progression is evident. For example, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH, 2007) recently defined mental health literacy as the “knowledge, beliefs and abilities that enable the recognition, management and prevention of mental health problems” (p. 7). CAMIHM emphasized

the link between health literacy and mental health literacy indicating that the same set of skills and abilities are inherent in both concepts. In this section I provide an overview of the current research on mental health literacy. In particular, I highlight the populations investigated within mental health literacy studies, and provide a review and critique of the common approaches to research design.

Populations examined within mental health literacy research. General population studies can contribute to the present discussion in providing a foundational understanding of initial approaches to research design, provide information on the professional groups recognized within the general population as being resources for help when experiencing mental health concerns, and further illuminate how child and youth care professionals may be (in)visible as helpers in the larger mental health system of care. Secondly, I provide an overview of the existing mental health literacy research focused on examining professional populations including psychiatrists, psychologists, nurses, social workers, counsellors, occupational therapists, and members of the clergy. I reveal the importance of examining helping professionals' mental health literacy, while illuminating the gap in the current mental health literacy research with respect to child and youth care professionals.

General population studies on mental health literacy. As a relatively new concept, mental health literacy has received international attention. Jorm et al. (1997) initially conducted a large cross-sectional survey with structured interviews to assess the public's recognition of mental disorders and their beliefs about the effectiveness of various treatments. The 2031 Australian adult participants were presented with a depression or schizophrenia vignette, which depicted features of either disorder based on

the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Most of the participants identified the presence of a mental disorder, however only 39% and 27% correctly labeled depression and schizophrenia respectively. Additionally, physicians and counsellors were rated as more helpful than psychiatrists and psychologists. Despite the lack of empirical evidence, participants viewed self-help strategies such as taking vitamins or adjusting diet as more helpful than many evidence-based treatments or interventions. In this introductory study, Jorm et al. concluded that for early recognition of mental disorders mental health literacy needs to be raised in the general population.

Building on Jorm et al.'s investigation, Goldney et al. (2001) examined and compared mental health literacy amongst three groups: participants with depression, with major depression, and with no depression. Goldney et al. discovered many participants could not recognize major depression and held limited understanding of the availability and effectiveness of standardized treatments. Furthermore, less than 10% of the 3010 participants stated that seeing a psychiatrist, psychologist, or taking medication would help, and those with major depression were more likely to report they did not know who could help. Identifying who may be able to help and provide care for persons experiencing mental suffering is vital for both the person in psychological pain, and the helping professionals, such as child and youth care professionals, who may recognize and respond to a suicidal adolescent.

General population studies have also been conducted in Canada specifically assessing the public's knowledge about depression. In Alberta, Wang et al. (2007) surveyed 3047 adult participants and found 75% could correctly recognize depression.

Although this finding appears quite positive, recognizing a mental disorder is only one part of mental health literacy. Beyond recognition, the concept includes knowledge of treatments and interventions and appropriate resources for help. Over a quarter of the participants (28%) in Wang et al.'s study believed in dealing with depression alone, and 43% believed that a "weakness of character" was a likely cause of depression (p. 442). Adolescents reported a belief that individuals on their own should handle depression as well (Lindsey et al., 2006). As social isolation is associated with an increased risk for depressive symptoms and suicide attempts (Hall-Lande, Eisenberg, Christenson, & Neumark-Sztainer, 2007), it is imperative that suicidal adolescents experience connection.

Attitudes that promote recognition and seeking help, as well as beliefs about mental disorders are part of current conceptualizations of mental health literacy. Wang and Lai (2008) in Canada investigated personal stigma in relation to depression. Those who were able to recognize depression in the study were less likely to endorse attitudes such as depression being caused by personal weakness. Almost half (45%) considered people suffering from depression as unpredictable, and 20% thought they were dangerous. Wang and Lai concluded being able to recognize and label the mental disorder is not adequate enough for addressing stigma against persons with depression.

Attitudes of helping professionals with respect to suicidal persons may inhibit help seeking such that suicidal behaviour may elicit negative feelings amongst staff members in psychiatric wards towards their patients (Rossberg & Friis, 2003). Social workers practicing in mental health settings have reported feelings of dislike and lack of concern when working with suicidal patients, as well as viewing this population as

“irritating manipulators” (Newhill, 1989, p. 252). Furthermore, health professionals may not believe the suicidal threats are real (Alston & Robinson, 1992). Working with suicidal adolescents undoubtedly is challenging and may evoke negative attitudes in professionals. Child and youth care professionals endeavour to adopt attitudes that promote and celebrate the strengths of young people and value their individual uniqueness (Mattingly, & Stuart, 2002). Inquiry examining child and youth care professionals’ mental health literacy practices may reveal new understanding of how attitudes and beliefs are influence conditions in their encounters with suicidal adolescents, and open the door for new research possibilities in this area.

Based on Jorm et al.’s (1997) conceptualization of mental health literacy, Goldney and Fisher (2008) examined the mental health literacy of those with major depression, both with and without suicidal ideation, and those who were neither depressed nor suicidal in a general population study. Goldney and Fisher sought to determine if the various community and professional programs introduced in Australia to heighten the populations’ mental health literacy had had an impact since their previous study (Goldney et al., 2001). Out of the 3015 participants, 241 were classified as having major depression, 79 of whom also reported suicide ideation. Improvements were noted in mental health literacy for all participants; however those in greatest need of intervention and support, those experiencing both suicide ideation and major depression, had fewer improvements. Furthermore, those in greatest need had not improved in seeking out help and assistance. Their study demonstrates the effectiveness of broad-based efforts to increase mental health literacy in the general population. It also clearly identifies persons experiencing mental suffering and distress, major depression and

thoughts of suicide continue to be at great risk in not receiving help and raises further questions. For example, what are the help-seeking barriers for those in greatest need?

Olsson and Kennedy (2010) recently investigated young peoples' recognition of mental disorders and help seeking in a small town in the United States of America. Students enrolled in health or fitness classes in grades 6-12 were provided with a scenario depicting an adolescent experiencing behaviours and negative emotions associated with either a mental health problem (e.g., depression) or a teen problem (e.g., relationship break-up). Students were asked to identify what was wrong with the young person in the scenario, who could best help, and how they would respond if the young person were their classmate. Olsson and Kennedy found student participants in the study had low recognition of mental disorders and few students recalled in-class discussions pertaining to mental health in their course work. Students who were able to identify the mental health disorder depicted in the scenario were more likely to indicate they would respond and try to help the young person (e.g., telling an adult). As evidenced in the discussion on adolescent help seeking within this chapter, mental health literacy is a two-way project. Young people are co-constructors of the encounters with helpers, such as child and youth care professionals, and both adolescent and professional each brings their knowledge, attitudes, and beliefs to the interaction. Furthermore, as discussed above, literacy is not a fixed attribute of individuals. Adolescents may try to help a classmate by informing an adult; however, the help available, accessed, or offered is mediated by participants and contexts. Thus, how professionals realize mental health literacy practices during such encounters with adolescents requires examination.

Lauber, Ajdacic-Gross, Fritschi, Stulz, and Rossler (2005) used an online survey to examine university students' recognition of depression and schizophrenia and reported that the variability in mental health literacy amongst students was dependent primarily on their faculty affiliation. For example, Lauber et al. found higher mental health literacy amongst medical and psychology students, and lower mental health literacy for male students of natural sciences, economics, and philosophy. Stereotypes of schizophrenia being associated with violence and split personality also emerged. Lauber et al.'s study invites interest in investigating the mental health literacy practices of child and youth care professionals to develop understanding of how disciplinary orientation influences recognition of mental health concerns and stigmatizing beliefs about suicidal adolescents.

Current research investigating professionals' mental health literacy.

Professionals can be a valuable resource in providing help and support to persons experiencing mental health concerns; yet not all professionals are viewed as being an appropriate resource for discussing such concerns. For example, Bushnell et al. (2005) explored reasons why patients of physicians did not disclose psychological problems they were experiencing. A third of the 775 patients (33.8%) did not believe a physician was the "right" person to talk to, or believed that mental health concerns should not be discussed with anyone (27.6%). Physicians conceivably can recognize mental health concerns and have knowledge of risk factors and symptoms; however, it appears the person-in-need's perception of to whom to talk to is of utmost importance.

Parker, Chen, Kua, Loh, and Jorm (2000) assessed the mental health literacy of Singapore psychiatrists, nurses, occupational therapists, psychologists, and social workers using vignettes depicting mania, depression, and schizophrenia. Additionally, Parker et

al. sought to compare Australian psychiatrists with Singapore psychiatrists. The two groups of psychiatrists differed slightly in overall recognition of the mental disorders, though across the professional groups there was a high level of diagnostic accuracy. Of note, other than psychiatrists, 21% of the professionals believed it would be helpful for the patient to talk with family or friends, and 23% indicated that the person suffering from depression has to recognize they have a problem. The latter finding is relevant to child and youth care practice in regards to working with depressed or suicidal adolescents. A young person may not recognize the symptoms they are experiencing as depression and may be limited in their ability to communicate what they are experiencing with those closest to them. The professional, then, must be able to recognize mental health concerns and the presence of suicidality to support the adolescent communicating with others who can help. Furthermore, if child and youth care professionals hold a belief similar to almost a quarter of the professionals surveyed in the Parker et al. study (i.e., persons need to recognize they have a problem), they may be less inclined to provide support to a young person who is not openly communicating their mental health concerns to them.

To compare the mental health literacy of physicians between cultures, Parker et al. (2001) surveyed Australian and Singapore physicians utilizing a depression and schizophrenia vignette. Their study highlighted similarities across cultures in high diagnostic accuracy and high agreement amongst the professionals in judging the helpfulness of resource people and interventions. The main difference between the two groups of physicians was the view of outcomes for the mental disorders presented in the vignettes, in that physicians from Singapore had more optimistic perspectives on prognosis. Child and youth care professionals' optimism about life may serve as counter-

influence to suicidal adolescents' hopelessness. Optimism, then, may be relevant to explore in regard to how professionals realize mental health literacy practices.

Lauber, Nordt, and Rossler (2005) examined the mental health literacy of nurses, social workers, vocational workers, occupational therapists, psychiatrists and psychologists to determine if there was consensus among different professional groups regarding mental disorders, and compared their knowledge with that of the general population. Although the professionals were able to recognize the mental disorders presented, some professionals recommended treatment for a "non-case", which depicted no symptoms. The professional groups primarily differed in their opinions regarding treatment and interventions, and had different opinions than the general population about medication. Professionals' differing perspectives on mental health concerns in Lauber et al.'s study demonstrates the situated nature of mental health literacy such that professionals interpret mental health concerns from their respective locations (e.g., discipline, profession).

Extending beyond depression, schizophrenia, and mania as explored in previous studies, Hay, Darby, and Mond (2007) investigated health professionals' mental health literacy for bulimia nervosa. The 301 professionals included dietitians, psychologists, and counsellors. Almost half (49%) of their participants were able to recognize either bulimia nervosa or an eating disorder and endorse evidence-based approaches, such as cognitive behavior therapy, as the most helpful intervention. Themes identified by professionals included a lack of confidence and training in treating bulimia nervosa. Hay et al. suggest professionals' low mental health literacy may inhibit efficacious treatment should bulimia nervosa not be recognized or if knowledge of evidence-based

interventions to treat the disorder is unknown. Recognition, confidence, knowledge of evidence-based interventions, and education regarding specific mental health concerns may influence child and youth care professionals' practices during encounters with suicidal adolescents. Examining how professionals realize mental health literacy practices extends current research from measuring declarative knowledge (e.g., identifying evidence-based approaches to treating bulimia nervosa).

Research investigating health professionals' mental health literacy continues. In the United Kingdom, O'Reilly, Bell, and Chen (2010) examined pharmacists' beliefs about treatments and outcomes of mental disorders using a survey instrument to measure mental health literacy. The majority (e.g., 92% for depression, 79% for schizophrenia) of survey respondents were able to correctly identify the mental disorder depicted in the vignettes. Pharmacists were also more likely to support evidence-based interventions and suggest poor prognoses without professional help. O'Reilly et al.'s study illustrates further how current conceptualizations of mental health literacy are aligned with a traditional perspective on literacy, as discussed above, and lead to research approaches that seek to measure literacy within individuals (e.g., pharmacists). Furthermore, it remains to be seen whether attributes assigned to mental health literacy (e.g., beliefs about outcomes of mental disorders) influence or emerge within the interactional context.

In addition to investigations into health professionals' mental health literacy, Stansbury and Shumacher (2008) explored African American clergy's mental health literacy in regards to older congregants. Using a grounded theory approach, Stansbury and Shumacher discovered evidence of clergy's active response in addressing mental health concerns and socio-emotional problems with older congregants. As an informal

resource that people may turn to when experiencing distress or mental suffering, the authors conclude mental health literacy for clergy members could be enhanced through training and information regarding navigating the mental health system of care. Research examining how child and youth care professionals realize mental health literacy practices can explain how professionals currently access or navigate the mental health system and, similar to Stansbury and Shumacher's study, can support identification of information needs.

An overview of the current research on mental health literacy illuminates that child and youth care professionals, as a group, have yet to be examined. General population studies have sought to determine which groups of professional study participants identify as formal resources for help when experiencing mental health concerns. Child and youth care professionals were not offered to participants as an option for help to choose from in the current studies, and were not identified by participants as a group to turn to in times of mental health need. Furthermore, while current research sheds light on attitudes and beliefs about mental health concerns amongst other professional groups, child and youth care professionals' attitudes and beliefs remain undetermined. Thirdly, mental health literacy studies with other professional groups and university students in alternative disciplines have occurred. Current mental health literacy research is aligned with traditional notions of literacy such that researchers have focused on measurement within individuals and indicated higher mental health literacy levels within certain professional groups or disciplines. In the following section I examine further the common research design of mental health literacy studies.

Approaches to research design within mental health literacy studies. I suggest that mental health literacy has been conceptualized from the beginning based on traditional notions of literacy. As discussed above, traditional notions of literacy have focused on literacy being located within individuals, and maintain that literacy is comprised of measurable skills, and enhanced through schooling. In the following section I review definitions of mental health literacy and how current conceptualizations of mental health literacy have influenced research design in mental health literacy studies.

Jorm and colleagues' (1997) initial definition of mental health literacy followed a traditional or autonomous (Street, 1984), interpretation of literacy. For example, Jorm et al. identified knowledge about mental disorders as one aspect of mental health literacy. A person who is mental health literate is viewed by Jorm et al. (1997) as having the knowledge to be able to label a mental disorder based on criteria distinguished in the *Diagnostic and Statistical Manual of Mental Disorders* [DSM] (American Psychiatric Association, 1994).

Following the autonomous view of (mental health) literacy, much research in this field has focused in part on assessing participants' abilities to correctly name mental disorders (see for example Jorm et al., 1997; Kermode, Bowen, Arole, Joag, & Jorm, 2010; Leighton, 2010). To assess participants' knowledge, researchers provide brief vignettes depicting symptoms of a mental disorder as defined by the DSM (see Table 1). Mental health literacy is measured as low or high based on the individual participant applying the correct label. In some instances, vignettes depicting a 'non-case' are presented alongside the mental disorder vignette (see for example Olsson & Kennedy, 2010). Mental health literacy in these studies, then, is measured by knowledge of DSM

criteria and corresponding label of the disorder as well as participants' ability to recognize the absence of criteria.

Research methods in the mental health literacy field have relied on broad survey data and quantitative analysis to assess and measure individuals' literacy. As Gee (2007) suggests such methods of investigating literacy, "rips literacy out of its sociocultural contexts and treats it as a social cognitive skill with little or nothing to do with human relationships" (p. 67). To illustrate, the depression vignette offered by Jorm et al. (1997) depicts John, a 30-year-old man experiencing trouble sleeping, sadness, changes in eating habits, low productivity, and difficulty making decisions (see Table 1). Imparting an imaginary context around John, we may find at the micro-level, tension in his personal relationships, a birth of a child, or loss of a parent. At the macro-level, there could be decisions at the provincial government level that impact funding for his workplace resulting in layoffs and increased workload amongst remaining employees, like John, who feel overburdened with the added responsibility. John may meet the DSM criteria for depression; however, his mental health concern may be more a function of his sociocultural location than a disorder specifically located within John.

While the current conceptualization for mental health literacy may provide an architecture (Coe, 2009) or a framework for research (Ranahan, 2010), qualitative approaches, in conjunction with social literacy and critical literacy theories, can deepen our understanding of the "relational" aspects of literacy (Kickbusch, 2001, p. 294), and how mental health literacy is situated and realized within a social ecological context (Wharf-Higgins, Begoray, & MacDonald, 2009). Thus, there are opportunities to extend and re-envision the current conceptualization of mental health literacy to address

dissatisfaction with pathologizing terminology concerning mental health (Garvey, 2008).

For example, Garvey (2008) redefines mental health and mental illness from an

Indigenous perspective as “social and emotional wellbeing” as a way of considering

mental health holistically (para. 9). Health, and mental health, encompasses “the social,

emotional, spiritual and cultural wellbeing of the whole community” (Garvey, para. 11).

Table 1

Sample Vignettes Used in Mental Health Literacy Research

Jorm et al., 1997	<p style="text-align: center;">Depression Vignette</p> <p>John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.</p>	<p style="text-align: center;">Schizophrenia Vignette</p> <p>John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbor. They realize he is not taking drugs because he never sees anyone or goes anywhere.</p>
Olsson & Kennedy (2010)	<p style="text-align: center;">Depression Vignette</p> <p>Jenny is a 15-year-old girl who has been feeling unusually sad and miserable for the last several months. She is tired all the time and has trouble sleeping at night. Jenny doesn't feel like eating and she has lost weight recently. She can't keep her mind on her studies and her grades in school have dropped. She puts off making decisions and even day-to-day tasks seem too much for her. The people who know her are very concerned about her.</p>	<p style="text-align: center;">Teen Problem (non-case) Vignette</p> <p>Mandy is a 10th grader. She is a good student and a member of the school volleyball team. Four days ago, Daniel, her boyfriend of 8 months, dumped her. Daniel told her he had met another girl who he liked more than her. Mandy has been a wreck for the past 3 days – she is crying all the time and can't concentrate on her schoolwork. She keeps asking her friends ‘What is wrong with me that Daniel doesn't love me anymore?’ She is especially upset because she and Daniel were supposed to go to the spring formal together, and now she won't have anyone to go with.</p>

Kermode,	Depression Vignette	Psychosis Vignette
Bowen, Arole, Pathare, & Jorm (2009)	Meena is 30 years old and was fine until six months ago when she began to feel tired all the time. She says that she is sad and has lost interest in life. Even her children and family don't make her feel happy. She cannot sleep and she has lost the taste for food, which she used to love. She has also lost interest in cooking because she can't concentrate. Sometimes she feels like jumping in the well to end her life.	Ram is 21 years old and is not married. He used to regularly help his father work on the farm, but for the last 10-15 days he has not been going to work. For the last 2-3 months he has been staying alone and aloof. He has not been bathing regularly and sometimes becomes aggressive for no apparent reason. He never used to behave in this way. On several occasions his father has found him talking to himself when nobody else was around. He has become suspicious of others and says that people are talking about him. For the last one week he has refused to eat food as he suspects his food is being poisoned by the neighbors.

Moving away from locating the mental health concern within individuals, Garvey recognizes the situatedness of mental health within the community context. Chandler and Lalonde's (1998) identification of six cultural continuity factors within individual Aboriginal communities and the corresponding link between the presence or absence of adolescent suicide further illustrates the need to reconsider mental health literacy within a sociocultural context. Adolescent suicide rates were significantly lower when all six cultural markers (i.e., self-government, active steps to secure land claims, band controlled schools, health services, cultural facilities, police and fire services) were in place within a community (Chandler & Lalonde). It is evident from their study, and drawing upon critical and social literacy theories that mental health and thus mental health literacy must be viewed contextually. Opportunities abound for research to move beyond measurement and determination of mental health literacy levels within individuals, to re-conceptualizing and expanding notions of mental health literacy as a complex, contextualized, social practice. Contemporary approaches to suicide education may, in part, contribute to understanding how mental health literacy is presently constructed and

measured as an individual characteristic. In the following section, I provide an overview of current pre- and in-service approaches to suicide education.

Current Landscape of Suicide Education

From a traditional perspective, literacy and schooling are inextricably intertwined (Gee, 2007). Thus, efforts to enhance mental health literacy commonly include creating and providing educational programs. Educational interventions, including awareness campaigns, have targeted specific populations such as postsecondary students (Potvin-Boucher, Szumilas, & Sheikh, 2010), or female adolescents (Pinto-Foltz, 2010), as well as the general population (Hickie, 2004). As my research interests are focused on child and youth care professionals' mental health literacy practices with suicidal adolescents, approaches to suicide education are an area of content that requires review and explication.

In the following section, two pathways to education in suicide prevention intervention are reviewed. First, I examine how and to what extent suicide is addressed through *pre-service* education across a variety of disciplines. It is useful to review how suicide content is taken up across disciplines as child and youth care professionals may, or may not, acquire their qualifications within schools of child and youth care despite practicing in the field (Anglin, 1999). Secondly, I explore the role of *in-service* education in suicide prevention provided to professionals by their employers through workshops and continuing education opportunities. *Pre-service* denotes educational activities which take place prior to a person taking up a job that requires specific training, and *in-service* refers to educational activities for persons after they are already employed (World Health Organization, 2004). Lastly, based on a view of literacy as situated and local (Street,

2009), I examine the epistemological assumptions of education leading to competence, or essentially, the link between schooling and literacy.

Pre-Service Education

Undergraduate education. In my review of the relevant literature, I found that the role of colleges and universities in educating future professionals in suicide prevention intervention at the undergraduate level has received limited attention. Many professionals providing direct care to young people obtain undergraduate degrees in disciplines such as social work, child and youth care, sociology, psychology, education, or applied human sciences. On occasion, professionals may be hired into positions to work with young people with formal education, such as an undergraduate degree in philosophy, which may be seemingly irrelevant to their actual practice (Anglin, 1999). Pedagogical approaches vary across disciplines. Some professional programs, such as child and youth care, education or social work, offer field placement experience in conjunction with theoretical content provided in the classroom, whereas programs, such as psychology, typically provide primarily theoretical content as preparation and the foundation for future graduate study. In some cases, programs of study explicitly state further in-service training after completion of an undergraduate degree may be required (University of Victoria, Department of Psychology, 2009).

While the content of many nursing and social work programs at the undergraduate level provide professionals with broad knowledge and skills (Peters, 2003), perspectives in child and youth care work have articulated a generalist approach to practice with children, youth, and families (Anglin, 1999; Eisikovits & Beker, 2001). Child and youth care generalists are concerned with all aspects, or the totality of the young person's

functioning, and operate alongside professionals from other disciplines who may be focused on one particular aspect of functioning. For example, Anglin (1999) maintains that teachers are primarily concerned with a young person's education. Providing broad-based education with the goal of creating generalists has the potential to limit many university-educated professionals in preparing them for specific incidents such as those involving suicide. In spite of the relative dearth of literature focusing on the role of universities in preparing undergraduate students for encounters with suicidal adolescents, a small number of studies have highlighted how topics related to suicide or child and youth mental health are included within university curriculum content across a range of disciplines.

Suicide content within introductory psychology curriculum. Undergraduate students within various disciplines are often required as part of their program of study to complete an introductory course in psychology. The course may contribute to students' preliminary understanding of suicide, or may be one of the few times the topic of suicide is discussed in their undergraduate education. In an effort to explore how topics related to death and dying were taken up in psychology courses, Coppola and Strohmets (2002) analyzed 28 introductory textbooks published between 1995 and 2000. While all of the textbooks in their study included some information about death and dying, on average only one to two pages per textbook were dedicated to this particular aspect of human lifespan development. Coppola and Strohmets also examined the nature of the discussion and found the topic of suicide was discussed most frequently. A general discussion regarding attitudes towards death, however, was only included in 8 of the 28 textbooks. As negative attitudes held by professionals encountering suicidal adolescents are well-

documented in the literature (Alston & Robinson, 1992; Newhill, 1989; Rossberg & Friis, 2003), can impact adolescent help-seeking when experiencing mental health concerns (Freedenthal & Stiffman, 2007; Wang & Lai, 2008), and are a part of current conceptualizations of mental health literacy (Jorm et al., 1997), more substantial discussion on attitudes towards death and suicide could be seen as benefitting undergraduate students who may encounter young people at risk in their future professional roles.

Suicide education within schools of public health. Reframed recently as a preventable public health problem (Browne, Barber, Stone, & Meyer, 2005), adolescent suicide may be a topic to be explored within Schools of Public Health (SPH). However, few formal educational opportunities are provided to students in SPH in the United States (U.S.) on prevention of youth suicide in comparison to other public health problems (Browne et al.). In a 2002-2003 inventory of the accredited SPH in the U.S., Browne et al. found only one course out of 163 mentioned suicide in its title, and none focused exclusively on suicide. While a few SPH require course work at the doctoral level on intentional or unintentional injuries, little is offered on suicide prevention for students at the master's or undergraduate levels. Inevitably, professionals obtaining entry-level positions with undergraduate qualifications from SPH may enter the workforce without a sufficient level of preparation for encounters related to suicide.

Suicide prevention curriculum for undergraduate medical students.

Physicians may be one of the first professionals to encounter a person at risk of dying by suicide. In investigating suicide deaths of persons under the age of 19, Farand, Renaud, and Chagnon (2004) found 78% had accessed medical services during the 12 months

prior to their death. However, preparation at the undergraduate level for medical students in suicide prevention is limited. For example, an Australian survey of medical schools revealed only 43% of undergraduate students ($n = 373$) reported formal training in suicide prevention (Hawgood, Krysinaka, Ide, & De Leo, 2008). In the same survey students self-rated their skills in suicide prevention (e.g., working with suicidal persons, intervention skills, and referral abilities) as low or moderate, and self-rated their knowledge-based items (e.g., problem-solving, interpersonal skills, and worker self-management) as moderate or high. Hawgood et al.'s study identified the need for a comprehensive approach to suicide prevention education in which knowledge is intertwined with pedagogical approaches for developing practical skills in suicide intervention.

Combining theoretical knowledge with practical experience. In a recent study, Henderson, Happell, and Martin (2007) explored second-year undergraduate nursing students' knowledge, skills, and attitudes after course work in mental health theory and clinical placement in a mental health setting. Exposure to a longer duration of course work in mental health theory influenced students' knowledge, skills, and attitudes. Students, who completed 25 hours of theoretical preparation were compared with students who had completed 35 hours of preparation prior to commencing a clinical placement in a mental health setting. Students who received the greater number of hours reported higher confidence in their skills in assessing violence, performing mental status examination, differentiating between delirium and dementia, differentiating between intoxication and psychosis, communicating with anxious patients, working well with patients with self-inflicted injuries, triaging mental health problems, and communicating

effectively with people who are suspicious or paranoid. Additionally, students who were exposed to longer course work completed a written assignment on suicide prior to their placement whereas the others did not. This former group of students self-reported higher confidence in skilfully assessing suicide risk, knowledge of the legal parameters of mental health care, and more confidence in their attitudes in understanding patients who harm themselves. Henderson and colleagues did not specify the specific theories studied by students, however, the self-reported increase in confidence and skills based on a greater amount of course work combined with field placement experience illuminates the need for further inquiry examining the interaction between education and mental health literacy in practice.

Suicide education across pre-service programs. Coordinators of undergraduate and post graduate programs for medicine, nursing, psychology, social work, theology, education, pharmacy, law, and journalism in Australian universities were asked to identify where knowledge, skills, and attitudes related to suicide prevention were taught in the curriculum (Hazell, Hazell, Waring, & Sly, 1999). The researchers assumed graduates of these specified programs were likely to encounter people at risk of suicide in their future professions, and were thus positioned to refer them to professional help, or had the capacity to enact social or environmental change. Although schools of child and youth care were not included, the study offered one of the first reviews of suicide prevention content in the world across a range of disciplines within pre-service programs.

Within seven of the nine programs surveyed by Hazell and colleagues, program coordinators identified topics related to suicide prevention as being included in course content. Specific items from each of the domains of knowledge (e.g., sociological,

psychological, and biological theories of suicide, commonly used means of youth suicide), attitudes (e.g., awareness of how own attitudes to suicide may effect the professional's role in prevention and management), and skills (e.g., how to elicit information from young people to allow the assessment of mental health problems) were rated in terms of inclusion in course content. Using a threshold of 70% of the items in the survey under each domain as an indicator of acceptable penetration into university courses, Hazell and colleagues identified nursing and medical schools as providing the most comprehensive coverage. Knowledge and attitude content items consistently were identified more frequently by coordinators than skill items across programs. The researchers concluded suicide prevention topics have penetrated into university programs across several disciplines, each with varying emphasis on knowledge, skills, and attitudes. Opportunities remain for further exploration of pedagogical approaches used in suicide education and how pre-service programs influence mental health literacy practices when professionals encounter situations involving suicide.

Child and youth mental health content in pre-service programs. Child and youth mental health specific content is difficult to isolate within a particular undergraduate program because it is often incorporated into existing curricula especially if individual faculty were particularly passionate and experienced in this area (Peters, 2003). In an effort to identify training needs and barriers to attracting undergraduate students into practice in child and youth mental health settings, Peters examined the nature and extent of child and adolescent mental health content in nursing, social work, and occupational therapy programs at the undergraduate level within the University of Auckland, New Zealand. A certificate program in community support work and a

counselling program were also included in the study. Forty-two participants from university settings and training programs were interviewed and a sample of course materials and websites were examined.

All of the curricula within undergraduate nursing programs in the study had some focus on adult mental health areas. On average, one to three hours focused specifically on child and adolescent populations within nursing programs. Content on adolescent suicide was identified as being provided within this time period. Field placements were found to be extremely limited in child and youth mental health settings (i.e., one to two students securing a placement each year).

Similar to nursing, all of the social work programs emphasized adult mental health content. Little attention was paid to child and adolescent mental health, and even less to specific mental health problems such as suicide. Social work field placements in child and adolescent mental health were often restricted to those students who already had mental health experience as service providers did not view mentoring of students as a priority in the midst of other responsibilities.

In comparison to nursing and social work, occupational therapy programs had a strong emphasis on mental health content (Peters, 2003), although adolescent suicide was not identified specifically in the programs' curriculum.

Lastly, two programs offering diplomas in counselling were examined by Peters (2003) for child and adolescent mental health content. Both programs primarily focused on adult content with emphasis on interpersonal communication skills, reflective practice, and various issues such as trauma, grief and loss, and group process. A diploma program in community support work offered content in recovery, people skills, and home-based

care; however, there was no mention of suicide in the curriculum content, and the program focused solely on adult populations. One certificate program in youth work included in the study identified suicide as briefly addressed in the curriculum.

Peters' (2003) comprehensive examination of child and adolescent mental health content in various undergraduate, diploma, and certificate educational programs within New Zealand is useful to our current understanding of how pre-service programs prepare students with the knowledge, skills, and attitudes for encounters with suicidal adolescents. Peters recommends the following:

- (a) develop a national requirement for inclusion of child and adolescent content in curricula, (b) establish incentives for university and post secondary institutions to undertake teaching in child and adolescent issues, and (c) advocate for professional agencies to make child and adolescent content a requirement for registration. (p. 2)

As suicide is a leading cause of death amongst young people (WHO, 2008), enhancing the child and adolescent mental health curricula may result in greater penetration of suicide education across university programs and provide future opportunities for examining education influences mental health literacy practices.

Graduate programs. Graduate education, including course work, internships, or practica, may be considered by some professionals as the most appropriate place for training in working with suicidal persons (Bongar & Harmatz, 1989, 1991). While graduate programs may offer students opportunities to specialize in certain areas or enhance their knowledge and practical skills through supervised field placement opportunities, historically the study of suicide has been limited. In Bongar and Harmatz's

(1991) examination of the current levels of training in the study of suicide within accredited schools of psychology in the United States, 56% of the National Council of Schools of Professional Psychology (NCSPP), and 35% of the Council of University Directors of Clinical Psychology (CUDCP) programs offered formal training in suicide during the 1988-1989 academic years. With training provided most often in the form of a lecture, the Bongar and Harmatz recognized the limitations of the banking model of suicide education: “We must be careful to guard against the conception of training in the study of suicide as a mechanical dissemination of factual knowledge...” (p. 241) and ensure there are learning opportunities for developing and practicing skills in suicide intervention prevention as well. To extend Bongar and Harmatz’s recommendations, from the perspective of New Literacy Studies conceptions of literacy education, Street (1997) contends that suicide educators and curriculum designers must account for “the variation in meanings and uses that students bring from their home backgrounds to formal learning contexts” (p. 47). That is, current approaches to suicide education may be re-envisioned to include opportunities for students “to recognize the role of institutional, historical and sociopolitical forces in the emergence of hopelessness and suicidal despair” (White & Morris, 2010, p. 2193)

Beyond lectures, some graduate programs may offer internships where they have the opportunity to practice and apply skills and integrate knowledge from formal course work. Internships may also provide opportunities for encounters with suicidal persons, yet without the requisite preparation at the undergraduate level or course work at the graduate level, students may face these encounters with little preparation. For example, 238 pre-doctoral psychology interns in the U.S. reported treating at least one suicidal

person during their graduate training, yet only half of the interns reported receiving formal suicide education through their graduate program (Dexter-Mazza & Freeman, 2003). Of particular interest to the present discussion on encounters with suicidal adolescents, 63% of the psychology interns surveyed reported treating suicidal young people between the ages of 15 and 24, and 38% treating young people under the age of 14. Suicide assessment and crisis response were the main topics for the majority of students who had received formal training in their graduate programs and yet only 16% reported receiving training in the ongoing care of suicidal clients. Similar to Bongar and Harmatz's (1991) earlier findings, almost two-thirds (73.8%) of the psychology interns had received their suicide education through lecture. In spite of the apparent lack of formal suicide education for half of the participants in the study, the psychology interns self-reported a high level of confidence in their abilities and knowledge in suicide intervention prevention. Although Dexter-Mazza and Freeman (2003) caution that students' confidence in their competence in practice with suicidal persons may be unwarranted as many have not received formal training within their graduate programs, their study troubles the assumption there is a link between schooling and literacy. Literacy acquisition may also be a function of contextualized apprenticeship and drawing on prior experience (Gee, 2010). How mental health literacy practices are realized and the conditions influencing such practices thus require further investigation.

School-based professionals' preparation for suicide prevention activities. As an environment where adolescents congregate daily, schools have the proximity and opportunity to provide young people at risk of suicide with professionals who are prepared for encounters involving suicide. School psychologists report filling various

suicide prevention roles including crisis intervention, suicide risk assessments, coordinating referrals, counselling support for suicidal young people, or facilitating suicide education for teachers and other school personnel (Debski, Spadafore, Jacob, Poole, & Hixson, 2007). However, in a questionnaire mailed to a random sample of members of the National Association of School Psychologists in the USA, less than one-half (40%) of the 162 participants reported education in suicide risk assessment during their graduate training (Debski et al.). Even though 93% reported participating in various suicide prevention roles and 77% indicated they had received a referral for a potentially suicidal student in the past two years, the majority of participants reported receiving their training through professional development workshops, self-study, or in-service training. Nearly all (93%) acquired this training after a young person's death by suicide, highlighting the gap in suicide content between pre-service and in-service education. Debski et al.'s study also raises the question as to how the experience of an adolescent dying by suicide intersects with a professional's education, and mental health literacy practices during encounters with suicidal adolescents. Conditions, such as experience and education, influencing how child and youth care professionals realize mental health literacy practices require examination.

High school health teachers may also play a role alongside school psychologists and other school personnel in responding to young people at risk of dying by suicide. In a survey of 228 health teachers, 47% of the participants reported receiving suicidal communications from a student, yet over half (58%) indicated suicide prevention education had not been offered within their school in the past five years (King, Price, Telljohann, & Wahl, 1999). While the majority (86%) felt they were able to refer a

student at risk to a counsellor, only 9% believed they could recognize a young person at risk of attempting suicide. Over half (65%) of the participants in the study held graduate degrees, yet they reported professional journals and workshops as being the primary source of education in suicide prevention. Only 46% indicated receiving information on youth suicide during their pre-service programs.

King and colleagues' (1999) study again highlights the apparent gap in suicide education between university programs and continuing education opportunities, with neither providing comprehensive training and preparation for professionals encounter young people at risk of suicide. Their study also reveals that students will seek out professionals and communicate their concerns and thoughts of harming themselves; however, health teachers, in this instance, may not be prepared or able to recognize those who cannot verbalize their suicidality.

Suicide education for Master's-prepared social work professionals. Research has also demonstrated little suicide education within social work programs at the graduate level even though social work professionals report working with persons at risk of suicide (Feldman & Freedenthal, 2006; Sanders, Jacobson, & Ting, 2008). For example, in a mixed methods national study in the U.S., Sanders and colleagues surveyed a random sample of self-designated mental health social workers ($n = 515$) to determine the prevalence in their practice of the experience of suicide attempts or deaths by suicide. Fifty-five (55%) per cent of their sample had experienced at least one client suicide attempt, and 33% experienced both a client's death by suicide and a suicide attempt by a client. While all of the participants in the study had obtained a minimum of a Master's degree in social work, of those who reported experiencing a client's death by suicide,

48% ($n = 76$) indicated they had received suicide education prior to the event, and 30% ($n = 47$) received training after the client's death. The social work professionals' reports of obtaining suicide education after a death is similar to reports by school psychologists (Debski et al., 2007).

In a related study, Feldman and Freedenthal (2006) also sought to determine the prevalence of encounters with suicidal persons amongst Master's level social workers. In contrast to Sanders and colleagues (2008), who specifically focused on self-designated mental health social workers, Feldman and Freedenthal surveyed professionals practicing social work across a range of settings including child welfare, nonpsychiatric and psychiatric hospitals, private practice, school settings, nursing homes, substance abuse services, and outpatient mental health. Over half (53.4%) of the 598 social workers who completed the web-based survey reported working with at least one person contemplating suicide in the previous month, and 92.8% reported encountering at least one suicidal client over the span of their professional social work practice.

Approximately one-fifth (21.2%) of the participants indicated they received formal training through course work focused on suicide, and 61.2% received education in suicide intervention prevention through their field placements. Two-thirds (67.4%) reported they did not receive enough training in their Master's level programs to work with persons at risk of suicide, though 72% agreed that after their graduate preparation they had obtained "enough knowledge on suicide intervention to work as effectively as possible with suicidal clients" (p. 471). Feldman and Freedenthal's study reveals the likelihood of encountering a person at risk for suicide in a range of social work practice settings and where suicide education is located, such as within graduate course work or field

placement experience. The findings from this study also invite further inquiry as to how, and to what extent, professionals' suicide education from course work or field placements is realized during their encounters with suicidal persons.

As evidenced in my review of the literature, pre-service programs do not appear to include suicide education comprehensively with many professionals seeking in-service education after graduation in suicide intervention prevention. To further address the aim of this section, in identifying how, and to what extent, professionals are prepared for encounters with suicidal young people, an overview of in-service programs is offered.

In-Service Education

Strategies to prevent suicide often include efforts to provide education to the general public, primary care physicians, or community gatekeepers (Mann, et al., 2006). Professionals often build on their university preparation through in-service programs. Suicide prevention intervention workshops may be voluntarily attended to enhance one's professional development based on personal interest, or may be offered by employers as part of a mandatory training program and orientation. These workshops are often referred to as *gatekeeper training* and are part of a suicide prevention strategy that is based on "seeking out people at risk for suicide for referral and eventual treatment" (Isaac, et al., 2009, p. 261). As reviewed above, attention to suicide education within pre-service programs varies. Professionals may seek out and benefit from gatekeeper training to be able to identify young people at risk for suicide and supporting them to seek further help and treatment in the larger continuum of care.

Defining gatekeeper training. Teachers, school counsellors, parents, police, youth workers, clergy, and other members of the public may be offered suicide education

through gatekeeper training (Burns & Patton, 2000). In-service programs are based on the premise that persons at risk of dying by suicide may exhibit warning signs of needing help to others. Paulson and Worth (2002) note “suicidal individuals often communicate their thoughts to someone” (p. 86), and young people frequently report they prefer informal sources of help rather than formal, or professional, sources of help. Adolescents identify family members, close friends, and partners as individuals to whom they would disclose emotional problems and mental health concerns (Booth et al., 2004; Burns & Rapee, 2006; Ciarrochi, Wilson, Deane & Rickwood, 2003; Gilchrist & Sullivan, 2006). While close relationships may be the preferred source of support, many professionals, such as child and youth care professionals, teachers, or school counsellors may be positioned within close proximity of a young person thinking of suicide and be able to recognize and respond to their distress. Gatekeeper training programs are designed to increase participants’ self-confidence in suicide intervention, recognize warning signs, increase their knowledge of mental health services available (Burns & Patton), reduce stigma associated with help-seeking, and promote organization-wide awareness of mental health and suicide (Mann, et al., 2006). A brief overview of standardized gatekeeper training programs is offered in Table 2. In the following section, I review the research literature evaluating standardized and non-standardized gatekeeper in-service programs.

Evaluation of In-Service Suicide Education

While it is difficult to determine the effects of gatekeeper training on suicide rates due to educational strategies often being part of a larger network of suicide prevention efforts (Isaac, et al., 2009), studies have reported improvements in professionals’ knowledge, attitudes, and intervention skills of both standardized and non-standardized

suicide education programs (e.g., Chagnon, Houle, Marcoux, & Renaud, 2007; Hayes, Shaw, Lever-Green, Parker, & Gask, 2008; Oordt, Jobes, Fonseca, & Schmidt, 2009).

Table 2

Overview of Standardized Gatekeeper Training Programs

In-service Program	Target Group	Content	Pedagogical Approaches
Mental Health First Aid	<ul style="list-style-type: none"> • general population • social workers • school teachers • community nurses • child and youth care professionals 	<ol style="list-style-type: none"> 1. Assess risk of suicide or harm 2. Listen non-judgmentally 3. Give reassurance and information 4. Encourage person to get appropriate help 5. Encourage self-help strategies 	<ul style="list-style-type: none"> • Slides • Videos • Discussions • Role-play • Group activities
Program Length			
12-hours			
Skills-based Training on Risk Management	<ul style="list-style-type: none"> • non-psychiatrically trained workers (e.g., nurses, volunteers, social service workers) 	<ol style="list-style-type: none"> 1. Risk assessment 2. Crisis management 3. Problem solving 4. Crisis prevention 	<ul style="list-style-type: none"> • Video demonstration • Role-play • Group discussion • Didactic teaching
Program Length			
8-hours			
Applied Suicide Intervention Skills Training	<ul style="list-style-type: none"> • general population • helping professionals (e.g., social workers, teachers, child and youth care professionals, nurses) 	<ol style="list-style-type: none"> 1. Recognize attitudes about suicide 2. Discuss suicide in direct manner 3. Identify risk alerts and develop safeplans 4. Demonstrate intervention skills 5. List resources available 6. Commit to improving community resources. 	<ul style="list-style-type: none"> • Didactic teaching • Large and small group activities • Videos • Slides • Role play
Program Length			
14-hours			
Question, Persuade, and Refer	<ul style="list-style-type: none"> • general population 	<ol style="list-style-type: none"> 1. Listening to person's concerns 2. Clarifying warning signs 3. Referring person to a professional 	<ul style="list-style-type: none"> • Didactic teaching • Role play
Program Length			
1-2 hours			

Chagnon and colleagues (2007) focused specifically on evaluating the effectiveness of a non-standardized gatekeeper training offered to youth work

professionals in Quebec. The 3-day training program, provided 1 day a week over 3 consecutive weeks, aimed to improve participants' attitudes toward suicide intervention with adolescents as well as enhancing their knowledge of the following:

- (1) risk and protective factors, distress cues, and signs of mental disorder;
- (2) persons to contact and professionals for referrals; and
- (3) actions to take in a suicidal crisis situation, as well as following an attempted or completed suicide.

(p. 137)

Teaching methods used in the program consisted of lectures and role plays. Participants showed statistically significant improvements in their knowledge, skills, and attitudes immediately after the training. Significant improvements in the ability to identify a young person at risk and in intervention were also noted immediately after the training. Skills were measured by having the helpers view simulations and clinical vignettes on videotape, then describe and justify their interventions. The researchers followed up with the participants 6 months after training to determine if a short suicide prevention intervention training program would have lasting effects on professionals' knowledge, skills, and attitudes. Gains continued with respect to attitudes, however participants' increase in knowledge and skills as measured immediately after the training were not maintained over the six month period. Gatekeeper training programs are relatively short interventions (i.e., from one hour to two full days), and Chagnon et al.'s study illuminates the limitations of short in-service programs on retention of learning. While there may be a need for comprehensive and ongoing suicide prevention in-service training to adequately prepare professionals for encounters with suicidal adolescents, the falling off of participants' perceived knowledge and skills also raises questions as to the

applicability or usefulness of the in-service program in the dynamic, contextualized interaction between professional and adolescent.

Some research suggests professionals with graduate level qualifications, and thus extended university education, also benefit from in-service opportunities. A 12-hour in-service program offered to participants in Oordt et al.'s (2009) study consisted of four hours dedicated to suicide assessment, four hours focused on the management and treatment of suicidal clients, and the final four hours focused on military-specific content areas and issues related to the care of suicidal Air Force personnel. The program was provided to psychologists, clinical social workers, psychiatrists, psychiatric nurses, and mental health technicians, and who primarily had graduate level university preparation. Participants reported that they made changes to their practices and policies (e.g., follow up with high-risk patients who do not keep scheduled appointments, screening of all patients accessing services for suicide) as a result of the education intervention. The 82 professionals who participated in the program were active duty U.S. Air Force mental health professionals with advanced education at the master's and doctoral levels; however, almost half of the participants (43%) reported having little or no formal training in suicide assessment and management, and 42% reported little or no continuing education in suicide intervention prevention post-graduation.

The results demonstrate graduate-level pre-service programs do not necessarily encompass suicide prevention intervention topics for professionals who work directly in mental health services. How professionals learn, acquire, and use knowledge during encounters with suicidal persons may be taken up in mental health literacy research.

Mental health first aid. In response to several studies investigating mental health literacy amongst the general public, the Mental Health First Aid (MHFA) training course was developed in Australia (Jorm, Kitchener, Kanowski, & Kelly, 2007). Previously in this chapter, mental health literacy was defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, para.1). Based on the premise that members of the public can provide assistance and support to someone experiencing a mental health concern, and identifying deficits in mental health literacy within populations (Jorm, Wright, & Morgan, 2007; Jorm & Wright, 2007; Jorm, Kelly, Wright, Parslow, Harris, & McGorry, 2006), the MHFA training course was developed to address the public’s assumed need for knowledge and skills in responding to mental health concerns.

Findings from research efforts suggest participation in the MHFA program influences practice. For example, in a qualitative study 19-21 months after attending the MHFA program, 78% of participants reported having encountered situations where they used the course content, that the course enabled them to take steps leading to a better outcome than might have occurred otherwise, and that they experienced increased empathy and confidence in managing crisis situations (Jorm, Kitchener, & Mugford, 2005). Further qualitative inquiry exploring how mental health literacy practices are realized would deepen our understanding of the links between in-service programs and practice.

Skills-based training on risk management. A suicide prevention training package entitled *Skills-Based Training on Risk Management (STORM)* (Morriss, Gask, Battersby, Franchescini, & Robson, 1999) was initially developed for front-line staff in

the United Kingdom (UK) working for the National Health Service (NHS). STORM aimed to develop skills and competence in the assessment and management of suicide risk in an interview situation (Hayes et al., 2008). Research findings suggest workers (e.g., nurses, voluntary workers, social service workers) experienced improvements in confidence, eliciting suicidal ideas and plans, risk assessment and management skills (Morriss et al.).

The STORM program was adapted in a later study for staff working within prison settings in the UK (Hayes et al., 2008). The 161 participants showed significant improvements in their positive attitudes toward suicide prevention, knowledge of risk issues, and confidence immediately after the training.

Applied suicide intervention skills training. As a gatekeeper training program specifically focused on suicide intervention prevention, Richard Ramsay, Bryan Tanney, Roger Tierney and William Lang developed Applied Suicide Intervention Skills Training (ASIST) in the early 1980s in Canada. This partnership is now recognized as *LivingWorks Education, Inc.* whose mission continues to be “the development and distribution of a standardized, quality-controlled suicide first aid training program that enhances the suicide prevention skills of a broad range of community caregivers” (LivingWorks Education Inc., 2007, p. x). The training program is offered as a two-day intensive workshop with the goal of enhancing participants’ abilities to assist a person at risk for suicide.

Though widely recognized and implemented, limited research has evaluated the ASIST program, yet results from Guttormsen, Hoifodt, Silvola, and Burkeland’s (2003) evaluation of the program indicate increased confidence amongst participants. For

example, participants reported feeling more secure in talking about suicide and feeling relieved by having acquired an approach as to how to intervene. Tierney (1994) also found participants in the ASIST program increased their skills in suicide intervention (e.g., asking directly about suicide) after attending the workshop.

Question, persuade, and refer. Similar to MHFA and ASIST, the Question, Persuade, and Refer (QPR) gatekeeper program is based on helpers providing first aid intervention to persons at risk of suicide (Quinnett, 2007). While the program recognizes the role of community members in responding to warning signs of suicide, the emphasis is on referring the person to a professional who is able to assess the risk and provide ongoing care.

Efforts to evaluate the effectiveness of the QPR training program have occurred. For example, after a one-hour in-service training for 76 nonclinical employees in a university hospital workplace setting, approximately half of the participants demonstrated some improvements in demonstrating gatekeeper skills at post-training (Cross, Matthieu, Cerel, & Knox, 2007). An observational measure was developed and used specifically to rate presence of specific skills (i.e., active listening, clarifying questions, asking the suicide question, persuasion to get help, referral to care) during role-plays. Six weeks after the training at follow-up, 29 participants demonstrated a wide range of skills during role-plays including asking directly about suicide, persuading the individual to accept help, and referring to community mental health services identified by the researchers as appropriate sources for suicide care. While significant improvements were reported in participants' declarative and perceived knowledge after training than before, Cross and colleagues suggest that knowledge improvements alone may not suffice for deployment

of gatekeeper skills during encounters with suicidal persons and more emphasis is needed on the practical application of skills.

Additionally, QPR training has shown some promising results for a sample of Residence Life Advisers (RA) supporting students within US college settings. Using a quasi-experimental design to empirically evaluate QPR training, Tompkins and Witt (2009) asked RAs to self-evaluate their knowledge of suicide (e.g., facts about suicide prevention, suicide warning signs), knowledge of resources (e.g., local resources for help with suicide, school's policies for helping students contemplating suicide), efficacy (e.g., comfort level in discussing suicidal issues with students), reluctance (e.g., encouraging suicidal students to get help), self-efficacy (e.g., confidence in helping someone who is suicidal), and gatekeeper behaviours (e.g., asking about thoughts of suicide). The RAs reported increases in preparation, efficacy, and intentions to act as gatekeepers for suicidal students. Of interest, these improvements did not translate into changes in self-reported enactment of key gatekeeper behaviours during follow-up approximately six months after the training. Tompkins and Witt suggest further program evaluations are needed that are able to incorporate several control conditions (e.g., duration of training, format of training). The study illuminates both the need for further investigation into how in-service programs influence mental health literacy practices during encounters with persons thinking of suicide.

A one-year follow-up of QPR based on a randomized controlled trial involving 249 secondary school staff in the US also showed varied effects (Wyman et al., 2008). Staff reported increases in preparation and efficacy to act as a gatekeeper for young people at risk of suicide, whereas training reportedly resulted in a medium-size impact on

increasing knowledge (e.g., accuracy in identifying warning signs and risk factors).

Additionally, the QPR program had a limited effect on increasing staff members' queries of students about suicide. Only 14% of participants asked more students about suicide after attending the QPR training program, yet these participants also showed greater communication with students at baseline prior to attending training. Wyman et al.'s study calls into question the assumption that schooling, or in-service education, prepares participants for encounters with adolescents experiencing mental health concerns, and what literacy practices (e.g., communication) may be limited, or enhanced through education.

Wyman and colleagues' (2008) study also surveyed a sample of 8th- and 10th-grade students ($n = 2059$) regarding prevalence of prior suicide attempts (e.g., "Have you tried to kill yourself in the last year?") and the students' help seeking attitudes and expectations. Results from the study indicated "[s]tudents who reported a suicide attempt were significantly less likely to report positive help-seeking attitudes regarding asking an adult for help at school" (p. 112). Returning to the earlier discussion regarding perspectives on health literacy, Wyman et al.'s study illuminates Rootman's (2009) suggestion that health literacy is dependent upon the degree of fit between students and school supports. Furthermore, from a critical literacy perspective, Wyman et al.'s study indicates opportunities exist for professionals to empower students who attempted suicide by analyzing their experience of help and participating in the construction of supports and services available to them.

Reluctance to seek help after a suicide attempt was also found by O'Donnell, Stueve, Wardlaw, and O'Donnell. O'Donnell and colleagues (2003) examined suicidality

amongst Latino and African American youth in the US and found that only 35% spoke with their parents or family members when they were experiencing problems, 20% reported having little or no support to turn to, and those who had attempted suicide previously were more likely to report they would not go to family members in the future. This is of great concern as having attempted suicide in the past can heighten the risk of dying by suicide in the future (Lewinsohn, Rohde & Seeley, 1994). If young people at greatest risk of suicide are not seeking help from adults in their daily lives, such as family members or school staff, there is a strong argument for gatekeeper training programs that increase participants' queries about suicidality. J. White suggests preventing youth suicide may require professionals to engage in more active strategies (e.g., observing, recognizing, asking questions) than waiting for adolescents to initiate seeking help (personal communication, July 6, 2009). The overview of the current literature provided here on suicide education programs invites the following question: How do in-service programs influence or not influence, professionals' mental health literacy practices when they encounter suicidal adolescents?

A Summary of Pre-service and In-service Suicide Education

Essentially, there are two main educational pathways through which professionals are formally prepared for potential encounters with suicidal adolescents. Pre-service curriculum in university programs may offer learning opportunities related to suicide prevention intervention at the undergraduate level; however, specific content in adolescent suicide is limited and generally only discussed if the instructor has a particular passion for the topic (Peters, 2003). As a topic of study, adolescent suicide may be too specific to be included in undergraduate programs focused on providing students with

broad, generalist knowledge and skills. Thus, suicide education may be left to the professional to obtain “downstream” (Oordt et al., 2009, p. 22), with the onus on the employers to provide in-service opportunities, and perhaps occurring after the professional has already encountered a young person at risk of suicide. Neither pre-service education, nor in-service opportunities can stand alone as educational interventions in an overall suicide prevention strategy, or for that matter, as the only means to enhance mental health literacy. More research opportunities remain to further understanding of how education and professionals’ self-reported confidence is realized in practice with suicidal persons.

In reviewing the existing literature on how, and to what extent, pre-service and in-service suicide education is provided to professionals who are likely to encounter suicidal adolescents the approaches and underlying assumptions of suicide education programs require further consideration. Consistent with traditional approaches to literacy discussed above, it is assumed within current approaches to suicide education that professionals who complete a pre- or in-service program are *literate* or *competent* in suicide intervention. The next section will offer a closer examination of what is taken for granted or assumed by developing competence and literacy in suicide interventions as well as the epistemological assumptions inherent in contemporary suicide education approaches.

Assumptions Within Contemporary Approaches to Suicide Education

Gatekeeper training and university programs may provide professionals with educational opportunities to enhance their understanding of suicide and enhance mental health literacy practices; however, it is not clear how, and to what extent, pre-service and in-service education limits, or prepares professionals for *actual* encounters with suicidal

adolescents. Encounters with suicidal adolescents are inherently complex and the apparent assumption within contemporary suicide pre- and in-service programs that knowledge translates easily to competent practice require scrutiny (White, 2009). Thus, the research question guiding my grounded theory study necessitates repeating: How do child and youth care professionals' realize mental health literacy practices in their encounters with adolescents? It is relevant then, to explore underlying assumptions inherent in pre- and in-service suicide education programs.

Research design within suicide education program evaluation illuminates what type of knowledge or outcomes are viewed as important, and how literacy in mental health and suicide is assumed to be located within individual participants. For example, research has relied on individual participants' self-reports of increased feelings of confidence (Hayes et al., 2008; Oordt et al., 2009), satisfaction with the training (Appleby, et al., 2000), changes in attitudes (Botega, et al., 2007), or self-efficacy in responding to a person at risk of suicide (Cross et al., 2007) as ways to assess program impact. Individuals are also assessed in their ability to report on knowledge about suicide, such as risk factors or warning signs, many studies reportedly increasing or changing participants' existing knowledge about suicide (Cross et al.; Hayes et al.; Reis & Cornell, 2008; Tompkins & Witt, 2009). Several instruments completed by individual participants are used in determining the effectiveness of suicide education programs, such as the Suicide Intervention Response Inventory (SIRI) (Neimeyer & Bonnelle, 1997), the Attitude to Suicide Prevention Scale (Herron, Ticehurst, Appleby, Perry, & Cordingley, 2001), or the Suicide Opinion Questionnaire (SOQ) (Domino, Moor, Westlake, & Gibson, 1982).

Despite efforts to empirically evaluate suicide education programs using standardized instruments, studies have received criticism for poor research design and inadequate evidence of education interventions bringing about behavioural change (Burns & Patton, 2000). While increases in confidence or identification of warning signs for suicide are positive outcomes of suicide education, mental health literacy practices may, or may not, be influenced by participation in pre- or inservice education. The assumption that suicide education leads to competence or mental health literacy in practice requires further discussion. First, I examine the notion of *competence* drawing upon literature within the field of education. Secondly, the assumption regarding *knowledge* as an indicator of competence is challenged based on the various ways of knowing, or literacies, professionals may rely on in practice.

Assuming the education-competence link. Competence refers to knowledge and skills as well as “the effective application of available knowledge and skills in a specific context” (Westera, 2001, p. 75). Competence is also viewed by educators as the standard for training and professional development (Westera). Professionals are assumed to be competent if they are able to master the requisite knowledge and skills and apply them in an effective way in actual situations. Thus, it is assumed that performance is key to competence, and assessment of performance is demanded by a competence-based curriculum design (Tuxworth, 1989). Aligned with traditional or autonomous notions of literacy (Street, 1984), educational approaches and curriculum design have been based on the individual acquisition of certain attributes, such as knowledge, skills and attitudes (Dall'Alba & Sandberg, 1996). Furthermore, education itself has been viewed as a process of changing participants’ behaviour patterns, including participants’ thoughts,

feelings, and actions (Tyler, 1949/2004). It is assumed in suicide pre- and in-service education programs that participants possess behavioural patterns that *require* development, and do not possess the requisite desirable knowledge (e.g., risk factors, warning signs), skills (e.g., how to ask about suicide) and attitudes (e.g., self confidence to ask for help). Through the process of suicide education, individuals *change* and *acquire* attributes for competent, or literate, functioning.

Compartmentalizing desired behaviour patterns and specific knowledge, skills and attitudes in this manner in educational settings historically stems from World War I when a large number of people required expedited training in specific skills (Tyler, 1949/2004). Jobs were analyzed and catalogued into activities and training programs were designed around objectives to meet efficiently these specific job activities. Generally, educational activities, including suicide education programs, have continued to be structured around learning objectives with all learning and teaching activities centered on meeting these pre-determined objectives, or learning outcomes. Popham (1972/2004) suggests that objectives are useless if they are not *measurable* and descriptive of the desired behavioural change. Performance, then, is intertwined with competence. It is assumed that suicide education will efficiently center on specific pre-determined and measurable changes in individuals' knowledge, skills and attitudes, and (literate) individuals will transfer these newly acquired behavioural patterns to a range of contexts where they work.

Troubling restrictions on learning. Parallel with notions of literacy acquisition, traditional approaches to education have received criticism. Within traditional approaches, learning that may occur beyond the scope, or outside of the identified

learning objectives, is viewed as less valuable in the process of evaluation (Doll, 1993/2004). Pre-determined goals and learning activities correspond with methods of evaluation, and learning outside of what is pre-determined is undesirable and unexplored (Doll, 1993/2004). Evaluation, then, can restrict both the lens of the educator and the participant towards valuing specific and externally defined learning and literacies.

Eisner (1967/2004) suggested that a model of education which views objectives by which to measure achievement, or what is often referred to as the *rational* approach to curriculum development, values some learning (e.g. spelling, long division) above other forms of learning that are immeasurable (e.g., curiosity, inventiveness, insight). As discussed previously within critical literacy theory, Freire (1970/2004) proposed the view that education occurs in encounters between teacher-learners, and learner-teachers, in their dialogue and inter-relationships. In his view, students are not passive-recipients, but both teachers and students are transformed through reflective action, mediated by the learning context. The situatedness of learning contexts and the relational experiences between educators and students do not lend themselves to pre-determined, specified outcomes, and thus require alternative methods of evaluation.

Within suicide education, learning objectives are designed to develop pre-determined attributes within the domains of knowledge, skills and attitudes. It is readily assumed participants are competent if they have acquired the desired attributes and perform them within the context of the learning environment (e.g., role play). It is also assumed competent performance within the learning context will transfer to a range of complex situations the professional encounters in their working life such as encounters with suicidal adolescents.

The apparent certainty in this approach to developing competence can be seductive: if we are able to design an educational program and ensure students acquire specific attributes through measuring changes in knowledge, skills and attitudes, then it follows that we have assurance of how they will perform in various contexts (Sellick, Delaney, & Brownlee, 2002). Traditional educators are governed by the criteria of *efficiency* and *effectiveness*, envisioning “skilled performance embodied in ‘competences’” as an “important and valued outcome of learning” (Usher, Bryant, & Johnston, 1997, p. 14). Certainly efforts to prepare professionals for encounters with young people at risk of killing themselves is desirable. However, the complexities of practice with suicidal adolescents does not necessarily lend themselves easily to rely entirely on competency-based approaches. Following this, there are opportunities for suicide education, and notions of (mental health) literacy acquisition, to move beyond traditional means-ends, outcome oriented models to embrace the unanticipated, unintended, “uncertain, ethically infused and local understandings of suicide” (White & Morris, 2010).

Troubling qualifications. Pre-service and in-service programs additionally are clear examples of the widespread acceptance that qualifications obtained through formal education; that is, completion of a particular program will lead to competent performance in real life situations. Qualifications in a modern society provide a way for others to expeditiously assume professional competence, and “systematically to *know* people in order to maximise their productive capabilities” (Usher et al., 1997, p. 74, emphasis in original). For example, a student may complete a undergraduate program in child and youth care and obtain a Bachelor’s degree qualification. Upon presentation of a

Bachelor's degree in child and youth care, employers and clients assume the individual will competently perform in a range of contexts and complex situations, essentially operationalizing the empirically-based authoritative knowledge of the area of study. Moreover, professionals may also perceive themselves as highly competent, literate, and capable after undertaking pre- and in-service programs, yet assumptions of actual capability should not be based solely on perceived capability (Hawgood et al., 2008).

The Degree of Fit³ Between Adolescents and Helpers: An Overview of Adolescent Help-seeking

A contextualized view of mental health literacy emphasizes the interactive, reciprocal, and relational features between persons. As Rootman (2009) suggests, (mental) health literacy is dependent upon the degree of fit between helper and helpee. The styles and forms of communication that initiate and sustain the interaction may be predicated on degree of fit. Help-seeking has been defined as “communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience” (Rickwood, Deane, Wilson, & Ciarrochi, 2005, p. 4). As critical literacy for many scholars is also concerned with social justice (Kendrick et al., 2005), communication may be equally dependent upon the emancipation of the adolescent to participate fully and meaningfully in choosing options for help. Central to understanding help seeking is a consideration of what adolescents view as resources that *fit* their needs for help because many adolescents do

³ Rootman, I. (2009, August). *Health literacy: What should we do about it?* Presentation at the University of Victoria: Victoria, BC.

not seek help from anyone (Booth et al, 2004). Mental health literacy practices of child and youth care professionals may, or may not, *fit* for the suicidal adolescents they encounter. I begin the following section with a review of adolescents' preferred sources for help for mental health and emotional concerns. Following this, I identify from the help-seeking literature, the barriers that adolescents report interfering with their help-seeking behaviour.

Preferred Sources for Help

Initiating seeking help may require the adolescent to overcome their apprehensions about being viewed as “crazy” or “disturbed” (Draucker, 2005, p. 158). Despite the social stigma that is associated with mental health issues, adolescents often reach out and communicate their concerns to someone. For example, in a study of 101 American Indian young people who had thought about suicide or attempted suicide, 76% reported they had turned to at least one person when they were suicidal (Freedenthal & Stiffman, 2007). Mental health literacy practices are influenced by communication (Nielsen-Bolhman et al., 2004), and communication skills of both the adolescent and the helper. Nielsen-Bolman et al. suggest communication is fostered within the context of healing relationships. For adolescents, healing relationships may be those closest to them.

Adolescents often report they prefer informal sources of help rather than formal, or professional, sources of help. As family, close friends, and partners are all identified by adolescents as people they would turn to when experiencing emotional problems or mental health concerns (Booth et al., 2004; Burns & Rapee, 2006; Ciarrochi, Wilson, Deane & Rickwood, 2003; Gilchrist & Sullivan, 2006; Jorm, Wright, & Morgan, 2007), the degree of fit between adolescent and helper may be a function of the quality of the

relationship. Relationships that are characterized by young people as trusting, confidential (Sheffield et al., 2004; Wilson & Deane, 2001), accepting (Wilson & Deane), caring, nonjudgmental, supportive and genuine (Boyd et al., 2007) are identified as *fitting* adolescents' needs for help.

Healing relationships for adolescents may change over time. As Mancuso (2008) suggests, mental health literacy and the degree of fit between adolescent and helper may also be developmentally mediated. Younger adolescents in grades 7-8 prefer their parents as resources for help, whereas older adolescents in grades 9-12 prefer their peers (Tishby et al. 2001). Fit may also be dependent on gender and ethnicity as Lindsey et al. (2006) found male African American adolescents reportedly seeking out help primarily from their mothers when dealing with depressive symptoms.

Mental health resources available on the Internet may also be a fit for some adolescents seeking help, or support adolescents in developing healing relationships with service providers. For example, Santor, Poulin, LeBlanc, and Kusumakar (2007) examined adolescents' use of a health information Web site amongst students (N = 2054) in grades 7-12. Over a quarter (27.2%) of the students logged onto the Web site to view health information sheets, complete a symptom screen, and pose or view questions and answers. Santor et al. found a positive correlation between students visiting the Web site and visits to school health centers, guidance counselors, and referrals to health professionals. The results of Santor et al.'s study indicate an additional pathway to establishing healing relationships with professionals for adolescents. While adolescents may use the Internet to access health information initially, some adolescents seek further

help from care providers and require healing relationships characterized by trust, support, and communication as discussed above.

Barriers Impacting Fit

Adolescents identify they prefer to talk with family members; however, some young people report having little or no support to turn to, and as discussed above, some who had attempted suicide previously were more likely to report they would not go to family members in the future (O'Donnell et al., 2003). As a prior suicide attempt can heighten the risk of dying by suicide in the future (Lewinsohn et al., 1994), adolescents who have no one to turn to is cause for concern. Moreover, some adolescents report a belief that depression should be dealt with alone. These individuals held less than favorable views regarding the options for help available to them (Jorm et al., 2006). Adolescents may engage in pretending to be “normal” and hiding distress as a way of avoiding undesired help (Draucker, 2005). Managing mental health issues alone can perpetuate and increase the intensity of the concern. For example, older adolescents may isolate themselves more as suicidal ideation increases (Ciarrochi et al., 2003), and social isolation can promote more hopelessness and depression (Hazler & Denham, 2002). The possibility for an adolescent to die by suicide may increase with the combination of decreased engagement with others and the belief that no one can help or understand. Instead of help-seeking, the adolescent engages in *help negation* (Stellrecht, Joiner, & Rudd, 2006; Rickwood et al., 2005) as they become increasingly disconnected from a healing relationship.

In summary, help-seeking fit, then, is dependent on communication, relationships that possess desired qualities, perceptions of, and the type of help that is available or

offered, beliefs about how to cope with mental health concerns, and the adolescent's connectivity to others. Help seeking, as a part of mental health literacy (Jorm et al., 1997) is a multifaceted, relational process that occurs within a sociocultural context. Incorporating a critical literacy perspective (McDaniel, 2004), relationships may be redefined and envisioned so adolescents are no longer viewed as the *seeker of help*, and professionals as the *providers of help*. Rather, changing the nature of the roles in the helping experience can lead to the adolescent being empowered to engage in collaborative, confident decision-making as to the type of help provided that fits their needs.

Chapter Summary

As background for my study I conducted a preliminary review of the literature in the areas of critical literacy theory, social literacy theory, health literacy, mental health literacy, current approaches to suicide education, and adolescent help seeking. As theoretical constructs for literacy, critical literacy and social literacy are valuable in extending current individualized conceptualizations of mental health literacy. In my study, mental health literacy is viewed as contextualized, situated and dependent upon the fit between the child and youth care professional and the suicidal adolescent. As noted in the suicide education literature, literacy and education are intertwined such that it is taken for granted, professionals' participation in pre- and in-service education programs leads to competence in practical situations involving suicide. Education may intersect with professionals' mental health literacy practices. As discussed previously, I will return to the literature in Chapter Seven to situate my findings. In Chapter Three I outline my grounded theory research design and procedures for investigating how child and youth

care professionals realize mental health literacy practices during encounters with suicidal adolescents.

Chapter 3

Design and Procedures

Corbin (2009) suggests that “[p]eople will choose the method that most speaks to them and they will use it in ways that make sense to them” (p.52). While the flexible and responsive nature of qualitative inquiry affords the researcher choice in the method, “the reasons for taking a particular decision or action should be explained and the implications explored” (Parahoo, 2009, p. 5). The purpose then of this chapter is to describe and provide a rationale for my choice of constructivist grounded theory method and the implications of this choice. I begin the chapter by locating grounded theory within qualitative research and provide a discussion on the historical and current context of this evolving research method. Next, I explicate the philosophical foundations and assumptions of symbolic interactionism, pragmatism and constructivism that underlie a grounded theory approach and, consequentially, my study. I provide a critique of grounded theory method, followed by a discussion outlining the rationale and implications of adopting *constructivist* grounded theory method in the context of classic or traditional grounded theory approaches for my investigation of how child and youth care professionals’ mental health literacy practices are realized in their encounters with suicidal adolescents. I describe in detail the design of the study, data collection and analysis, and research timeline. Lastly, I establish the quality and usefulness of my study and identify the limitations of my research.

Defining and Locating Grounded Theory within Qualitative Research

Grounded theory method originated in the “second moment” of the historical development of qualitative research (Denzin & Lincoln, 2005, p. 16.). Denzin and

Lincoln suggest this *second moment* in qualitative research history was a modernist phase beginning post World War II until the early 1970s. During this phase qualitative researchers sought to formulize qualitative methods and often clothed their work in positivist and postpositivist discourse. The dominance of sophisticated quantitative methods reigned at this time where “positivist conceptions of scientific method and knowledge stressed objectivity, generality, replication of research, and falsification of competing hypotheses and theories” (Charmaz, 2006, p. 4). Yet there was an emergence of “critiques of quantification together with social constructionist statements” that instigated reappraisal and renewal amongst sociologists in the 1950s (Bryant & Charmaz, 2007b, p. 36). Many sociologists were conducting fieldwork and writing about social processes with the goal of developing theory out of data, yet they did not formulate their work into methodological texts (Morse, 2009). Barney G. Glaser and Anselm L. Strauss took on this task and published *The discovery of grounded theory* (1967) as a guide and systematic rules for procedure for generating theory from the data itself. Glaser and Strauss provided a valid basis for qualitative research, which could claim equivalent status to quantitative work in the grounded theory method (Bryant & Charmaz, 2007b). Locating grounded theory within qualitative research requires a gaze back to its discovery.

History and Development of Grounded Theory and Next Generation Approaches

Historical context. The emergence of grounded theory challenged existing methodological assumptions based in mid-20th century positivist conceptions of scientific method and knowledge (Charmaz, 2006). As suggested previously, most researchers at this time sought to discover causal explanations, make predictions, and assumed that a

researcher was an unbiased, passive observer. Scientific ways of knowing were viewed as valid, while other possible ways of knowing were rejected. Thus, qualitative or interpretive approaches were not valued, much less acknowledged. The aim then for Barney G. Glaser and Anselm L. Strauss was to provide a clear basis for systematic qualitative research and demonstrate that qualitative researchers can produce outcomes of equal significance to those produced by the then predominant statistical-quantitative approaches (Bryant & Charmaz, 2007b). They collaborated to write the foundational text *The discovery of grounded theory* in 1967. Glaser and Strauss provided a valid basis for qualitative research, which could claim equivalent status to quantitative work in the grounded theory method (Bryant & Charmaz, 2007b).

Shortly after, Glaser and Strauss separated ways, with Glaser remaining steadfast to the original principles of grounded theory outlined in the primary text (Birks, Chapman, & Francis, 2006a), and Strauss moving forms of grounded theory forward based on his earlier symbolic interactionist influences (Mills, Chapman, Bonner, & Francis, 2007). The separation of Glaser and Strauss led to different versions of grounded theory, including what is now known as *Glaserian* and *Straussian* grounded theory (Stern, 1994). “Those close to the two researchers tell us that the differences in approach, though subject to evolution over the years, have been there from the beginning” (Stern, p. 220). The initial merging of Glaser and Strauss also represented combining “two contrasting – and competing – traditions in sociology... Columbia University positivism and Chicago school pragmatism and field research” (Charmaz, 2006, pp. 6-7). Glaser remains steadfastly consistent with his view that grounded theory is a method of discovery (Charmaz, 2006, p. 8) and following a systematic set of methods will lead to a

discovered reality and verifiable theory (Charmaz, 2000). A Glaserian approach assumes as well that the researcher passively listens during interviews with participants, and raises different perspectives among participants to an abstract level of conceptualization (Glaser, 2002a). The researcher then, is not focused on the *story* of the participants, rather the focus is on conceptualization of latent patterns (Glaser).

After the separation, Strauss's version of grounded theory continued to evolve. Birks et al. (2006a) suggest Straussian grounded theory departs from the original method in four particular ways: "the position of the researcher in relation to the data; approach to analysis; verification versus validation; and criteria for evaluation" (p. 7). Counter to the Glaserian approach, and more aligned with constructivist grounded theorists, Straussian grounded theorists acknowledge the researcher is not separate from the research and analysis and must be self-reflective about how the researcher influences, and is influenced by, the research process (Corbin, 2009). Additionally, Corbin identifies "the self is the instrument of the research", requiring the researcher to trust their instincts during the research process (p. 51).

A Straussian approach to analysis has often been the subject of criticism for having "prescriptive scientific rules" (Charmaz, 2000). While Glaser offers only two types of coding: substantive (i.e., open and selective coding), and theoretical (i.e., conceptualizing substantive codes to build theory), analytical procedures in Straussian grounded theory involve three complex phases. Open coding involves brainstorming to open the data to all potentials and possibilities and to consider all possible meanings (Corbin & Strauss, 2008). Axial coding relates concepts to each other (Corbin & Strauss),

and selective coding identifies the core category to pull the theory together (Birks et al., 2006b).

In regards to evaluation, Corbin and Strauss (2008) identify eight conditions that foster the construction of quality research, ten criteria for judging the quality of a grounded theory study, and thirteen additional criteria for evaluating the credibility of the research based on the kinds of information provided by the researcher in the presentation of his or her findings. This exhaustive list of criteria for evaluating research stands in direct contrast with the succinct requirements for rigour initially proposed by Glaser and Strauss (1967) of fit, work, relevance, and modifiability. Further discussion of evaluating the quality of grounded theory research will be discussed in the latter section of this chapter.

Next generation approaches. Though Glaser and Strauss are widely recognized as the principal creators of grounded theory, those who have encountered and used the method have contributed significantly to its evolution. Grounded theory has evolved, molded by its users, in a variety of disciplines such as education, nursing, business, and social work (Morse, 2009). Scholars agree that “[t]he influence of grounded theory is now so widespread that it can be argued that it has profoundly changed the face of social science” (Morse, p. 13) and “inspired generations of new scholars to pursue qualitative research” (Bryant & Charmaz, 2007b, p. 31). Grounded theory methods are now being repositioned in the current philosophical and epistemological landscape “to understand such issues as those shaping the research process, the roles, social locations, perspectives of the researcher, the production of data, and the dialectical relations between sensitizing concepts and induction” (Bryant & Charmaz, 2007b, p. 50). Beyond Glaserian and

Straussian (Stern, 1994) grounded theory methods, the evolution of grounded theory now includes dimensional analysis (Bowers & Schatzman, 2009), situational analysis (Clarke & Friese, 2007; Clarke, 2009), and constructivist grounded theory (Charmaz, 2000, 2006, 2008). Yet Corbin (2009) suggests “[t]he method remains rooted in pragmatism and symbolic interactionism, with its emphasis on structure and process” (p. 37). Differences between next generation approaches are thus found more in how the research is approached, and how researchers think and write about their work (Corbin). Furthermore, “grounded theory depends on what you define as the genuine method and on your epistemological perspective” (Charmaz, 2009, p. 136). For example, a social constructivist epistemological perspective in grounded theory permits the researcher to explore the taken-for-granted assumptions within the processes of social activity (Best, 2008). Though grounded theory methods offer “systematic inductive guidelines for collecting and analyzing data to build middle-range theoretical frameworks that explain the collected data” (Charmaz, 2000, p. 509), grounded theory method continues to be a “contested concept” (Bryant & Charmaz, 2007a, p. 4). As Bryant and Charmaz suggest, grounded theory method is internally complex, has had considerable modifications as circumstances have changed, and there is continuous competition for acknowledgement of the original achievement of Glaser and Strauss’s *discovery*.

Constructivist grounded theory method. As a former student of the late Anselm Strauss, Kathy Charmaz has significantly contributed to the development of grounded theory method and challenged the objectivist leanings of the traditional model that Glaser and Strauss had earlier proposed (Bryant & Charmaz, 2007a; Puddephatt, 2006). From a constructivist’s perspective, knowledge is “lodged within the sphere of social

relatedness” (Gergen, 1994, p. 30). The complexity of social life is preserved during the process of understanding researcher participants’ social constructions (Charmaz, 2008). Constructivist grounded theory method pushes grounded theory further in the interest in the active construction of subjective and inter-subjective social knowledge (Lincoln & Guba, 2005). Charmaz separates constructivist grounded theory from the Glaserian approach in two significant ways: in rejecting a detached position of the researcher (Birks et al., 2006a), and in embracing an open-ended practice with emergent, constructivist elements (Charmaz, 2000).

First, constructivist grounded theory emphasizes the subjective role of the researcher in the interpretation of participants’ construction of meaning from their experiences (Birks et al., 2006a). In contrast to earlier grounded theory approaches where researcher reflexivity was viewed as a source of data, constructivist grounded theory requires the researcher to engage in reflexivity (Charmaz, 2009). The researcher maintains a reflexive stance “to recognize how their own subjective influences impact on the research process and outcomes” and to “enable meanings to be interpreted in the wider cultural, social and temporal contexts” (Birks et al., 2006a, p. 9). A constructivist grounded theory method recognizes that the researcher is implicated in the process of creating the data and the following analysis (Charmaz, 2000). The researcher, the participant, and the following interpretation are all shaped by this interaction.

Beyond interpretation, Mruck and Mey (2007) suggest the researcher also influences the choice of research topic which likely stems from personal experience. As I previously explained (see Chapter One), the impetus for my research topic was my personal and professional experiences, my disciplinary background, and the timing of my

study. I began with openness and self-awareness of my location and throughout the research study I engaged in self-questioning, examining “*what I know and how I know it*” (Patton, 2002, p. 64). For example, during analysis of my initial interviews I labeled a developing category as *assessing risk*. Following a discussion with a member of my committee, I questioned how I had identified this category and what personal knowledge I brought to this label. I realized that I was blindly imposing my own understanding of the child and youth care professionals’ action without considering the taken-for-granted assumptions underlying the term *assessing risk*. By taking up a reflexive stance I was able to step back from the data, acknowledge what shaped my perspective and question how participants “know what they know” (Patton, p. 66) when they discussed *assessing risk*.

Secondly, Charmaz (2000) cautions that when guidelines and grounded theory procedures are categorized into steps, such as those proposed by Strauss and Corbin (1990), the emergent, interpretive, interactive and flexible elements of the research process are lost. Constructivist grounded theory re-positions earlier more objectivist grounded theory methods within the current philosophical and epistemological landscape and that “[t]his repositioning will allow us to understand such issues as those shaping the research process, the roles, social locations, perspectives of the researcher, the production of data, and the dialectical relations between sensitizing concepts and induction” (Bryant & Charmaz, 2007b, p. 50). Repositioning grounded theory methods addresses the criticisms that label the method as “positivist” or “limited to micro-analyses” (Bryant & Charmaz, 2007b, p. 50).

Philosophical Foundations of Grounded Theory Method

Grounded theory is both method and methodology such that the procedural rules provided initially by Glaser and Strauss outlined a systematic way, or *method* of accomplishing a research project, and methodology in its underlying philosophy of how knowledge is constructed (i.e., pragmatism, symbolic interactionism). I will mainly use the terms *grounded theory* or *grounded theory method* as is typical in grounded theory writing. The philosophical foundations underpinning original grounded theory method include pragmatism and symbolic interactionism. As I adopted a constructivist grounded theory approach, my study is also influenced by principles of constructivism. The specific implications of these foundational lenses for my investigation into child and youth care professionals' mental health literacy practices are outlined in Table 3.

Pragmatism. The pragmatist philosophical tradition of the University of Chicago was embraced by Strauss during his doctoral training and influenced the development of grounded theory method. Truth and reality were viewed by pragmatists “as constructions *within* inquiries and, as such, malleable to further reconstruction” (Holmwood, 2011, p. 20). Reality then, exists within action, is continually created by actors, or people, and objects exist based on their being acted upon (Strubing, 2007). Aligned with pragmatist philosophy, grounded theory is focused on action as the central unit of analysis (Star, 2007).

Table 3

Philosophical Implications for Research Study

Assumptions	Implications for Investigation
Symbolic Interactionism	
Human beings act toward things on the basis of the meanings that the things have for them (Blumer, 1969).	The meaning of the suicidal encounter between child and youth care professionals and adolescents influences how they act or respond to the situation. Furthermore, the meaning child and youth care professionals ascribe to the role as <i>participant</i> in the present investigation has implications on the researcher-participant interaction.
Meanings are derived from, or arise out of, social interaction (Blumer).	Symbolic interactionism “focuses on the activities that take place between and among actors” where “ <i>interaction</i> is the basic unit of study” (Charon, 2007, p. 29). The meanings of child and youth care professionals’ mental health literacy practices are derived from the interaction between the professional and youth, as well as the professional-participant and me as the researcher.
Meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things she or he encounters (Blumer).	Interpretation and analysis are a formative process where I check, challenge and modify meanings of the data. Theoretical sampling strategies were used to explicate, develop and refine categories from the data, and thus modify prior understanding or meanings of the data.
Pragmatism	
Reality exists within action and is continually created and acted upon (Strubing, 2007).	Action is the focus of the investigation. Mental health literacy practices are viewed as situated actions located within encounters between child and youth care professionals and adolescents.
Reality is constantly “under construction” (Strubing, p. 585) where continuous interpretations are required and revised (Star, 2007).	I entered the investigation with an open stance, paying close attention to the data. I did not set out to verify pre-conceived notions of mental health literacy practices.
Inquiry is a problem-solving activity that is oriented towards action (Holmwood, 2011).	The objectives of my study are to inform child and youth care professionals’ actions during encounters with suicidal adolescents, and inform curriculum within pre-service education. That is, my intentions are to address the concern of practice with suicidal adolescents with changes to practice and changes to curriculum.

Constructivism	
Knowledge and meaning are constructed within the context of interactions (Schwandt, 2003).	Research findings are co-created (Guba & Lincoln, 2005), and the central focus of the investigation is on the interaction between myself as the researcher, and participants (Ponterotto, 2005).
Reality is subjective, pluralistic, and subject to interpretation (Appleton & King, 2002).	I did not intend on proving, or disproving, preconceived ideas of mental health literacy practices. Rather, the perceptions and stories of participants illuminate issues of importance for mental health literacy practices during encounters with suicidal adolescents.
Knowledge is ideological, political, and permeated with values (Rouse, 1996).	Taken-for-granted assumptions about mental health literacy practices are recognized (Best, 2008), and furthermore, challenged.

Furthermore, pragmatism suggests environments evoke actions and people act in consideration of their social and physical environments (Strubing, 2007), and “interpret events from a situated and complexly principled point of view” (Star, 2007, p. 88). Reality is constantly “under construction” (Strubing, p. 585) and actors are required to continually interpret and revise their interpretations (Star). This cyclical interpretive process conveys the idea that understanding is derived from consequences such that people interpret and respond to actions, rather than acting based on prior knowledge for the purpose of verification. Based on pragmatist philosophy, grounded theorists thus enter the inquiry without pre-set categories, being open to what is experienced, and what draws attention in the data (Star).

In addition to focusing on action and entering the investigation without pre-determined categories, inquiry is a problem-solving activity that is oriented towards action (Holmwood, 2011). “Theory is always oriented towards practical problems” (Strubing, p. 595) where theory and praxis are linked (Greenwood & Levin, 2003). With this pragmatic perspective in mind, grounded theory investigations are useful if they result in practical answers to problems (Stern & Porr, 2011).

Symbolic interactionism. “Pragmatism informed symbolic interactionism, a theoretical perspective that assumes society, reality, and self are constructed through interaction and thus rely on language and communication” where interaction is dynamic, interpretive, and considers “how people create, enact, and change meanings and actions” (Charmaz, 2006, p. 7). The link between symbolic interactionism and grounded theory originated within an advisor-student relationship. The co-originator of grounded theory method, Anselm Strauss, was born in New York City in 1916 and earned a degree in sociology from the University of Virginia (Stern, 2009). He completed his graduate work at the University of Chicago earning both magisterial and doctoral degrees in sociology. His advisor at the University of Chicago was Herbert Blumer, a symbolic interactionist (Blumer, 1969).

Blumer (1969) suggests symbolic interactionism is centered on three fundamental premises: humans act toward things based on the meanings or interpretations that things have for them, the meaning of such things is derived from social interaction with others, and these meanings are worked with and modified through an interpretative process. Social interaction is the site of meaning construction where actions unfold according to the meaning ascribed to the situation (Blumer, 1969; Charon, 2007). The origins of symbolic interactionism are found in the work of George Herbert Mead (1863-1931) and, as noted previously, the philosophy of pragmatism (Charon). Interpreting actions are central to symbolic interaction (Blumer, 1969). Knowledge and reality then, are emergent and always in process as people interact with each other, define the situation, act upon their interpretations of the situation and others’ actions, which may alter or shape their

perspectives (Charon). Blumer's influence on Strauss helped shape what is now known as grounded theory.

Constructivism. “[A] research paradigm sets the context for an investigator’s study” (Ponterotto, 2005, p. 128) and the principles underlying the researcher’s paradigm can influence the research strategies. I approached the study from a social constructivist lens, where knowledge was viewed as *constructed*, not *discovered* (Schwandt, 2003). Furthermore, knowledge was constructed within the context of my interactions with participants. In contrast with a positivist paradigm where the goal is scientific explanation, the goal of constructivism is to understand the meaning of a phenomenon (Ponterotto, 2005). However, meaning or knowledge are not fixed entities in constructivism that externally exist and can be discovered (Schwandt, 2003). Meaning may be brought forward through reflection “stimulated by the interactive researcher-participant dialogue” (Ponterotto, p. 129). Knowledge, understanding, and meaning were developed or *constructed* during my interactions and engagement with participants in the study. It is assumed here as well that my prior knowledge and understanding of child and youth care practice with suicidal adolescents that I bring to the study was co-constructed within my interactions, relationships and experiences with young people over time.

A distinguishing feature of constructivism then is the central focus on the interaction between the researcher and the participants, or object of investigation (Ponterotto, 2005). My findings are thus co-constructed through interactive dialogue and interpretation in the interaction between the researcher and participants. The goals of constructivist research are idiographic and emic (Ponterotto). That is, constructivist research is focused on understanding of the individual, and their constructs or behaviours

are unique, complex, and not generalizable. A constructivist views knowledge “as lodged within the sphere of social relatedness” (Gergen, 1994, p. 30). Each interaction between myself and participants was unique. Reality, then, from a constructivist perspective is pluralistic and subject to different interpretations (Appleton & King, 2002).

It was also accepted here that *understanding* could not come from logical empiricism such as neutrality of observation (Schwandt, 2003). Understanding what people were doing was dependent on the context, beliefs, values, or practices which all involve interpretation (Schwandt). Understanding, and therefore knowledge, was assumed to be “the product of particular communities, guided by particular assumptions, beliefs and values” (Gergen & Gergen, 2004, p. 71). The participants’ and researcher’s assumptions and membership in particular communities guide knowledge, understanding, meaning and interpretation. Thus, it was my obligation to practice reflexivity during the research process by explicating my assumptions and commitments because “we are part of the world we study and the data we collect” (Charmaz, 2006, p. 10).

Strengths and Critique of Grounded Theory Method

The explicit strategies and the applicability of the theory to professional practice are significant strengths in grounded theory research in general, and specifically for educational issues. Grounded theory method “offers a foundation for rendering the processes and procedures of qualitative investigation visible, comprehensible, and replicable” (Bryant & Charmaz, 2007b, p. 33). The process, procedures, and strategies for conducting qualitative grounded theory research offer benefits to both experienced and novice researchers (Charmaz, 1995). The experienced researcher, as well as the new-kid-on-the-block like myself, can use the method to organize, manage, and structure data

collection and analysis (Charmaz, 1995). Glaser and Strauss (1967) aimed to provide social science researchers with the strategies to generate theory based on data. While generalizable to an extent to other settings and future instances, the theory remains intimately linked to the data (Morse, 2009). The incremental development of the theory allows for verification at each step in the research process, resulting in a theory that is useful and solid (Morse, 2001). This result does not mean that grounded theory is “authoritative,” rather it is specific and meaningful to the context, situation and participants in the investigation (MacDonald & Schreiber, 2001, p. 46). Professionals from various applied disciplines such as education, social work, child and youth care, or counselling psychology can use theory generated from grounded theory research for resolving practical problems encountered in the workplace (Glaser & Strauss). The usefulness and applicability of the generated theory informs child and youth care practice with suicidal adolescents and enhances existing mental health education approaches.

Grounded theory method also provides child and youth care professionals with a body of theoretical knowledge that complement their experiential knowledge (Corbin, 2009) about practice with suicidal adolescents. The method is highly suitable for investigating “individual process, interpersonal relations and the reciprocal effects between individuals and larger social processes” (Charmaz, 1995, pp. 28-29). Grounded theory can document changes within social groups and the core processes that are central to the changes, and “allows us to explicate what is *going on* or *what is happening* (or *has happened*) within a setting or around a particular event” (Morse, 2009, p. 13). Grounded theory method thus offers opportunities to understand how child and youth care professionals’ mental health literacy practices are realized in their encounters with

suicidal adolescents. Understanding the social processes around events and within practice settings supports identification of gaps in child and youth care professionals' knowledge and experience which can be addressed through pre- and in-service educational programs. Thus the theory generated from my study informs child and youth care professionals and educators alike regarding mental health literacy practices.

While Glaser and Strauss certainly brought status and recognition to the field of qualitative research, their work reflected the positivist notions of knowledge held dearly at the time. For example, the title of their work *The discovery of grounded theory* implies positivist assumptions that reality can be discovered, explored and understood, and thus reality is knowable, unitary, and waiting to be discovered (Bryant & Charmaz, 2007b). Additionally, a key positivist feature of the early-grounded theory method is the uncritical stance towards data and the assumption that data are external and can be accessed in a straightforward manner (Bryant & Charmaz, 2007b).

Such criticisms of grounded theory method have often been based on a lack of awareness of the development of the method since its *discovery* by Glaser and Strauss in 1967. Grounded theory has been criticized for being a positivistic and objectivist method (Charmaz, 2000), assuming “an external world about which an unbiased observer can discover abstract generalities that explain empirical phenomena” (Charmaz, 2009, p. 128). Stern (2009) suggests Glaser and Strauss (1967) were writing *The discovery of grounded theory* to convince an audience of positivists that there are other legitimate ways to approach data. As traced previously in the history of grounded theory method, there have been several contemporary revisions of the initial approach. Methodology is a “living thing... possessing the possibility of change” (Corbin, 2009, p. 37). However, the

lack of awareness by critics of the various changes and differences amongst approaches may continue to be a limitation of grounded theory method.

Grounded theory methods have also received criticism for a lack of researcher reflexivity and that the researcher is rendered invisible in the process (Clarke, 2005). The relationship between the researcher and the participant has been neglected in the principal grounded theory texts and grounded theorists need to give attention to the social construction of knowledge between researchers and participants (Hall & Callery, 2001). Mills, Bonner and Francis (2006) observe that attention to the researcher-participant relationship requires the researcher to consider the power differentials in their relationship with participants and commit to reciprocity in their relationship with participants. Furthermore, to enhance credibility of a grounded theory research study, Chiovitti and Piran (2003) propose that the researcher articulate their personal views and insights in journals, postcomment interview sheets, and monitor how the literature was used in the study (see Chapter 1 and Chapter 2 for discussion). Researchers need to “become more visible and accountable for, in, and through our research” (Clarke, 2005). Contemporary approaches to grounded theory, such as constructivist grounded theory method used in this investigation (Charmaz, 2000, 2006), recognize the need for researchers to explicate their assumptions or recognize the power differences between the researcher and participant in the interview context.

Furthermore, it is accepted in the contemporary view of grounded theory as in other qualitative research that “the self is the instrument of the research” (Corbin, 2009, p. 51) and thus qualitative research is “inherently subjective” (Starks & Trinidad, 2007, p. 1376). Though early forms of grounded theory method considered the researcher as

“neutral knower” (Lempert, 2007, p. 247), next generation approaches recognize the researcher’s location and presence in the process of inquiry. Researchers are no longer invisible in contemporary grounded theory methods, but are now recognized as the co-creator of meaning with participants (Mills et al., 2006). Based on the critique of earlier approaches to grounded theory and my social constructivist lens, I determined that a contemporary, constructivist grounded theory method was the best approach to answer my research question on how child and youth care professionals realize mental health literacy practices in their encounters with suicidal adolescents.

Rationale for Constructivist Grounded Theory Method

Despite the contested nature of grounded theory, the method is valuable in contributing to research on social or interactional processes (Maijala, Paavilainen, & Astedt-Kurki, 2003). Recent reconceptualization has transformed health literacy as an interactional process that it is dependent on the “degree of fit” (Rootman, 2009) between the individual and the healing professional within a larger social ecological context (Wharf-Higgins, Begoray, & MacDonald, 2009). Mental health literacy, as a concept derived from health literacy, has not undergone the same transformation and continues largely to be conceptualized and investigated at the individual level (see Chapter 2). Adopting a grounded theory approach to examining professionals’ mental health literacy practices serves to extend current understanding of mental health literacy by investigating the concept as an interactional process.

Furthermore, as literacy is a relational act (Giroux, 1987), and a socially constructed practice that is locally negotiated (Norton, 2007), a grounded theory approach can identify the conditions under which specific actions occur, attend to actions

and processes as well as to words, and illuminate taken-for-granted assumptions and how these may affect professionals' actions (Charmaz, 2006). While ethnography may offer an "insider's view" (Charmaz, 2006), or phenomenology may illuminate the "lived experience" of child and youth care professionals (Starks & Trinidad, 2007), the research question of how professionals' mental health literacy practices are realized during encounters with suicidal adolescents was best answered through a grounded theory approach.

Lastly, theory in grounded theory method is generated from the participants themselves. As discussed in Chapter Two, current mental health literacy research has largely focused on measuring individual participants against a pre-conceived mental health literacy framework. In contrast, by adopting a grounded theory approach, how mental health literacy practices are realized is derived from the participants. Grounded theory method, then, is an appropriate and useful approach to answering my research question of how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents.

Data Collection

The Participants

At the outset the size of the population for a grounded theory study cannot be established (Schreiber, 2001). Initially participants are purposefully selected based on their ability to help inform the research (Stern, 2009). The selection of further sources of data follows the strategy of theoretical sampling. That is, as categories are generated from the data, the researcher seeks out further groups for data collection so the categories may be tested, refined, elaborated, and saturated (Schreiber, 2001). The following section

provides a description of recruitment procedures, participants and extant texts included in my study.

Initial informants. The population of interest and key informants for my study was child and youth care professionals who provide services and care for young people across a range of settings and who have experienced suicidality amongst youth in their care. As an aim of my study was to inform curriculum, I was particularly interested in professionals who had received their undergraduate pre-service education specifically within child and youth care programs within western Canada. Having ensured the initial participants met this criterion, as an outcome of my study, educators may be informed of specific education needs within child and youth care programs regarding mental health literacy practices enacted by professionals during encounters with suicidal adolescents.

Additionally, to be eligible to participate in my study, participants needed to have encountered a suicidal adolescent in their practice. The practice context of interest, encounters involving suicide, requires further explication. The clarification of terms provided by Silverman, Berman, Sanddal, O'Carroll, and Joiner (2007) for the purpose of consistency amongst child and youth care professionals were adopted for the present investigation (see Table 4). Participants who volunteered for the study confirmed during my initial phone contact they had experienced at least one encounter with an adolescent that involved suicide-related behaviour, suicide-related communication, or suicide-related ideation.

Due to time and cost constraints, participants were also required to be located within western Canada to allow for ease of data collection.

Table 4

Nomenclature for Suicidality

Term	Definition	
Suicide-Related Behaviours	A self-inflicted, potentially injurious behaviour for which there is evidence (either explicit or implicit) either that (a) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end; or (b) the person intended at some undetermined or some known degree to kill himself/herself.	
	Suicide Attempt	A self-inflicted, potentially injurious behaviour for which there is evidence (either explicit or implicit) of intent to die, and may result in no injuries or injury.
	Suicide	A suicide attempt with fatal outcome.
Suicide-Related Communications	Suicide Threat	Any interpersonal action, verbal or nonverbal, without a direct self-injurious component that a reasonable person would interpret as communicating or suggesting that suicidal behaviour might occur in the near future.
	Suicide Plan	A proposed method of carrying out a design that will lead to a potentially self-injurious outcome; a systematic formulation of a program of action that has the potential for resulting in self-injury.
Suicide-Related Ideations	Any self-reported thoughts of engaging in suicide-related behaviour.	

(Adapted from Silverman et al., 2007, pp. 267-272)

Recruitment efforts for child and youth care professionals were three-fold. First, I began by obtaining third party consent from various schools of child and youth care in western Canada (see Appendix A) for the distribution of my recruitment materials (see Appendices D and E) via their alumni lists. Secondly, I contacted six youth-serving agencies located within both urban and rural communities across the province of British Columbia to request support in distributing my recruitment materials (see Appendix B).

Lastly, I requested permission to distribute my recruitment materials within known child and youth care online communities and through the provincial child and youth care professional association (see Appendices C and A). Recruitment, data collection and analysis occurred somewhat simultaneously.

My recruitment materials invited participants to contact me directly through a confidential email address I provided. A phone appointment was arranged via email with each volunteer (see Appendix F). During the initial phone contact I used a script (see Appendix G) that outlined what was required for participation and then I evaluated their suitability according to the criteria outlined previously. I also verbally reviewed the consent process and if they were still interested in participating, I sent each volunteer a copy of the Participant Consent Form (see Appendix H) via email for his or her review. Following this I contacted the potential participant to see if they had any questions or concerns, and if their interest continued, arranged a time and location for our interview at their convenience.

A total of 18 child and youth care professionals responded to my recruitment efforts. Seven of the 18 respondents did not meet the education criteria for participation in my study and subsequently, were not eligible to participate. Five of the seven held graduate qualifications in child and youth care, and two held qualifications in disciplines other than child and youth care, yet occupied a child and youth care role in the community. One respondent who met the criteria decided prior to the interview to withdraw from the study due to other commitments. Following the emergent research process required that I did not set a required number of participants at the outset. A final total of ten child and youth care professionals participated in my study.

Subsequent informants. Following the categories generated from analysis, or the analytical trail, I subsequently recruited supervisors of child and youth care professionals located within youth-serving agencies because upon completion of data collection and analysis from the first group of participants, supervisors were identified as having an influence on the encounters child and youth care professionals had with suicidal adolescents. In order to participate in my study, volunteers needed to hold a supervisory position within a youth-serving agency and have experience supervising the practice of a child and youth care professional who had encountered a suicidal adolescent. I used both purposive and snowball sampling procedures during my recruitment of supervisors. Respondents to the initial call for participants at the beginning of my study who did not meet the criteria, yet did meet the criteria for participation as a supervisor informant, were re-contacted via email with a Letter of Invitation to Participate (see Appendix I). Two supervisors were contacted and both responded via email to the invitation with interest in participating and contact number where they could be reached. I phoned each volunteer and discussed the criteria for participating and outlined the consent process (see Appendix G). At that time, one of the supervisors I contacted decided they did not feel they would have anything to contribute to my study and declined to participate. The remaining supervisor verbally agreed to volunteer for my study and I provided this person with a copy of the Participant Consent Form (see Appendix J) for their review. After a few days, I contacted the potential participant to ask about any questions or concerns about the consent process. The supervisor remained interested in volunteering so I arranged a time and location for our interview at the supervisor's convenience.

As noted previously, I additionally used a snowball sampling procedure in the recruitment of supervisor participants. Supervisors who might wish to participate in my study were identified in collaboration with child and youth care professionals who participated as my initial key informants. Three of the 10 child and youth care professionals each identified a potential supervisor who might wish to participate in the study. I provided each child and youth care professional with a Letter of Invitation to Participate (see Appendix K) for him or her to forward to the identified supervisor. All three supervisors contacted me directly via email expressing their desire to volunteer for the study. I phoned each supervisor and discussed the criteria for participating and outlined the consent process (see Appendix G). Supervisors were provided a copy of the Participant Consent Form (see Appendix J) for their review and I contacted each volunteer within a few days to answer any questions or address any concerns they had about participating. All three supervisors remained interested in participating and interviews were arranged at a time and location of their convenience. Thus a total of 4 supervisors of child and youth care professionals who had encounters with suicidal adolescents participated in my study.

Continuing my theoretical sampling journey, the perspectives of educators in schools of child and youth care were also sought to further extend and refine categories identified during data analysis. Many child and youth care professionals who participated in my study identified aspects of their pre-service education in child and youth care impacting their practice with suicidal adolescents. The sole requirement for educators to participate in my study was holding a faculty position within a school of child and youth care. Educators were not required to have direct experience with a suicidal adolescent.

Educators were identified by initial informants as contributing to child and youth care professionals' mental health literacy practices as many professionals reported drawing upon knowledge from participation in child and youth care pre-service programs. As email addresses of Faculty members from schools of child and youth care within western Canada were publicly available, I contacted 25 potential participants via email with a Letter of Invitation to Participate (see Appendix L). My recruitment efforts garnered nine respondents, four of whom declined to participate for various reasons such as time constraints, limited number of recent teaching assignments, or stating they did not have anything to contribute to my study. The remaining five educators who responded to my invitation were contacted by phone to discuss what would be involved in participating and outline the consent process (see Appendix M). Following this phone call, I sent volunteers a copy of the Participant Consent Form (see Appendix N) for their review. I followed up with each volunteer via phone or email (depending on their preferred method of communication) to answer any questions they may have about participating. All five educators remained interested in volunteering and interviews were arranged at a time and location of their choosing.

Data then were collected from a total of 19 participants, including child and youth care professionals, supervisors within youth-serving agencies, and educators in schools of child and youth care . During interviews, some participants described more than one encounter with a suicidal adolescent, which resulted in the discussion of 22 separate incidents used in the analysis. Descriptive features of the participants are provided in Appendix O.

Interview Procedures

Interviews within grounded theory method allow researchers to be able to gather specific data and immediately pursue emerging ideas and issues (Charmaz, 2006) and permits the researcher to learn what is not necessarily anticipated beforehand (Charmaz, 2009). The researcher and participant engage in an interview process that is typically a focused conversation on questions related to the study (deMarrais, 2004). A sample interview guide adapted from Charmaz (2006) is included in Appendices P and Q, though it is the intent of grounded theory approaches to keep the interview as informal as possible. The interview guide and identified open questions provide some structure to the interview and ensure the conversation is focused on the research topic at hand. As indicated previously, interviews with child and youth care professionals were not the only source of data for “[a] good grounded theorist will seek out more than one data source to provide a wider perspective on the phenomenon of study” (Schreiber, 2001, p. 64). Interviews were viewed as the starting point for the inquiry into the nature of child and youth care professionals’ mental health literacy practices in encounters with suicidal adolescents. As noted previously, interviews with subsequent informants included supervisors of child and youth care professionals and educators in schools of child and youth care. Educators were provided the option of attending a focus group interview or an individual interview. Due to scheduling conflicts and limited response to recruitment efforts, all educators participated in individual interviews.

I conducted each semi-structured interview (initial or follow up interview) at the participant’s location of choice. Interviews thus occurred at participants’ homes, workplaces, or coffee shops. When participants desired, I conducted interviews within

group meeting rooms I was able to book at the University of Victoria or Vancouver Island University. Each interview began with a review of the consent process including the participants' freedom to withdraw from the study, confidentiality of information, and risks and benefits for participating. I answered any questions participants had and then I documented volunteers' consent to participate on the Participant Consent Form (see Appendices H, J and N). I provided each participant with a copy of the form. Participants were informed they did not have to answer any question or share any information with which they were not comfortable. I used an interview guide (see Appendices P and Q) adapted from Charmaz (2006) as an outline for the interview and prompted as needed to explore more fully participants' responses and followed their interests within the broad topic area during the interview. Each interview was between one and two hours in length and all interviews were audio recorded. I transcribed the interviews verbatim (i.e., using the exact words of participants) and provided a copy to each participant within two weeks for their review. After approximately one week, I followed up with each participant either on the phone or through email to see if they wished to make any changes or clarifications to their transcript. The consent process was reviewed again at the beginning of the follow up contact. Only one participant initiated changes to their transcript, which involved removing minimal verbal responses (e.g., "uh-huh", "um").

Interview data preparation and management. I used participant identifiers (e.g., CYC-04) to represent the names of participants throughout all collection and analysis materials and when referring to any statements made by participants. Line numbers were inserted into each transcript for easy retrieval of quoted material. A list of participants' names, contact information, interview location and date, and descriptive

characteristics (e.g., role, educational qualifications, area of practice, years of experience) was kept in a separate file from the transcripts themselves. To ensure anonymity, all identifying information (e.g., employer's name, adolescents' names, location, etc.) was removed from each transcript.

Transcribing each interview allowed me to experience the interview and hear the participants' voices as they discussed their encounter with a suicidal adolescent. As I transcribed, I often stopped to memo my thoughts or ideas about what I was hearing. I used a software program (ExpressScribe) to slow the recording to a pace I could easily provide an accurate transcription of the interview. On average, each interview transcription took 3 to 4 hours, resulting in approximately 800 pages of data.

Data management was facilitated with Microsoft Word. Each transcript was initially coded line-by-line using the track changes feature in Microsoft Word (see Figure 1). In a separate document for each transcript a coding hierarchy (e.g., parent, children, sibling) was developed using tables with each identified code linked to a line number in the transcript (see Table 5).

Figure 1. Line-by-line Coding Example

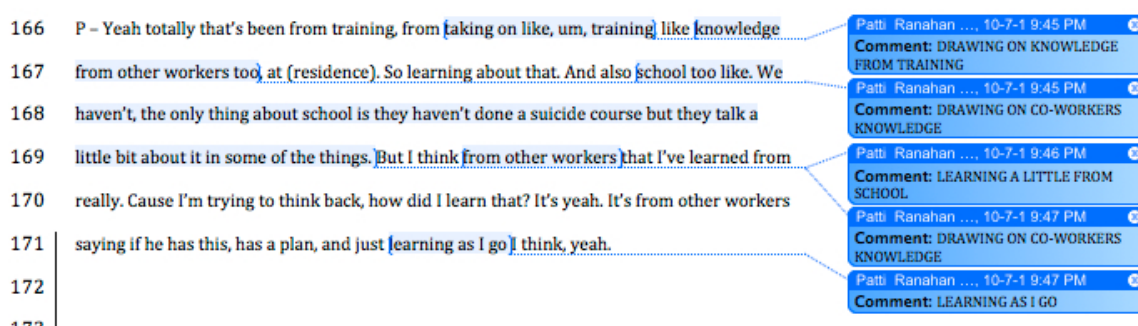


Table 5

Participant Coding Hierarchy Example

PARTICIPANT CODING HIERARCHY EXAMPLE	
SIBLING CODE	CORRESPONDING LINE-BY-LINE CODE AND PARTICIPANT TRANSCRIPT LINE NUMBER
BEING THERE FOR THEM	<ul style="list-style-type: none"> • ADDRESSING YOUTH'S PRACTICAL NEEDS 102-103 • ADDRESSING YOUTH'S NEED FOR FOOD 171-179 • ACKNOWLEDGING FEELINGS 176-177 • ASKING WHAT YOUTH NEEDS 219 • ACKNOWLEDGING YOUTH'S STORY/FEELINGS 234-239 • LETTING YOUTH KNOW CYC IS AVAILABLE 269-270 • BEING THE ONLY PERSON YOUTH TOLD 365-370 • KNOWING YOUTH'S TRUST IN ME 371 • BEING CALM FOR THE YOUTH 371-372 • ACKNOWLEDGING YOUTH'S FEELINGS 386 • TRYING TO BE PRESENT 405, 407-409 • BEING IMMEDIATE WITH YOUTH 464-467 • COMMUNICATING FEELINGS TO YOUTH 464-467 • JOKING WITH YOUTH 505-512 • USING HUMOUR 648 • VALUING YOUTH'S EXPERIENCE 629-630 • VALUING LISTENING TO YOUTH 632-634, 649 • NOT JUDGING YOUTH 633, 647-650 • TAKING THEM SERIOUSLY 636 • BEING HONEST/IMMEDIATE 657-659 • SHOWING EMPATHY 734-735

After the first five interviews and using the constant comparison method (Glaser & Strauss, 1967), I developed a codebook that visually structured, grouped and collapsed codes further into categories (see Table 6). Based on the data, I constructed a definition of each category, linking the definition to specific participant data (e.g., participant identifier and line number). The codebook evolved and several additions and refinements were tracked as new data was collected and analyzed. I repeatedly returned to the data set and definitions were double-checked for accuracy against quotations from participants. As an additional way to visually represent the data, I created a separate file and table that

Table 6

Code Book Example

DEFINITION	
CATEGORY: RULES OF ENGAGING APPRAISING	<p>Reading the adolescents' behaviour, noticing the unusual, assessing the adolescents' state (e.g., calmness, instability, affect, impulsivity, acting out), observing behavioural changes, unexpected responses, physical indicators of self-harm, knowing/watching for signs, observing atypical behaviour.</p> <p>Using dialogue to assess/convey seriousness, talking with the adolescent, balancing conversation with the tasks of assessment (e.g., asking about plan, asking scaling question), hearing adolescent ask for help, asking questions, exploring observations/ thoughts of suicide, gathering information through dialogue, supervisor engaging in dialogue with child and youth care professional and youth.</p> <p>Interpreting/reading clues/seeing the signs (e.g., plan, scaling question, checking in) of suicide to determine the seriousness or risk (i.e., attention seeking) of the adolescent's intent, checking off the list, asking the questions, following up youth dismissing suicidal statement (e.g., "just joking"), determining if it's attention seeking, taking it seriously, drawing on training as to what questions to ask.</p>
	<p>INT-01: 51, 57, 75, 80, 81, 90, 91, 108, 109, 111, 115, 258, 243, 461</p> <p>INT-02: 52, 57</p> <p>CYC-01: 51, 114, 37, 56, 42, 211, 117, 118, 87-88, 86, 115, 107, 267, 307,</p> <p>CYC-02: 17-19, 165-167, 18-19, 21-22, 25-26, 130, 429-430, 496-497, 596-597, 599-600, 479-484, 482, 209-210, 368-369, 437-438, 447-448, 488, 490-491, 590, 598-599, 494-495, 241-243, 438-443, 448-451, 597-598, 245-250, 422-426, 454-455, 578-579, 581-582, 11-13, 115-116, 418-419</p> <p>CYC-03: 118, 119, 133, 175, 310, 112, 321-325, 521, 523, 114, 145, 335-336, 341, 490-491, 163, 184, 361, 100, 519, 113, 495, 503-504, 364-368, 167, 390-391, 499-500, 187, 505, 545</p> <p>CYC-04: 237-241, 79, 140, 142-143, 117, 291-293, 181, 338-340, 697-700, 718-719, 128, 374-375, 144-145, 153-159</p> <p>CYC-05: 404-406, 599, 149-150, 151, 253-257, 183-184, 189, 403-404, 619-623, 601-603</p> <p>CYC-06: 108, 126-127, 145-146, 201-209, 120-130, 216-218, 220-221, 234-239, 372-375, 449-453, 449-456, 463-464, 468-469, 472-473, 493-499, 500-505, 512-513, 562-568, 536-568, 536-539, 558, 536-537, 539-544, 590-592</p> <p>CYC-07: 168-169, 171-173, 173-175, 185-186, 188-191, 193-194, 194-199, 207, 222-224, 260-263, 267-273, 346, 467-472, 559-560, 584-585, 590-591, 592-593, 647-649, 667-670, 676, 693, 731-733, 694-697, 701-707, 760-766, 766-772</p> <p>CYC-08: 111-118, 123, 145-146, 153-155, 154, 185, 155-157, 167-169, 205-206, 204-207, 238-243, 273-278, 396-398, 410-413, 454-460, 490-492, 374-376, 379-382, 675-681, 683-690, 394-399, 400-402, 392-394, 436, 496-501</p> <p>SUP-01: 152-156, 158, 167, 275-277, 314-315, 338-339, 412-414, 449-451, 458-460, 504-509, 167-168, 199-206, 313-314</p> <p>SUP-02: 85-87, 106-107, 107-110, 144-145, 154, 192-194, 663-667, 92-99, 117-118, 241, 279-280</p> <p>SUP-03: 107-108, 623-628, 117-118, 241, 279-280</p> <p>SUP-04: 421-426, 445-448</p>

linked categories with participant quotations. All preparation and management served to refine and synthesize the data set.

Additional Data Source: Documents

Combining interviews with document analysis can serve to illuminate a fuller picture of child and youth care professionals' mental health literacy practices. Extant texts were used as a supplementary source of data to provide useful information and comparison with interview data. For example, several participants referenced a "suicide assessment tool" they were obliged to use within their setting should a suicide concern arise. In many instances, the suicide assessment tool was provided by their employer and written into policy; that is, employers required its use. Participants provided copies to me of the agency's policy and assessment tools during the course of their interviews. Other documents identified by participants and used in the analysis included a course outline for a child and youth mental health course, and a publicly available report entitled *Practice principles: A guide for mental health clinicians working with suicidal children and youth* (Ashworth, 2001) (see Appendix O). In my analysis of the documents I abided by Charmaz's (2006) suggestions and asked several questions of the texts including the following:

- What are the parameters of the information?
- On what and whose facts does this information rest?
- What does the information mean to participants?
- What does the information leave out?
- Who has access to the facts, records, or sources of the information?
- Who is the intended audience for the information?

- Who benefits from shaping and/or interpreting this information in a particular way?
- How, if at all, does the information affect actions? (pp. 37-38).

The combination of interviews and document analysis increases the power of evidence (Wilson & Hutchinson, 1991) through triangulation; that is, obtaining multiple views on the research concern (Gibbs, 2007). While I recognized that “text and context are in a continual state of tension, each defining and redefining the other, saying and doing things differently through time” (Hodder, 1998, p. 112), participants identified during the interview the relevance of these documents to their actions in the context of their encounters with suicidal adolescents. Documents then, offered an additional perspective on the developing theory.

Data Analysis

Grounded theory is an emergent research method as the researcher chooses appropriate strategies throughout the process of inquiry to manage problems as they arise (Charmaz, 2008). That is, “the design of grounded theory is one of exploration, not a mapped course” (Stern, 2009, p. 69). Though the process of data collection and analysis unfolds as the study moves forward, grounded theory identifies specific strategies that will be followed during the proposed investigation. Despite differences and allegiances to varied forms of grounded theory, the universal strategies of the method include “(a) simultaneous collection and analysis of data, (b) a two-step data coding process, (c) comparative methods, (d) memo writing aimed at the construction of conceptual analyses, (e) sampling to refine the researcher’s emerging theoretical ideas, and (f) integration of the theoretical framework” (Charmaz, 2000, pp. 510-511).

Timeline

As shown in Table 7, the study was approved by the University of Victoria Human Research Ethics Board (see Appendix S) in May 2010 and concluded with the final data collection in February 2011.

Table 7

Research Timeline

May 26, 2010	May 27, 2010 – September 24, 2010	October 1, 2010 – November 19, 2010	December 21, 2010	January 16, 2011 – February 18, 2011
Approval of the Human Research Ethics Board	Recruitment and Interviews with Child and Youth Care Professionals	Recruitment and Interviews with Supervisors of Child and Youth Care Professionals	Approval by the Human Research Ethics Board for Modification of Approved Protocol	Recruitment and Interviews with Educators within Schools of Child and Youth Care
	Collection and analysis of extant texts (e.g., agency policy documents, curricular documents)			

Simultaneous Data Collection and Analysis

Grounded theory methods are distinguished from many other qualitative approaches in the simultaneous collection of data and data analysis phases of research (Charmaz, 1995). Concurrent collection and analysis permits “early identification of emerging codes and preliminary categories that give direction for further data collection and analysis” (Birks et al., 2006b, p.13). Theory is thus generated as the researcher concurrently collects, codes, and analyzes the data (Glaser & Strauss, 1967). As Corbin and Strauss (2008) suggest, I began analysis after the first interview and proceeded sequentially after deriving concepts from the first pieces of data. Further data were collected based on a *theoretical sampling* approach, which is described in the following section.

Theoretical Sampling

As a key strategy in grounded theory method, theoretical sampling is a strength of the method such that theoretical sampling “enables researchers to discover the concepts that are relevant to this problem and population, and allows researchers to explore the concepts in depth” (Corbin & Strauss, 2008, p. 145). Grounded theory research involves an inductive process where the theory is developed from the data, and a deductive process which involves selecting samples purposefully to check the developing theory (Becker, 1993). Theoretical sampling began after the first session of data analysis and continued throughout the research process (Corbin & Strauss, 2008). As noted previously, grounded theory differs from other approaches where all data are collected first and then subsequently analyzed. Rather, “collection is controlled and directed to relevance and workability by theoretically sampling for the emerging theory” (Glaser, 1978, p. 46).

During the initial sampling process I included participants with minimal differences. This allowed me to identify “the basic properties of a category” (Dey, 1999, p. 171). Wider differences are encouraged in the next sampling stage to “bring out the widest possible variation in categories” (Dey, p. 171) and recruit “participants with differing experiences of the phenomenon so as to explore multiple dimensions of the social processes under study” (Starks & Trinidad, 2007, p. 1375). As the method is emergent, I was permitted to pursue the unexpected (Charmaz, 2008). I was able to explore concepts in depth and take advantage of unexpected events (Corbin & Strauss). Grounded theory method’s “openness to empirical leads spurs the researcher to pursue emergent questions and thus shifts the direction of inquiry” (Charmaz, 2005, p. 512). Theoretical sampling offers flexibility to follow up theoretical leads, adapt as needed to

the situation, events, and participants (Morse, 2009). Despite the systematic procedures for handling qualitative materials, grounded theory offers great flexibility in checking, refining, and developing ideas about the data (Charmaz, 1995). This flexibility allowed me to elaborate and clarify participants' perspectives and my observations in the moment.

Theoretical sampling also permitted me to seek out more than one data source and gain a wider perspective on the phenomenon of professionals' mental health literacy practices in their encounters with suicidal adolescents (Schreiber, 2001). For example, after data collection and analysis of interviews with my initial group of several child and youth care professionals, supervisors were identified as influencing their actions. Following this lead I recruited and interviewed supervisors for a wider perspective on professionals' practice. Theoretical sampling, then, strengthens the quality of my study by sufficiently expanding and elaborating developing categories (Charmaz, 1994).

I proceeded with theoretical sampling, step by step, following the analytical trail, moving between analysis and more data collection. Corbin and Strauss suggest the path is unknown ahead of time, yet the journey stays focused on the identified population. The researcher is "guided by emerging gaps in his theory and by research questions suggested by previous answers" (Glaser & Strauss, 1967, p. 47). Consistency is not the goal in theoretical sampling, nor are rigorous sampling methods, such as random sampling, relevant in grounded theory methods (Dey, 1999). The aim was to follow the important theoretical leads until reaching the level of "data saturation" (Corbin & Strauss, 2008, p. 148). The saturation point occurs when no new categories or relevant themes are generating and the categories are thoroughly developed "in terms of their properties and

dimensions, including variation, and possible relationships to other concepts” (Corbin & Strauss, p. 148).

Two-step Coding Process

“Coding gives a researcher analytic scaffolding on which to build” (Charmaz, 2005, p. 517), is the essential link between data and theory (Holton, 2007), and serves as the vehicle to move the researcher from “transcript to theory” (Walker & Myrick, 2006, p. 549). Coding was not an objective endeavour, devoid of the participants’ and my own assumptions. Rather, coding invited me to scrutinize my assumptions, and ask questions of participants, or to colleagues, about why I developed certain codes (Charmaz, 2005). As a constructivist grounded theorist, developing codes is not a “neutral act” (Charmaz, 2009, p. 130). I brought an awareness of my own location and how this influenced my perspective on the data including the codes I constructed (Charmaz, 2011). Explicating my starting assumptions at the beginning of the research (see Chapter 1) and adopting a reflexive stance throughout the research process allowed me to acknowledge and question my own interpretations of the data (Charmaz, 2006). Furthermore, as Morse (2009) suggests, “...thinking about the data cannot be standardized” (p. 14) and one set of data is open to multiple interpretations (Corbin & Strauss, 2008). Inevitably, researchers from different disciplines, locations, and paradigms may perform grounded theory in dissimilar ways resulting in codes not being identical (Morse). Validating my interpretations during the research process consisted of “grounding” codes in data, checking my interpretations with participants, and repeatedly returning the data to scrutinize my analysis (Corbin & Strauss).

Line-by-line coding. In the two-step iterative coding process, I began by line-by-line coding, or “first-level coding” (Schreiber, 2001, p. 69), studying the data closely and starting to conceptualize ideas (Charmaz, 2006). As a reductive process (Walker & Myrick, 2006), line-by-line coding fractures the data into manageable segments (Stern & Porr, 2011). The data were carefully examined and words, phrases or sentences were identified as a single unit of meaning such that I tried “to use the words of the participant in labelling the unit” (Schreiber, p. 69) to focus analysis on the views of the participants and remain close to the data (see Figure 1). Codes labelled from participants’ words are referred to as *in vivo codes* (Charmaz, 2006). Using *in vivo coding* at the beginning of analysis is a strategy used to avoid the well-known pitfall of *forcing* the data (Elliott & Jordan, 2010). Forcing refers to the researcher applying pre-conceived categories to the data (Glaser, 1978), instead of fitting codes to the data themselves (Charmaz, 1994). For example, a participant early in my study used the phrase “learning as I go” when describing how their knowledge of practice with suicidal adolescents developed over time. This phrase was initially adopted as an *in vivo code* in the study, yet further refined as it was integrated into the theory. *In vivo codes* may also be a shorthand term specific to a particular group (Charmaz, 2006). For example, the term “suicide watch” was used by participants in describing an action taken in the process of their encounter with a suicidal adolescent. Initially adopting the *in vivo code* “suicide watch” and subjecting it to further synthesis and scrutiny offered deeper understanding of participants’ actions and meanings they attributed to the phenomena under study.

While examining the words and meanings of participants I also used gerunds when coding the data. Gerunds are words that depict action and thus focused the analysis

on the sequential process of child and youth care professionals' mental health literacy practices in their encounters with suicidal adolescents (Charmaz, 2006). For example, the code "gathering information" was used to identify data segments that described the interactional process of inquiry professionals engaged in during their encounters.

Congruent with a grounded theory approach, data collection and analysis occurred simultaneously. As coding is an iterative, inductive and deductive process, "each interview... is coded before the next is conducted so that new information can be incorporated into subsequent encounters" (Starks & Trinidad, 2007, p. 1376). Thus each interview was influenced by the one that came before in clarifying what was previously shared or gathering more information to address remaining questions (Stern & Porr, 2011).

Focused coding. The second step involved focused coding where I separated, sorted, and synthesized the data (Charmaz, 2006). Focused coding relies on the initial codes identified during line-by-line coding to sort large amounts of data and categorize them more precisely (Charmaz, 2000). New data were constantly compared to existing data and first-level codes were collapsed into categories creating a coding hierarchy (see Table 5). Schreiber (2001) explains, "the researcher goes from specific incidents to abstractions, which are then checked against the incidents in an iterative process" (p. 70). As I looked for similarities and differences among sources of data, gaps were illuminated and I was able to identify where more information was needed. This constant comparison during the coding process, as described in the next section, allowed for movement from description to abstraction, development of further interview questions, and the discovery of variations and patterns in the data (Corbin & Strauss, 2008).

Comparative Methods

Constant comparison is the most vital strategy of the grounded theory method (Stern, 2009), and at the heart of grounded theory's "matrix operation" (Stern & Porr, 2011, p. 65). I moved back and forth at each level of the analysis from labelled codes to developing categories to changing data sources and interview guides. Comparative methods include comparing incidents applicable to each category, integrating categories and their properties, delimiting the theory, and writing the theory (Glaser & Strauss, 1967). Comparisons are made at each level of analytic work such as between data collected in interviews and observations, or between data collected at earlier points in the research process with data collected later on (Charmaz, 2006). The comparisons are made to identify similarities and differences (Corbin & Strauss, 2008) and to systematically pinpoint the contextual conditions of the recorded incidents (Charmaz, 2005).

Comparison is "essential to all analysis because it allows the researcher to differentiate one category/theme from another" (Corbin & Strauss, p. 73). As Gibbs (2007) suggests, this organization process prevents the duplication of codes and transforms them from description to "theoretical or analytic ways of explaining the data" (p. 54). Properties and dimensions of each category were also identified through comparative methods (Corbin & Strauss). As I engaged in comparative analysis I organized the codes into a hierarchy to depict visually the differences between categories and their properties therein.

Throughout this analytic process I continued to refine and collapse codes into categories while maintaining a record of how each code was defined (see Table 6). Through constant comparison, patterns, explanations, and models developed (Gibbs) leading to an integrated theoretical framework.

Integration of Theoretical Framework

Charmaz (2005) suggests that the data must answer theoretical questions. The outcome of thorough data collection and analysis, and the goal of grounded theory research “is to generate a theory for a pattern of behaviour which is relevant for those involved” (Backman & Kyngas, 1999, p. 151). Schreiber (2001) refers to this process as “third-level coding” where the relationships between and among categories identified during the first and second-level coding process are examined (p. 71). While the goal of grounded theory research is to generate theory, the focus is on *theory as process*, not *theory as product* (Glaser & Strauss, 1967). Thus sufficient discussion of the dimensions and properties of the categories integrates the process of generating the theory into a useable and relevant framework. Stern (2009) states that “[a] grounded theory research report is a description of how the processes make up the discovered theory and often includes a comparison of how this theory and existing theory adds to our knowledge” (p. 68).

Memo writing. It can be difficult to move beyond description to developing theory or committing to a single unified concept or central category (Corbin & Strauss, 2008). Writing memos can be “the intermediate step between coding and the first draft of the completed analysis” (Charmaz, 2000, p. 517). Memos written throughout the research process can bridge the gap between lists of codes and generating theory. Memos can also tell the “analytic story behind the data” (Corbin & Strauss, p. 105). The analytic story, or “chronicle of the research journey,” includes the researcher’s reflections, ideas, thoughts, feelings, and impressions and begins at the initial point of conceptualizing the study (Birks, Chapman, & Francis, 2008, p. 69). Memos were used to map research activities

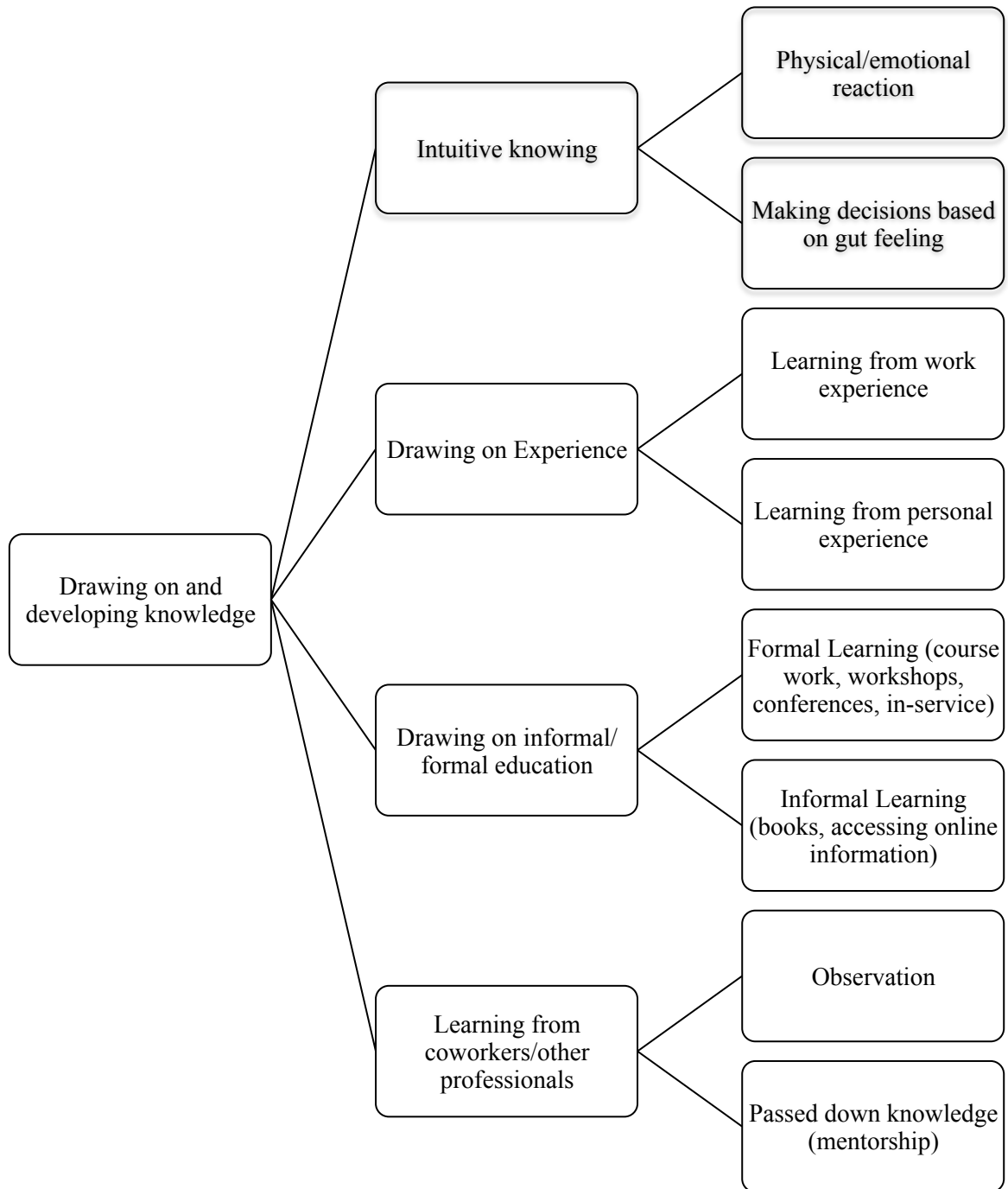
such as documenting the decision-making trail and thus demonstrate the logical flow of the research process (Birks et al., 2008). Beyond assuring trustworthiness through an audit trail, memos also function as a reflexive practice throughout the researcher's analysis (Starks & Trinidad, 2007). Memos recorded my hunches, questions, curiosities as I walked the research journey. As theoretical integration progressed, memos also were a tool to maintain my focus on the recurring basic social psychological process of

Balancing Proximity and Perimeter.

Diagramming. Mapping the analysis visually provided an opportunity to “gain analytical distance” throughout the research process (Lempert, 2007, p. 258). This distance from the data allowed me to consider the links between categories, generate new ideas about the identified processes, and thus raise the analysis to an abstract level. As previously noted, I initially organized codes into hierarchies. Visually, coding hierarchies were represented as flow charts (see example Figure 2) and then grouped in tables. Grouping codes in this way allowed me to understand more clearly the relationships and inter-connections across codes.

Grounded theories are also strengthened if they are situated in terms of the social, historical, local, and interactional contexts (Charmaz, 2006). As the process identified from the data, I used diagrams additionally to explore these macro and micro influences which impact child and youth care professionals' mental health literacy practices. For example, at the local, individual level the process was influenced by the connectivity between the professional and their colleagues. The quality of communication both before the encounter with the suicidal adolescent, and during the interaction influenced the professionals' actions (see Chapter Five for further discussion). Diagramming throughout

Figure 2. Flow Chart Example July 2010



the analysis was essential to providing “...an incisive analytic framework that interprets what is happening and makes relationships between implicit processes and structures visible” (Charmaz, 2006, p. 54).

Establishing Quality and Usefulness of the Study

Judging the quality of grounded theory studies is viewed as a shared activity between the researcher and the reader where evaluation of *fit*, *relevance*, *workability*, and *modifiability* occurs (Glaser & Strauss, 1967). Glaser and Strauss propose that the credibility of the theoretical framework offered by the researcher rests upon the clarity of his or her statements and description about the theory. The reader “should demand explicitness about important interpretations” (p. 233). The challenge for the researcher is to present an iterative research process where data collection and analysis are conducted simultaneously in a comprehensible format that the reader can understand (Suddaby, 2006). Using constant comparison, the concepts I identified *fit* with the data. As the researcher, I must tell a convincing story, a precise detailed account of the events, interviews, and experiences that led to the generated theory (Glaser & Strauss). That is, the research story is a blurring of both process and product (Charmaz, 2006).

Guba and Lincoln (1989) provide several techniques to establish credibility in qualitative studies including prolonged engagement, persistent observation, peer debriefing, negative case analysis, progressive subjectivity, and member checks. An account of how each of these techniques was applied in my study is presented in Table 8.

Quality also required that I seek participants who were key informants in addressing the research concern. Initially I needed to determine what data would provide answers to the research question when considering what group or site to study (Corbin & Strauss, 2008). Corbin and Strauss further suggest the researcher must consider the kinds of data required and make decisions based on “which data have the greatest potential to capture the kinds of information desired” (p. 151). As my investigation concerned child

Table 8

Techniques To Establish Credibility

Technique	Definition	Application to Study
Prolonged Engagement	<ul style="list-style-type: none"> Substantial involvement at the site of inquiry Immersing oneself in the context and culture 	<ul style="list-style-type: none"> In-depth interviews with Child and Youth Care professionals, supervisors, and educators with follow up interviews as needed Following up on theoretical leads though further interviews, and collection and analysis of curricular and policy documents added to my immersion within site/context/culture
Persistent Observation	<ul style="list-style-type: none"> Sufficient observation, prolonged engagement Detailed focus on the problem or issue being pursued 	<ul style="list-style-type: none"> Problem explored from multiple perspectives Detailed focus on problem from multiple sources Prolonged engagement due to research design and movement back and forth from collection and analysis
Peer Debriefing	<ul style="list-style-type: none"> Engaging with disinterested peer in discussion of one's findings, conclusions, tentative analysis 	<ul style="list-style-type: none"> Regular discussions of findings, conclusions, analysis occurred with supervisor, committee members, fellow graduate students, research club
Negative Case Analysis	<ul style="list-style-type: none"> Revising working hypothesis 	<ul style="list-style-type: none"> Peer debriefing and feedback from supervisor, committee members, and others incorporated in final analysis Comparisons between different groups of the same substantive type were sought (i.e., different departments in different agencies, different roles within Child and Youth Care profession) (Glaser & Strauss, 1967)
Progressive Subjectivity	<ul style="list-style-type: none"> Monitoring researcher's own developing construction Progressive subjectivism to check on the degree of privilege 	<ul style="list-style-type: none"> Writing memos began with the first analytic session and throughout the process (Corbin & Strauss, 2009) Checking and scrutinizing interpretations throughout
Member Checks	<ul style="list-style-type: none"> Testing interpretations with members of the stake holding groups from whom the original constructions were collected 	<ul style="list-style-type: none"> Participants provided opportunities (i.e., follow up interviews, reading transcripts) to discuss interpretations, generate categories and concepts, and developing theory Presentation of theory to scholars, students, and professionals at Child and Youth Care conference in April, 2011

(adapted from Guba & Lincoln, 1989)

and youth care professionals' mental health literacy practices with suicidal adolescents, credibility was established with the recruitment of the initial purposive sample of child and youth care professionals who have experienced an encounter with a young person at risk of suicide. Furthermore, credible grounded theory research requires sufficient data to merit the researchers' claims and cover a wide range of empirical observations (Charmaz, 2006). Grounded theory researchers must ensure the identified categories are fully developed in terms of their dimensions and properties (Backman & Kyngas, 1999). Thus to see that the theory was *workable*, other sources of data were sought based on theoretical sampling including supervisors, educators and relevant documents, to ensure the identified theoretical categories were thoroughly developed.

Quality grounded theory research must also resonate or have *relevance* to participants or people who share similar circumstances (Charmaz, 2006). As the basic social process was identified I checked with a few participants to see that it resonated and fit with their experience of encountering a suicidal adolescent. Guba and Lincoln (1989) suggest for methodological rigour the constructed realities of participants must match the realities represented by the researcher. Follow up interviews with some of the participants provided opportunities to check my constructions with the realities of participants. In addition, I presented the theory at a conference for child and youth care professionals, students, and scholars in April, 2011. During this presentation I elicited feedback from the attendees and found that the **Balancing Perimeter and Proximity** process both resonated and fit with their experiences with suicidal adolescents.

Methodological rigour is also enhanced through confirmability (Guba & Lincoln, 1989). The logic and path of analysis was explicit and easily tracked through my use of

memos, diagramming, and structured two-step coding process as described in the previous section. The theory I identified was sufficiently developed to explain child and youth care professionals' mental health literacy practices during encounters with suicidal adolescents. Further research or application to practice by child and youth care professionals may lead to new relevant data and future theory modification.

Limitations

As described throughout this chapter I have attempted to follow closely a constructivist grounded theory approach during my investigation. Despite my efforts to be thoroughly informed in this method and methodology, as a novice researcher there is a possibility I have made procedural or conceptual errors. I have presented my approach and steps to data collection and analysis as clearly as possible in the present chapter.

The basic social process described in the following chapters does not represent the end of the story regarding child and youth care professionals' encounters with suicidal youth. While recognizing the theory could be developed further in the future, I believe it is "sufficiently formulated" for my investigation to be closed at this time (Glaser & Strauss, 1967, p. 225).

Glaser and Strauss (1967) posit that a grounded theory approach, as used in my study, does not generate the only explanation of mental health literacy practices with suicidal adolescents:

By the close of [sic] investigation, the researcher's conviction about his own theory will be hard to shake, as most field workers would attest. This conviction does not mean that his analysis is the only plausible one that could be based on his data, but only that he has high confidence in its credibility. (p. 225)

Based on the steps I have taken in building this theory as outlined in this chapter, I have confidence that the process I called **Balancing Proximity and Perimeter** explains child and youth care professionals' mental health literacy practices during encounters with suicidal adolescents.

Chapter Summary

In this constructivist grounded theory study, data were collected within semi-structured interviews with child and youth care professionals, supervisors at youth-serving agencies, educators in schools of child and youth care , and from documents identified and provided by participants. Data collection and analysis occurred simultaneously between May 2010 and February 2011. In this chapter I outlined the grounded theory research design and procedures for investigating child and youth care professionals' mental health literacy practices during encounters with suicidal adolescents. The philosophical foundations of pragmatism, symbolic interactionism, and constructivism were explicated along with the rationale for a constructivist grounded theory approach.

In the following three chapters I present the **Balancing Proximity and Perimeter** process that I identified as the core category in my grounded theory research on how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents. In Chapter Four, I present, identify and explain the professionals' mental health literacy practices as *Rules of Engaging*. In Chapter Five, I explain the conditions and consequences influencing the **Balancing** process. In Chapter Six, I present an overview of the theoretical model of **Balancing Proximity and Perimeter**.

Chapter 4

Findings 1:

Rules of Engaging Within the Balancing Proximity and Perimeter Process

I identified the **Balancing Proximity and Perimeter** process as the core category from the data set comprised of interviews with child and youth care professionals, supervisors at youth-serving agencies, educators within schools of child and youth care, and analysis of documents identified by participants as influencing the encounter. The core category is described and explained in three chapters as follows: Chapter Four on Rules of Engaging with Suicidal Adolescents, Chapter Five on Conditions and Consequences within the **Balancing** process, and Chapter Six on Integrating and Presenting the Theoretical Model of **Balancing Proximity and Perimeter**. Keeping with grounded theory practice, in presenting the findings from my study, I endeavour to focus on the concepts arising from the interviews *in toto*, not individual participant's stories (Charmaz, 2006). Additionally, I sought to "get as close to the participants' explanation as is humanly possible" (Stern & Porr, 2011, p. 34) in presenting how mental health literacy practices were realized in the encounters of these professionals with suicidal adolescents.

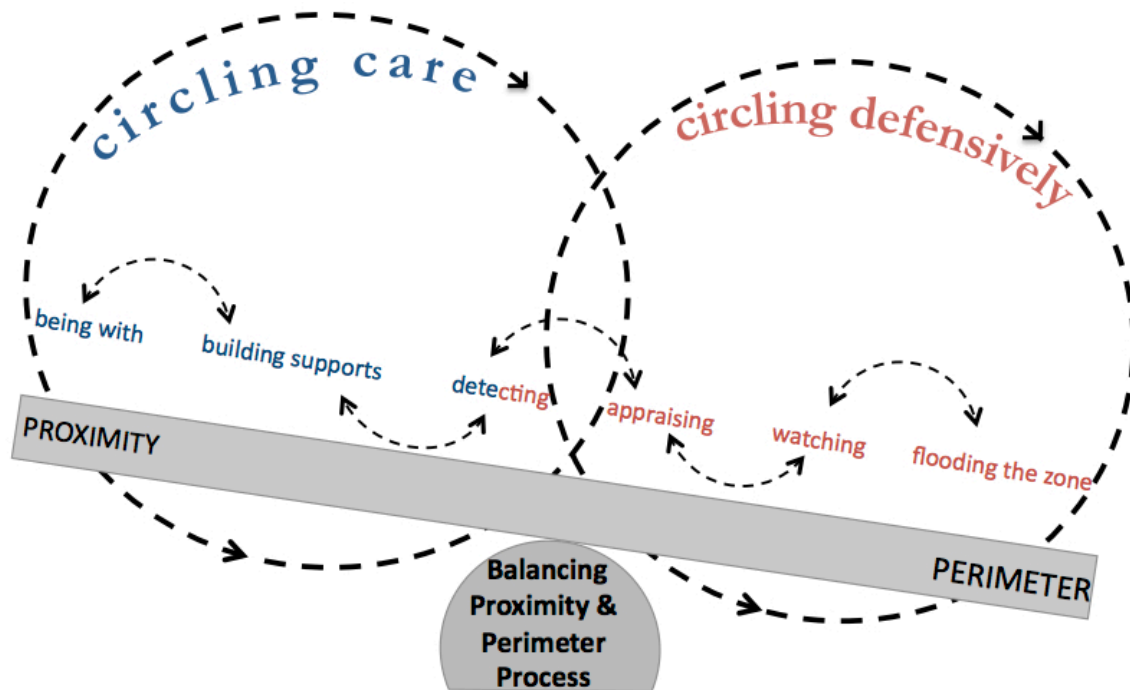
For clarity in presenting my findings I have used various font styles to distinguish elements of the theory. The core category, the **Balancing Proximity and Perimeter** process, is identified by bold print. The two sub-processes (i.e., circling care and circling defensively) are underlined. The sub-category and its respective properties are bold print and in italics (e.g., ***Rules of Engaging, Being With***).

In presenting my findings I have used quotations from every participant to illustrate the elements of the theory I generated from the data. Participant identifiers (e.g., CYC-01) were used in the presentation of quotations. The initial (INT) two child and youth care professional participants in my study were assigned the participant identifiers “INT-01” and “INT-02”. Further participants who were child and youth care professionals were assigned the participant identifier “CYC” with a corresponding participant number (e.g., CYC-03). Supervisors were identified by “SUP” and educators were identified by “ED” with corresponding participant numbers (e.g., SUP-01, ED-03). Documents used in the analysis were identified by “DOC” with a corresponding number (e.g., DOC-01).

Rules of Engaging: Mental Health Literacy Practices within The Balancing Process

What I have termed the **Balancing Proximity and Perimeter** process represents various practices comprised of actions and interactions realized by child and youth care professionals during encounters with suicidal adolescents. Based on the conditions and consequences described in the data (to be discussed in Chapter Five), and to address the research question of how child and youth care professionals’ mental health literacy practices are realized, I refer to the practices as *Rules of Engaging*. The gerund term *engaging* captures the notion of movement during the encounter along the proximity-perimeter continuum within the sub-processes of balancing circling care and circling defensively (to be discussed in Chapter Six). I describe and explain the category *Rules of Engaging* as having six properties: (a) being with; (b) building supports; (c) detecting; (d) appraising; (e) flooding the zone, and (f) watching. In Figure 3, I positioned the six properties, or *Rules of Engaging* along the proximity-perimeter continuum, locating

Figure 3. Rules of Engaging: Professionals' Mental Health Literacy Practices



some of the properties (i.e., *Being With*, *Building Supports*) within the circling care sub-process, and other properties (i.e., *Appraising*, *Watching*, *Flooding the Zone*) within the circling defensively sub-process. *Detecting* is located on the continuum where the sub-processes overlap, showing movement from proximity to perimeter. In this chapter I will discuss *Detecting* as part of perimeter practices within the circling defensively sub-process. The *Rules of Engaging*, or properties, are also wrapped along the continuum by arrows in Figure 2 to illustrate the back and forth movement, or fluidity across properties, or practices realized by child and youth care professionals. I established each of these properties through focused coding and a comparison of codes across participants and incidents. Each property, and its related dimensions, is discussed in this chapter.

Proximity Practices

Child and youth care professionals take up practices during their encounters with suicidal adolescents that initiate and sustain relational proximity with the adolescent. The *Rules of Engaging* are depicted along a proximity-perimeter continuum, which represents practices as fluid and dynamic (see Figure 3). That is, though each practice, or property, will be discussed and described as a stand-alone part of the larger **Balancing** process, movement along the continuum is neither linear nor fixed, and practices, in some instances, may run concurrently with other practices in the process. Practices are fluid in that they flow into each other, and dynamic in that motion, or movement characterizes them. Proximity practices contain the following properties: *Being With* and *Building Supports*. Both properties are characterized by actions that connect the child and youth care professional with the adolescent. *Being With* and *Building Supports* enables child and youth care professionals to remain in close relational proximity with the adolescent. Relational proximity in the process is dependent upon many influencing factors and conditions to be discussed in Chapter Five.

Being with. Using an *in vivo* code, I identified the sub-category “*Being With*” as part of the engaging practices child and youth care professionals realize in their encounters with suicidal adolescents. Participants often used the term “with” and “present” interchangeably: “You have to be really present I think and not try to be in your own head as well. Like, and that’s the main key I guess... just to be with them.” [CYC-06] *Being* seems to symbolize an embodied existence in the encounter. *With* signifies a collaborative approach where the adolescent and the professional are sitting alongside

each other. The *With* position of the child and youth care professional was aptly conveyed by one educator:

So one of the, one of the gifts of our work is that we don't do clinical counselling in a sit-down, eye-to-eye kind of a way. We do things alongside the kids. So we're driving them to an appointment when we can have a conversation with them. We're playing pool when we can have a conversation with them. We're walking down the street sharing a cigarette when we can have a conversation with them. These are the opportunities that we can take to address things that other people don't address with them. It strikes me that that's one of the key roles for a [child and youth care] worker. [ED-05]

Being present, or *With* the adolescent consisted of various attending behaviours (e.g., patience, non-verbal communication), communication skills (e.g., expressing empathy), building relationship (e.g., nonjudgmental approach, expressing care), and having an awareness of the adolescent's uniqueness and specific needs. To illustrate, a child and youth care professional discussed *Being With* the adolescent and what they are communicating non-verbally:

"I'm here for you. I'm calm for you. I know what I'm doing for you. And don't worry; things will work out for you." And that's an unsaid thing that is translated through the communication of like just that, you know, being with that person and the aura, and the, and you know, again, the non-verbal cues that you give out, right? As a professional and a calm, always talk in a calm manner with them and, and I realize like I have that skill set with them. [INT-01]

This participant conveyed non-verbal expression of calmness and presence energetically by her tone of voice, and body posture. Such presence was aligned with how the professional envisioned her role and skills during the encounter.

In order to be with the adolescent in a space of connection and presence, the child and youth care professional had to set aside other assigned responsibilities and tasks.

Being With was realized as an interactional, two-way concept; that is, the adolescent experiences a quality of connection with the professional during the encounter. As the participant quoted below indicates, adolescents would notice and, at times, communicate to the professional when they experienced the professional as distracted and not meeting their need to be heard:

And get rid of that “Okay I got to be out of here by this time. I’ve got this to do. I’ve got that to do.” You have to put that aside. I’ve got to be present. If I’m not present they’re going to know it. And that’s one thing in child care I’ve had called on a couple times till it brought me to attention it’s like “Yeah, you’re here but you’re not listening to me.” And it’s like “You know what? You’re right. I’m not. I’m actually, you know, halfway out the friggin’ door on my way home. That’s totally disrespectful. I’m really sorry. Let me listen to you.” [CYC-07]

Generally, as professionals tried to remain focused on hearing the adolescent and conveying they are ***Being With*** them, the expectations and task of assessing suicide risk also required *setting aside* as one child and youth care professional explains:

So, I think we need to be human, have a human experience with them. And kind of have a conversation with them, and not make it so much about getting through this task, you know, of assessing, but just being present with them. [INT-01]

Being With required child and youth care professionals to be focused on the adolescent, listening to their experience, and communicating their presence non-verbally as well.

For professionals, *Being With* also fostered a sense of personal connection and heartfelt attachment to the adolescent. Child and youth care professionals cared for the adolescent, by expressing compassion and concern about the inconsolable psychological pain the adolescent was experiencing. Caring for the adolescent can evoke concern and sadness in the professional when learning the adolescent is suicidal:

Well for me personally, because I'm very personally attached to her, how was that? It is – I don't know how to put that into words – but it's like, it's like an "Oh no. Oh no." Right? And then it's like, it saddens you because you know, you care about this youth you're working with and how sad must she be at the time to even think about that or want to attempt that, right? So it pulls on my heartstrings.

[CYC-05]

As a part of the process of *Being With*, child and youth care professionals conveyed care for the adolescent holistically. In the midst of the encounter, professionals were aware of the adolescent's physical needs and offered food and nourishment, or recognized and met their needs for privacy and dialogue by offering a quiet space away from other youth. *Being With* involved responding to the needs of the adolescent and caring for them in their entirety, not only responding to their suicidality. As explained by one child and youth care professional, "...giving a shit about them over the whole time and not just when they're in crisis, right?" [CYC-05]

Furthermore, *Being With* encompassed aspects of being in-between. Child and youth care professionals recognized and differentiated their role from other helping

professionals involved based on time and proximity to the adolescent. The encounter often involved professionals spending long lengths of time sitting with adolescents in hospital emergency rooms, in the car driving to appointments, in school offices, or in the kitchen of the group home in the early morning hours. They sat *in-wait* until the next helping professional such as a mental health therapist, nurse, or the next group home worker on shift, stepped in. That is, the child and youth care professional functioned as the “in-between” professional. For however long they waited, the time allotted was focused on building a relationship with the adolescent, generating connection and relying on that connection to gather information. One child and youth care professional below explains this *Being With* and in-between practice:

And I built that relationship, you know. I do. Yeah. And I just, I found that, I find it easy to build that and with the emergency response it's almost that it be instant, right? Cause you're only with them for maybe 4 hours, or 24 hours and it's like sometimes they come from really crappy situations so it's like you got to get as much information as possible to make sure the kid's okay before, you know, so everyone knows what's going on because you're that person in between what's just happened and the social worker in the morning. [CYC-05]

Being With and in-between also featured child and youth care professionals distinguishing their role from other helping professionals as building and being in relationship with the adolescent. While other professionals may have a relationship with the adolescent, child and youth care professionals viewed their role as building relationship. Professionals focused on relationally knowing the adolescent and did so amidst sometimes conflicting perspectives of other service providers. When child and

youth care professionals thought their opinion was not heard, the relationship with the adolescent became a place to return to for the child and youth care professional, to know and understand the youth more, and provided clarity for the professional on their role:

So they'd [service providers] have collateral meetings and we'd share our information and it's like "No. It's an act." The kid needs to go into acting, because it's not. He's very smart and he can verbalize exactly what he needs and wants and this is, you know, I don't know what his game was, right? So my role with him, what I decided was basically relationship building. So that's what I did with him. I thought, okay. I'll go to the grassroots of child and youth care and just build a relationship with him. So I wasn't the authority, I wasn't. I was just... you're building a relationship. [CYC-08]

As an engaging practice, *Being With* involved communicating both verbally and non-verbally presence and connectedness, using listening and communication skills, spending time alongside the adolescent, feeling personal attachment and concern for the adolescent, caring for them beyond their suicidality, and functioning in-between other service providers by building a relationship. At some point in the **Balancing** process, a number of child and youth care professionals moved beyond their immediate connection with the adolescent and attempted to build supports.

Building supports. *Building Supports* within the **Balancing Proximity and Perimeter** process can be seen as the connections the child and youth care professional establishes, or attempts to establish, outside of their own immediate relationship with the adolescent. A distinguishing feature of *Building Supports* was the child and youth care professional collaborating with the adolescent in identifying whom to talk to, and

participating in the discussion by employing identified supports. That is, child and youth care professionals continued to sit alongside the adolescent as they moved beyond their immediate relationship to include others in the process. *Building Supports* consisted of proximity practices in which the child and youth care professional fostered relationships and connection with the adolescent's peers, caregivers, or family members. The child and youth care professional may communicate their concerns about safety for the adolescent, advocate for parents within the mental health system, and engage peers in talking with the adolescent. Underlying *Building Supports* were beliefs regarding the significance of family in the adolescent's life as conveyed by the following child and youth care professional:

I'm big on families being involved with the child. So if, now in an ideal world, if a child came, or a youth came to me with suicidal tendencies, my first place that I would want to go is to the family and find out what's going on with the family because I just find that that's the foundation of a person and particularly a child or youth, and so in reality, where they need to be heard the most is from their parents. [CYC-01]

Along with beliefs about involving family, child and youth care professionals in *Building Supports* brought an awareness of their ethical obligations⁴ to inform others when an adolescent is thinking of suicide. Professionals knew they were required to communicate their concerns for the adolescent to others as part of caring for them, and many professionals elicited the adolescent's participation and collaboration in *Building Supports*. Professionals recognized the adolescent's needs for comfort and safety and

⁴ Ethical and legal obligations for reporting govern limits of confidentiality. The three rules that permit breaking confidence typically defined are harm to self, harm to others, or disclosure of abuse of a minor.

used “we” terms to express they were still *Being With* the adolescent even in the telling.

The following quotation illustrates the collaborative movement between *Being With* and *Building Supports*:

I pulled off in the parking lot and then he started talking about it. And then I said, “Do your parents know?” And then I was like “I’m dropping you off at your house,” and then the three rules of confidentiality are obviously like when someone’s hurting themselves or whatever. So I told him that, and then I was like, “Do you feel comfortable telling your parents what you just told me or should I tell your parents?” And then we both just decide I would bring it up with his parents and just sort of talk about that. [CYC-06]

For some child and youth care professionals in my study, telling others of the adolescent’s suicidality was a challenge. Tension can emerge in *Building Supports* between protecting the adolescent from harm and betraying the adolescent’s confidence by informing others. The trusting relationship established while *Being With* required the professional to inform the adolescent of their obligation to report any concern that the youth may harm themselves. A child and youth care professional described the process of letting the adolescent know the reporting procedures and balancing protection and betrayal:

If a youth states or claims that they’re going to hurt themselves or hurt anyone else, like we already, like we have confidentiality. We were already at the beginning of, intake actually and in relationship building, and when they first come to our program we tell them right off the bat if they claim they’re going to hurt themselves or others by policy or by law we have to report and involve,

involve the police, involve, you know? So they're already aware if they claim this that this is the kind of the follow up is that we have to report it. So they are already aware of that. So that piece is important because you know you could jeopardize relationships with that if you don't have that piece there because then they think, you're, you're betraying them, or you're against them. [INT-01]

Evidence of informing adolescents of the limits of confidentiality was also found in my examination of agency documents used in the analysis. For example, people accessing services were expected to sign a form at the beginning of their involvement with the professional that included the following statement:

If my counsellor has reason to believe that I might injure myself or someone else, or that other persons are at risk for some reason, she/he has a legal and ethical mandate to intervene, even if this means breaking confidentiality. [DOC-01]

Such statements or rules regarding breaking confidentiality were evident across incidents which were described by participants. Professionals, as shown previously, subsequently assumed the adolescent would be aware that if they indicate they were suicidal confidentiality would be broken by the professional.

Beyond informing the adolescent of reporting procedures and limits of confidentiality, negotiating protection and betrayal while *Building Supports* included consideration for the timing of when others would be notified (e.g., "When is a good time to tell your mom?" [CYC-06], or whether or not family members or caregivers would actually be supportive (e.g., "Parent was saying... 'He's just making it up; he's just trying to get attention'." [SUP-04] In communicating concerns about the safety of the

adolescent, professionals were aware of how others may perceive the adolescent's suicidality.

Engaging the adolescent's peers as supports for the adolescent was also a dimension of the professionals' practice of *Building Supports*. Peer involvement was critical in some encounters in highlighting the suicidal concern and seeking help for their friend from the child and youth care professional. In order for peers to be included in *Building Supports*, they also needed to have a connection to, or knowledge of, the child and youth care professional. That is, the professional needed to have a communication pathway and be accessible to the peers surrounding the adolescent. The following professional explains how a peer facilitated support and help seeking for a suicidal adolescent:

Then I heard through her best friend who texted me that she was suicidal the night before but she wouldn't come and see me the next day. And so her boyfriend brought her to me and said that he had been watching her all night long because she's threatening to overdose. [CYC-04]

The connections the child and youth care professionals have with the adolescent's peers can be relied upon to provide needed communication to the professional about the emotional state of the adolescent. As illustrated above, friends served as partners in circling care for the adolescent and thus were essential to the practice of *Building Supports*. Beyond general communication and facilitation of help seeking, *Building Supports* may include the professional involving friends in the discussion with the adolescent about their suicidality. For example, one child and youth care professional engaged in a dialogue with a young male about his suicide ideation. His girlfriend joined

in the conversation and the professional used his/her observations of their connection to illustrate he was not alone. As the professional explains:

And he started to talk about how he wanted to kill himself, and then his girlfriend came in.

Researcher – To the [life skills] class?

[His girlfriend came] into the [life skills] class and was part of that conversation.

She participated in that conversation ‘cause he just carried on the conversation about how nobody cared about him and he didn’t want to be here anymore. And I started to challenge some of that by, because he had his girlfriend with him, and they seemed quite happy together. And so it seemed contradictory to me that he’s standing there telling me nobody cared about him but he’s got his girlfriend on his arm. [CYC-02]

Building Supports was a collaborative practice in the **Balancing** process between the adolescent and the child and youth care professional. Consideration for the adolescent’s confidentiality, the timing of when to connect with potential supports, and drawing in those closest to the adolescent, such as family members or peers, were all aspects of the practice of *Building Supports*. As identified previously, the professionals remained with the adolescent, positioned themselves alongside as they moved beyond their immediate relationship and joined with others. Thus, *Building Supports* was a practice that situated the professional in relational proximity to the adolescent.

Being with and *Building Supports* as properties of *Rules of Engaging* in the **Balancing** process served as proximity practices realized by child and youth care

professionals during their encounters with suicidal adolescents. The following section explains and describes perimeter practices.

Perimeter Practices

Disengaging practices are located on the outer ends of the *Rules of Engaging* continuum (see Figure 3). Such practices enacted by child and youth care professionals typically moved them away from relational proximity and circling care with the suicidal adolescent. Perimeter practices are comprised of the following four properties: *Detecting*, *Appraising*, *Flooding the Zone*, and *Watching*. The following section describes and explains each property and related dimensions.

Detecting. During the **Balancing** process, child and youth care professionals engaged in the practice of *Detecting* in their encounters with suicidal adolescents. *Detecting* was comprised of ascertaining the existence of signs, or indicators that suicide may be a concern. Professionals gathered information to investigate adolescent's behaviour, statements, history, mental health diagnoses, or current emotional state. When *Detecting*, professionals may draw upon knowledge of the adolescent's family history, service involvement, or assessment reports. Professionals also gathered information from the adolescents through observation or direct questioning.

As information was compiled, child and youth care professionals read or interpreted the information, looking for the presence of "warning signs" or "risk factors". *Detecting*, then, required professionals to make meaning of the signs and attribute particular information as being related to suicidality.

The practice of *Detecting* had a distancing effect in their relationship with the adolescent as it refocused the professional's energy away from a relational connection,

previously evident in *Being With* or *Building Supports*. Child and youth care professionals explained various behaviours they observed in adolescents that they would attribute to suicidality. One child and youth care professional describes behaviours that she/he would anticipate being linked to suicidality amongst all adolescents:

Well, that they're withdrawn. The kids are very, very withdrawn and keeping to themselves. Certainly kids that are cutting or mutilating themselves in one way or another. Those kind of kids, kids that are just off to themselves. And even the kids that are being bullied. Kids that are being bullied, another whole area of kids, and that poor self-esteem. You see kids like that are saying things like they don't like their pictures, they're picking themselves apart. They don't like anything about themselves. They're "stupid". "I can't draw". "I can't this", "I can't that". That kind of thing. That whole negative cloud that seems to be around them. [CYC-02]

Further, when working with a specific adolescent, professionals explained they would lookout for particular "triggers" or precipitating factors, unique to that adolescent, that could contribute to suicidality. One child and youth care professional describes detecting a change in mood, dialogue, or conflict with a parent as indicators of concern:

What else do I watch for? I watch for when she's getting down, you know? Like when she's talking about like how she's alone and why does she deserve this, and you know? Her mom, she'd talk about her mom quite a bit, is when I find that I'm more aware of – or not more aware. When she talks more about her mom and then there's sort of conflict, that's when I probably call social worker and be like "Okay, now we need to watch because this conversation is happening, right?"[CYC-05]

The practice of *Detecting* involved professionals investigating and observing “signs” that were frequently implicit in behavioural observations. As they detected behaviours, child and youth care professionals created lists of signs they attributed to suicide:

She had high risk behaviour. There was a lot of the suicidal signs. At that time there was no direct talking about it to me anyways, of you know, like “I wanna kill myself”, like “I feel hopeless” kind of discussion. She had high risky behaviour, sex without protection. She was cutting. [CYC-01]

Anyway so there was assessments through there, by [service provider] and also just the communication that we had with the family, also her general behaviour was suspicious. And there were some questions around whether or not she could possibly be suicidal. [INT-02]

And just some of the friends that she had and some of the choices that she made around living and eating and very kind of recluse and depressed and dark in her living environment. [INT-02]

The aspect of creating lists of signs or indicators of suicide while *Detecting* pulled their efforts away from listening and attending to the adolescent, into creating a cognitive map of links between signs and behaviours. That is, while it may be possible for the practices to occur concurrently, many child and youth care professionals stepped away from *Being With* while *Detecting*.

Child and youth care professionals when engaged in *Detecting* made links between mental health diagnoses and suicide. Similar to listing various signs, professionals listed mental health diagnoses as an aspect of ascertaining the presence of suicidality. Child and youth care professionals identified the label of the disorder and

attributed various behavioural observations to the disorder. Knowing the adolescent's mental health diagnosis was interpreted as having a distancing impact between the child and youth care professional and the adolescent, as this aspect of *Detecting* readjusted the focus of the professional in the direction of the diagnosis to labelling the disorder:

One is, appears to have a very personality disorder emerging for sure. A strong narcissism, and maybe some borderline and maybe some you know, a lot of defended, which would fall under probably narcissism too. Defended narcissism, and not easy to work with in therapy, so not likely going to get a whole lot of help there. We've had diagnosis where it's considered generalized anxiety disorder, which can be the trigger to offshoot into something else and with narcissism can go over. I mean borderline can go over into the psychotic states. [CYC-03]

In some encounters, adolescents may be more explicit in their suicidal communication with child and youth care professionals. *Detecting*, or reading the "signs", is expedited in circumstances where the adolescent communicates more directly about their thoughts of suicide. Direct suicidal communication through body language and through written communication can be detected by the child and youth care professional:

So I had gone over to him and we were just talking and stuff and I was like "Obviously you're not feeling good today? Like what is up with you?" And then he was just saying he was up on the Internet. He's a gamer, and he's up on the Internet until like 4 AM and then he gets up at like 8 AM to go to school, and so he's not getting a lot of sleep. And so I confronted him on that and then he just told me about some other things in his life and then he like flipped open his Swiss

army knife and then he was going like this [participant moves finger across neck], like brushing on his neck and I like sort of looked over at him. [CYC-06]

There was lots of trauma with her mom at that time. Her mom wasn't speaking to her. You know, kicked her out. There'd been a physical altercation. There'd been new people in the group home. Her school was breaking down. She was trying to break down the placement so bad, she just wants foster placement. I mean there was a huge build up. You know, and then like there was a suicide note. "I'm going to jump off the bridge." And then this other youth attempted and she saw [it]. [CYC-05]

During some encounters, child and youth care professionals struggled to ascertain the validity of the presence of authentic suicidal ideation when reading the signs. As professionals engaged in *Detecting* practices, they may struggle with a lack of alignment between the pre-determined signs they attributed to suicidality, and their observations. As explained by one professional, the disconnect can be challenging:

But the challenging thing with this kid is that he didn't present as depressed. That would be you know, [participant looks downward]. He didn't present you know, as your typical. The other depressed youth that I may have come into contact with would've been in their rooms. Locked in their rooms with their earphones on and separate from their family. This kid had lots of friends, right? Had huge peer group, so it was just a very odd, challenging. Like, what's going on here? [CYC-08]

Child and youth care professionals engaged in the practice of *Detecting* to investigate whether or not the adolescent was suicidal. Professionals read the "signs" and made links

between suicide and their behavioural observations, knowledge of family history, or the adolescent’s mental health diagnosis. Gathering information was central to *Detecting*; however, as explained by one professional, the typical pre-determined signs do not always fit the adolescent’s behavioural presentation. Child and youth care professionals additionally described some encounters with adolescents who were more direct in their communication, which resulted in expediting the *Detecting* practice, and professionals moving onto the practice of *Appraising*.

Appraising. *Appraising* practice sorts the information gathered during *Detecting* by labelling the adolescent’s suicidality into categories of “high”, “medium”, or “low” risk. During *Appraising*, specific questions may be asked in the sorting process. The movement of child and youth care professionals to pre-determined questions and assigning the adolescent to a category of risk positioned *Appraising* as a disengaging practice on the continuum of *Rules of Engaging* (see Figure 3). Child and youth care professionals’ practice of *Appraising* was interpreted as mechanistic descriptions often supported by the use of structured assessment tools locating signs of suicide with levels of risk. To illustrate, the following is an example from an assessment tool provided by a participant and used in the analysis (see Table 9 [DOC-04]):

Table 9

Assessment Tool Illustration

	LOW	MEDIUM	HIGH
METHOD	weapon unavailable, unrealistic, or not thought of	lethality left to chance with some likelihood of intervention	lethal, available method with little chance for intervention

The “method” in the assessment tool above refers to the plan the adolescent may have thought about, or put in place, in order to die by suicide. The term “lethality” is used to describe the likelihood that death would occur based on the means (e.g., gun, pills, carbon monoxide, hanging) the adolescent plans on using to die. The “chance for intervention” refers to the possibility of being rescued or interrupted by another person while implementing the suicide plan.

The questions asked by professionals during *Appraising*, and how they asked the questions directly, were comparable across encounters. Professionals asked the adolescent in a direct manner if they are suicidal, and then asked if the adolescent had a plan as to how they would kill themselves. The following quotation illustrates how professionals explain the use of pre-determined questions when *Appraising*:

So just some real, point blank “Are you thinking about killing yourself? Do you have a plan? What is your plan?” And then, you know, access, timelines; we already know if they have a history with themselves or family. So, yeah, so, it’s a really clear you know, “Are you thinking?” “Yes.” “What is your plan?” “My plan is to overdose on Tylenol.” “Where are you going to get the Tylenol?” You know, and that’s, so we just do a real, clear. [SUP-01]

In situations where they feel uncertain if the adolescent is providing an honest answer, professionals may persist.

Like I’m not afraid to say like “Are you thinking about suicide?” and you know, “Do you have a plan?” And then like saying, “No. What is your plan?” You know? Like if they’re beating around the bush or I don’t feeling like they’re being

completely honest, I'll like sit there until they're like honest with me I guess.

[CYC-05]

The presence of a plan and how the child and youth care professional appraised the plan (see Table 9) guided the subsequent line of questioning:

And then you know the first thing is OK. Do you have a plan? You know, is this something you're thinking about or do you actually have a plan to do it? Cause we're at two different scenarios here. If you got a plan, what's the plan? How are you going to achieve that plan? You know? If not, okay, so let's talk about it.

What's going on for you right now that you think you might want to kill yourself?

[CYC-07]

Appraising may begin with the professional asking the pre-determined set of questions as explained above. Following this, child and youth care professionals explain how the answers to the questions allow them to categorize the level of risk.

Researcher - You mentioned the protocol. What's involved in the protocol?

It's a series of questions to determine how, how at risk the student is of committing suicide.

Researcher – Okay. What types of questions would be on that? Do you remember?

Do you want to kill yourself? Have you ever tried to kill yourself? Have you had a loss of someone close to you recently? I think if you answer “yes” to “Do you want to kill yourself?” Then “Do you have a plan?” They're fairly open questions and guidelines. And then as you score them then, there's 5 questions, if they get 3 out of 5 they're medium risk. If they get 4 out of 5 they're high risk. [CYC-04]

Despite the apparent clarity provided by assessment tools and protocols obtained from participants in categorizing the adolescent's risk for suicide, some child and youth care professionals describe difficulties with *Appraising*. Clearly there are challenges in determining the category of risk and how additional questions are put in place to add to the appraisal process:

The thing that probably, and for my own self, is you know, what's the level of risk? Is it low, medium, high? And sometimes that's really difficult to assess, right? Cause it's a little bit low, but you know, was there a time when? So looking at was there a time when they've moved from low into, you know? Was it just desperation or depression and say "well I might as well kill myself" and "I didn't mean that." And the question I always ask is "Did you want to die? Did you want to die or did you want to stop the pain?" And most of them will say "I want to stop the pain" and that could be bullying, that could be alcoholic parents, you know those kinds of things. But that's always the question. [SUP-04]

At times professionals also incorporate into the practice of *Appraising* their own belief about the potential for the adolescent to act on his/her thoughts of suicide.

Like that's, you know, he was talking suicide and even he had it planned out. You know, he was going to hang himself or cut himself with a paper cutter. So he was like, it was, it was so hard to describe because it was harder to think whether he was, it was attention, or it was real. But you always take it as real, right? Like you know, you always take it as it's a, cause I believed he could've done it. I believed he could've done it. [CYC-08]

Child and youth care professionals during *Appraising* listened carefully to the adolescent's responses to the questions in order to distinguish between categories of risk.

One professional explains the difference s/he is listening for during *Appraising*:

Like he was stating that he was going to have a, he was going to do what his plan. You know, he already had a plan in place and he was just going to act on the plan, as opposed to just saying "I'm thinking of hurting myself," or "I'm going to do this now." There's the difference the dialogue. [INT-01]

An additional dimension of *Appraising* involved professionals asking the adolescent to rate themselves on a scale. Scaling questions are a technique used in solution-focused therapy to sharpen and make concrete complex aspects of a client's life (De Jong & Berg, 2008). Child and youth care professionals in my study used scaling questions to measure subjectively the adolescent's mood and support categorizing the adolescent's risk for suicide. As illustrated in the quotations below, professionals would ask the adolescents to rate themselves on a scale of 1 to 10, and determined the level of risk and subsequent actions based on the number the adolescent provided:

Even though she's sharing this and I'm getting the understanding of how lost she was and stuff, her mood was still quite on a scale for her from 1 to 10, like she, she was like a 7. So my concerns for her at that time weren't high. She wasn't high risk at that time. So checking with her, and knowing that she had those things, we just ended the conversation. [CYC-01]

Like when I'm meeting with them and he's – we go on a scale of 1 to 10 – anything over an 8 we've got some problems with him as far as his own locus of control, bringing it down in. [CYC-01]

Child and youth care professionals relied on the practice of *Appraising* to categorize the adolescent's suicidality as "high", "medium", or "low" risk. They relied on a pre-determined set of questions, assessment tools, and scaling questions to support their *Appraising* practice. Professionals explained the category assigned to the adolescent determined subsequent decisions and practices enacted by the professional. Although the following quotation is lengthy, it explains aptly and summarizes how professionals realize *Appraising* practices during their encounters with suicidal adolescents:

So if they're low risk we just, we document it and we call the parent and we say "I've just gone through the suicide protocol with your son or daughter." We might, the student and I might come up with a plan about resources that they can use when they feel that way again. And then I give them the number of [mental health service] and it's up to them if they follow through. If they're medium risk we strongly recommend that their student get help or sort of a judgment, we can call the [mental health crisis support] ourselves. And if the parent refuses to get help and we think that the child needs help then we call [child protection services] and then high risk, you know, we go around. We document it. We inform the counsellor. We inform the vice principal. We inform the parents and the [mental health crisis support]. We keep the student with us until the [mental health crisis support] can respond. [CYC-04]

As illustrated in the above description, *Appraising* and *Flooding the Zone* are interconnected and fluid such that the consequences of *Appraising* lead to particular actions when *Flooding the Zone*. Professionals move out and away from circling care

when their encounters with adolescents become structured and pre-determined. The following section describes and explains the practice of *Flooding the Zone*.

Flooding the zone. In every encounter with a suicidal adolescent, professionals enacted practices in which a myriad of professionals or services were contacted and informed of the adolescent's suicidality. Child and youth care professionals made various decisions during the encounter regarding the timing of informing others, whom to inform, and what information was provided. In some instances, professionals relied on agency policies or institutional protocols as guidelines for their decisions. Supervisors or pre- or in-service education may also have influenced their decisions. Such conditions that influenced professionals' practices will be discussed further in Chapter Five.

During data analysis I identified professionals' practice of informing others as *Flooding the Zone*. The concept is derived from a strategy used in team sports (e.g., football) where many players on one team are sent to a particular area of the field leaving the opposing team in that zone outnumbered and overpowered. Building on the sports analogy, *Flooding the Zone* in my study described the strategy professionals used to overpower the likelihood of the adolescent dying by suicide by surrounding the adolescent with services and other helping professionals. Distinct from *Building Supports*, when professionals were *Flooding the Zone*, they contacted persons usually unknown, or at some distance, from the adolescent. In addition to those contacted being potentially unknown to the adolescent, it was uncertain how, or if, the child and youth care professional would remain with the adolescent when *Flooding the Zone*. Disconnection between the professional and adolescent located *Flooding the Zone* within the realm of perimeter practices professionals realized in their encounters with the

adolescents as professionals moved from circling care, to circling defensively within the **Balancing Proximity and Perimeter** process.

Flooding the Zone was characterized by several actions by professionals. Child and youth care professionals began with making a decision to access services. At times, professionals did not enact ***Appraising*** practices, and ***Flooding*** was the first response upon learning the adolescent was suicidal. As conveyed by one professional, “So, my first thought was to get, make sure that the right support was in.” [INT-02] For others, actions during ***Appraising*** may direct their next steps and be influenced by guidelines set in place by their employer. This child and youth care professional decided to ***Flood the Zone*** based on how she/he had categorized the adolescent while ***Appraising***:

[T]he school district has a protocol that we have to follow when someone says that they’re suicidal. And so I followed the protocol and the last step if someone is at medium or high risk then you have to call in someone from mental health and addictions so I called the crisis response worker. [CYC-04]

Flooding is additionally based on who is currently involved in the adolescent’s life, although they may be at more of an arm’s length than the proximity of the child and youth care professional. Essentially, as illustrated in the quotation below, this aspect of ***Flooding the Zone*** is characterized by listing what parties should be notified about the adolescent’s suicidality: “Legal guardian needs to know this is where we’re at; this is what we’re doing. Probation officer needs to know. If there’s a forensic clinician involved, they need to know. And we as a team need to know.” [SUP-01] Child and youth care professionals are expected to “be able to figure out who needs to be involved, who needs to be talked to, and who needs to be brought together to deal with the issue.”

[ED-03] With reference to the sports analogy of *Flooding the Zone*, child and youth care professionals are required to list the players. They may follow agency guidelines in creating this list, derive players from an existing list of contacts, or be able to identify other players that may need to be involved in the situation. However, not all adolescents feel supported by the child and youth care professionals' *Flooding* practice.

During encounters with suicidal adolescents, the practice of *Flooding the Zone* in notifying others can create distance in their relationship with the child and youth care professional distancing themselves from the youth's perceived needs. Even when efforts by the professional are enacted to be collaborative with the adolescent in identifying supports, the adolescent may not want others to become involved or aware of their suicidal concerns. They may feel their needs are being addressed in the existing relationship they have with the child and youth care professional. Even with the best intentions for providing support, the adolescent may experience *Flooding the Zone* as a disengaging practice:

So, he started getting a little angry, that he didn't need anything or whatever. Like he doesn't need anything and we're like "Okay." And we're like "Well let's make an action plan. Like whatever it is. Like what is something that you need? And like how can we assist you even though this isn't a big deal anymore or like you're not going to do it?" And then so he said, he's like "Well, I'm in this fucking boys' group, like there's two fucking youth workers." Like he kept saying it like that. "Like there's two youth workers in there." And he's like "I already told this person there and this is like why I don't want to say anything 'cause it has to be told to so many people." [CYC-06]

In some situations, more intrusive measures are enacted when *Flooding* whereby child and youth care professionals respond by immediately accessing emergency services. If the first response upon hearing the adolescent may be suicidal was met with police intervention, the police then directed the subsequent decisions:

[I]f they're going to hurt themselves or hurt others, you know, we call first foremost, we call 911, and then when they come in, we connect with that, you know, with the police and just ask whether or not this person needs to go to the hospital or not and most times they do take them to be assessed. [INT-01]

Whether it is the police being informed of the adolescent's suicidality, or another helping professional or service, analysis of the data set indicated child and youth care professionals not only informed others, but also deferred the situation to others when *Flooding the Zone*. Some child and youth care professionals viewed their *Appraising* practice as limited in comparison to what other professionals could offer. As one professional said, "I have my protocol, but it's very brief. They have much bigger screening tools than I do." [CYC-04] Positioning oneself outside of a helping role when encountering a situation involving suicide also conveyed a self-identified lack of expertise amongst child and youth care professionals

Because I was, only my role at the time was [teaching life skills] and I was asking questions. I was prodding and trying to see where this was going to go with him, asking him certain questions, which really wasn't my place. I wasn't his counsellor. I should have referred him. [CYC-02]

Flooding the Zone positioned child and youth care professionals outside of the sub-process circling care on the proximity-perimeter continuum where they would be

relationally engaged and in physical proximity to the adolescent. For various reasons (e.g., beliefs about own role, beliefs about own expertise) in some encounters, professionals handed off the adolescent to police, to counsellors, or to crisis response workers. A professional summarizes this aspect of ***Flooding*** in the following statement: “We had the pager number on speed dial of the crisis response workers, so you’d call them and they would show up within the hour usually and they would deal with it all.” [CYC-04] Other service providers who were seen as holding the expertise and role of managing situations involving suicide reinforced deferring to other services as an aspect of ***Flooding***. At times, child and youth care professionals were clearly informed by other helping professionals “we’ll take over” and that “they don’t want you mucking about in it.” [ED-02] ***Flooding the Zone*** in such instances required the child and youth care professional to step away from the adolescent physically and relationally.

In some encounters, professionals were not able to defer to crisis response workers, police, or existing connections to “deal” with the situation, and ***Flooding the Zone*** practices were characterized by negotiation. Professionals were required to navigate the mental health system and negotiate ways to ensure other services would be provided. As part of this aspect of ***Flooding***, child and youth care professionals relied on their knowledge of eligibility requirements and access points for particular services, fostered relationships with other professionals, and knew what services were available in the community. In some instances, child and youth care professionals negotiated ways of jumping the queue to have the adolescent receive services. As one child and youth care professional explains, insuring that an adolescent seen at the hospital is expedited when police are involved:

I feel like it's more secure to call cops and have them take her and you know what, to be honest with you, hospital [staff] will see them faster. As opposed I'm coming in and I notice a lot of times when I come in with the individual and, if I start to talk for the individual they don't even, they don't want to hear it. The triage nurse is like "no they can speak for themselves." They're really rude like that. And they're like "no they can speak for themselves" and then they'll be talking to the individual. They don't want the workers to be with them. [INT-01]

Negotiation while *Flooding the Zone* may require child and youth care professionals to manage the situation when other services do not want to "take over" [ED-02] or "deal with it all" [CYC-02], or "take it on" or "hold the responsibility". [INT-02] As services were sometimes found to be compartmentalized to address particular, specified concerns, the child and youth care professional was required to negotiate during *Flooding* which concern was the priority, and subsequently, who was responsible. One professional explains their experience of negotiating responsibility:

She has FASD, developmental disability, a confirmed history of sexual abuse... and had 20- plus suicide attempts in her time in hospital, now [mental health services] would not take that on. They said that her developmental disability was more prominent than her mental health. I don't necessarily agree, not when somebody has twenty-some suicide attempts in six-month period. That was interesting, so instead of taking it on, [mental health services], after negotiation, quite a lengthy negotiation, and this is where the political part comes into it, you sadly enough have to negotiate who's going to be the responsible party for a

person who's extremely vulnerable and suicidal. So, they did not want to hold the responsibility. [INT-02]

The practice of ***Flooding the Zone*** involved notifying and informing others of the adolescent's suicidality. Child and youth care professionals may be guided by agency policies as to whom they were to notify, or they may create lists of services and other helping professionals that may, or may not be known to the adolescent. As a (disengaging) practice, ***Flooding*** was not always well received by the adolescent and was often enacted without any collaboration between the adolescent and professional. When ***Flooding***, some child and youth care professionals stepped aside while other service providers assumed ownership for the situation. Professionals were required to know what services were available and their eligibility requirements. Such knowledge allowed professionals to expedite access to services or negotiate for services to be involved in supporting the adolescent.

Watching. The descriptions provided by child and youth care professionals, supervisors, practice guidelines, and policies consistently reflected enacting the practice of watching the adolescent. Various terms and phrases were used to denote the practice of ***Watching*** such as "having an eye on" or "getting extra eyes on", "checks", "monitoring", or "putting [adolescent] on suicide watch". As some terms for ***Watching*** were agency-specific, to protect anonymity I will replace such terms with "watching".

Watching constitutes a property of the category ***Rules of Engaging*** and is situated on the continuum further away from the sub-process circling care as identified in from the data as a perimeter practice (see Figure 3). ***Watching*** involved child and youth care professionals monitoring the movements of the adolescent and maintaining close

physical proximity. *Watching* was distinct from the engaging practice of *Being With* as the intent of the practice served an alternate purpose. As described previously, *Being With* was a practice in which the child and youth care professional was energetically present, drawing on communication skills to listen to the adolescent, attending to the adolescent's needs, and building a relational connection. *Watching*, on the other hand, was a monitoring activity, often structured temporally, with the intent of supervising the adolescent's actions. Child and youth care professionals were *Watching* for any efforts made by the adolescent to attempt to act on their suicidal ideation. That is, *Watching* was a practice that was viewed as preventing suicide, ensuring the adolescent was physically safe and kept alive.

As the practice consistently was focused on monitoring activities and physical safety and did not constitute relational engagement, *Watching* was interpreted as a disengaging practice. While professionals were in close physical proximity to the adolescent, *Watching* was often devoid of the collaboration evidenced in *Being With*. Adolescents were “put on” or “placed on” a system of monitoring and may not be informed of what *Watching* would entail:

I'm going to be checking in on you. We don't tell them it's every 15 minutes, obviously for the reasons that you don't want to schedule, but we do let them know that we're going to be checking on them a lot. [SUP-02]

The timing of the “checks” when *Watching* varied from “...through the night, so 5-minute checks, and checks, that's light, breathing, watching”, [SUP-02] to “put her on suicide watch which means that the worker has to go in every 2 hours to check up on

her.” [SUP-03] The absence of collaboration in the practice of *Watching* was evident to the adolescent as well:

I said, “Do you have a plan?” And he says, “Yes I do but you’re not going to know what it is. I’m not telling you anything; I’m just going to do it. You can’t watch me 24 hours. You’re by yourself.” “Oh Frigg!” So yeah, I had a panic attack I have to say. [CYC-07]

Watching was not always a realistic or effective practice with the adolescent even though child and youth care professionals may be instructed not leave the adolescent alone.

However, *Watching* often took precedence over all other activities as evidenced in the following quotation:

And I really had to pee, [laughter] but part of the protocol is do not leave the student alone and the [colleague] was already very non-supportive and so I didn’t want to ask him to watch her and I wasn’t sure if I could leave [peer] in charge of her, so I missed my lunch and I missed any breaks and we sat there until about 1:30pm and this was started at 10 o’clock in the morning. [CYC-04]

Assurances of “close supervision” and “one-on-one supervision” were emphasized in practice guidelines referenced by one child and youth care professional. [DOC-02]

Agency policies also emphasized *Watching* as not leaving the adolescent alone. To illustrate, an agency protocol included in the analysis states, “Stay with the child/youth to ensure safety.” [DOC-03] Thus, professionals may assume that *Watching*, at any cost, ensured safety.

Despite the structure of *Watching* not lending itself to meeting a child and youth care professional’s own needs around breaks, or for collaboration with the adolescent as

illustrated above, when someone else was available professionals experienced a sense of reassurance from knowing others would be *Watching*:

So I just felt like I had wanted them to maybe take it a little bit more seriously and I just – yeah. That’s how I felt. But I knew they were, I knew they were good parents in that they, they were aware of it, and like they were watching and like they would have an eye on him and stuff like that. [CYC-06]

Watching did not always lead to the adolescent being safe from harm. Though child and youth care professionals may have received directions to watch and instructions regarding the frequency and timing of checks on the adolescent, there appeared to be a disconnect between actually knowing the adolescent’s emotional state and the practice of *Watching*. Such a disconnect may be attributed to not knowing what to watch for:

When this staff came in to monitor she was watching but you know, in hindsight, not all the clues and the experience of kind of what to watch for. So the young girl decided she was going to sleep. So, she rolled over and went to sleep but in her hand she had somehow managed, you know, in the washroom, (not really quite sure how) to have a blade. So, she was rolled over and going to sleep but she was cutting when the staff was actually sitting right there. And so, not until the sheets became quite crimson red did she realize and she had gotten a good, quite a deep, deep cut. [SUP-02]

A clear aspect of *Watching* was maintaining physical proximity to the adolescent so they could be observed and even checked for signs of life. Professionals in some encounters went to great lengths to maintain such physical proximity and keep their eyes on the adolescent. Though the following quotation is rather lengthy, I’ve chosen to

include this child and youth care professional's description of *Watching* to illustrate how the practice can be enacted at all costs:

And then he boots it out the door and so my coworker and I kinda follow him and kinda chase down with him, like walk behind him. And as he starts walking onto oncoming traffic and we're following him and we're on radio talking to the [supervisor] that's in from previous shift, being on the phone, giving a description of what he was wearing so the police can come and get him. So we start following him and instead of him going up towards the bridge, he starts walking towards the bottom pathway, which is a good sign for us because he's not going up the bridge to jump. So he sees us that we're following him and so yeah. And he just, basically we keep following him and this is happening and it's raining too at the same time. So we're like getting soaked and we're following this kid. [INT-01]

The dynamic of the adolescent physically trying to move away, and the professional subsequently following them in an effort to maintain physical proximity was realized in other incidents as well. For example, a child and youth care professional described following an adolescent in their car for 2 hours. Thus, maintaining physical proximity and "eyes on" the adolescent was a central aspect of the practice of *Watching*.

Watching also was realized during encounters with suicidal adolescents as an ownership or responsibility for all events within particular amount of time. Underlying professionals' *Watching* practices were concerns regarding the potential for harm to occur to the adolescent, and the need to protect themselves from blame. In *Watching*, professionals essentially took responsibility for the adolescent's life and engaged in activities (e.g., documentation) as a way of proving and tracking they did what they could

to keep the adolescent alive: “Every time [adolescent] cut herself, or talked about suicide I wrote an incident report. I mean, I did massive paperwork on this girl ‘cause I was very concerned that we might lose her on our watch.” [SUP-01]

Professionals were not only concerned about their responsibility for the adolescent’s life, concerns about the aftermath of an adolescent’s death by suicide and the ramifications on their own wellbeing were also evident:

I just, I mean, is it fear? I don’t know. I keep saying, “I don’t want anyone dying on my watch”, but, and I haven’t. And I’ve talked with people who have had clients complete and it’s devastating because for the rest of your life you’re thinking “What else could I have done?” is what people have told me and I’d probably be in that same place. [SUP-04]

Experiencing a death by suicide could place professionals in a position of questioning their abilities and actions. Taking ownership for the watch, following the watch guidelines, ensuring *Watching* was enacted in a structured, well-documented manner, and maintaining physical proximity, were all characteristics of child and youth care professionals’ *Watching* practice during the **Balancing Proximity and Perimeter** process.

Chapter Summary

The **Balancing Proximity and Perimeter** process was identified as the core category explaining how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents. In this chapter I presented the category *Rules of Engaging*, which is comprised of the following six properties: (a) *Being With*; (b) *Building Supports*; (c) *Detecting*; (d) *Appraising*; (e) *Flooding the*

Zone, and (f) *Watching*. I identified and explained each of the properties and how they are situated along the proximity-perimeter continuum.

In Chapter Five I present the conditions and consequences that influence the **Balancing** process, movement along the proximity-perimeter continuum, and the relationships between conditions and child and youth care professionals' mental health literacy practices, or *Rules of Engaging*.

Chapter 5

Findings 2:

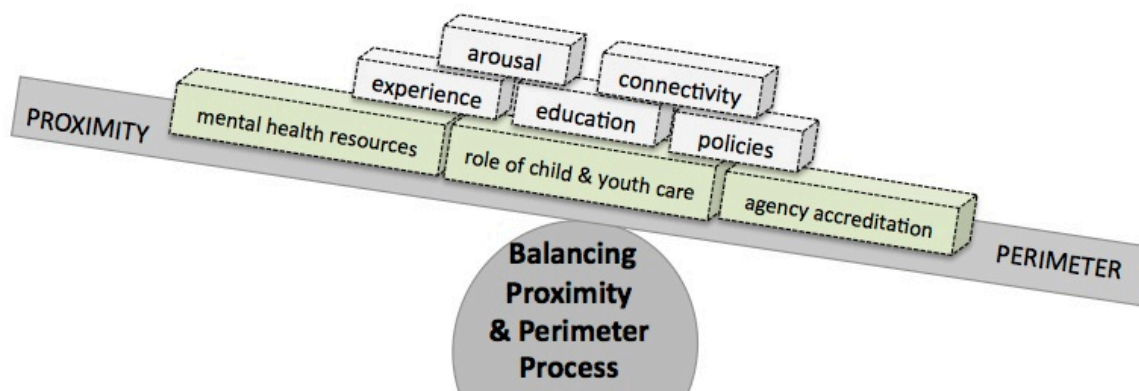
Conditions and Consequences Within the Balancing Process

In my analysis of the category *Rules of Engaging* within the **Balancing Perimeter and Proximity** process, I placed the properties on a continuum. The properties are not specific to individual child and youth care professionals as professionals can and do move across the continuum, and may also enact more than one property, or practice, simultaneously. Movement along the continuum is both promoted and impeded by certain conditions (Charmaz, 2006). Conditions, then, lead to further actions, which result in various consequences (Corbin & Strauss, 2008). Child and youth care professionals' mental health literacy practices are not viewed as static "but as continually changing in response to evolving conditions" (Corbin & Strauss, 1990, p. 5). The aim of grounded theory is "to build a theoretical explanation by specifying phenomena in terms of conditions that give rise to them, how they are expressed through action/interaction, the consequences that result from them, and variations of these qualifiers" (Corbin & Strauss, 1990, p. 9). Chapter Five is dedicated to explaining the relationships among such conditions and child and youth care professionals' mental health literacy practices, or *Rules of Engaging* and identifying the consequences, or outcomes, of professionals' response to encounters with suicidal adolescents. Presenting my findings in this way advances my work "beyond describing phenomena" (Charmaz, 2006, p. 118).

As explained in Chapter Four, the category *Rules of Engaging* is comprised of six properties: (a) being with; (b) building supports; (c) detecting; (d) appraising; (e)

flooding the zone, and (f) watching. The six properties are influenced by five micro conditions: (a) connectivity within work relationships; (b) policy documents; (c) suicide education; (d) experience, and (f) arousal (see Figure 4). A further three macro conditions are also at play in the **Balancing** process: (a) role of child and youth care professionals; (b) availability and accessibility to mental health resources for suicidal adolescents, and (c) accreditation requirements for provincially funded agencies (see Figure 4). The following chapter defines and explains the conditions, the relationships between conditions and the properties of the category *Rules of Engaging*, and the consequences of professionals' inter/actions.

Figure 4. Conditions Influencing Balancing Process



Influencing Micro Conditions

The **Balancing Proximity and Perimeter** process is comprised of a combination of micro and macro conditions. Although I will be explaining and presenting micro conditions and macro conditions separately in Chapter Five, conditions, actions, and consequences are interconnected and are neither separate nor apart. Corbin and Strauss (2008) describe the interplay between such aspects of the process:

As analysts, we are interested in the interplay between micro and macro conditions, the nature of their influence on each other and subsequent inter/action, and the full scope of consequences that result, then how those consequences feed back into conditions that become part of the situation and subsequent inter/action or emotional responses. (p. 91)

Blocks are used in Figure 4 to illustrate the micro and macro conditions influencing the **Balancing** process. The blocks are stacked on the continuum in Jenga⁵ style and illustrated with dashed lines to symbolize the interplay discussed by Corbin and Strauss (2008), such that the presence of a condition may support and intersect with the presence of another condition, and so on. The conditions are situated on the perimeter – proximity continuum to represent the influence conditions have within the larger **Balancing** process in moving child and youth care professionals towards, or away from, alternate ends of the continuum. Further, blocks may be viewed as weight added to the continuum perhaps tipping the child and youth care professionals' movement in different directions. Child and youth care professionals are not balancing the conditions; rather, the conditions are impacting the professionals' realization of practices during the encounter. In the following section I describe and explain the five micro conditions, or those conditions that are closer to the child and youth care professionals (Corbin & Strauss), as identified in Figure 4.

⁵ Jenga refers to a game in which small wooden blocks are balanced on top of each other. Players attempt to remove a block and re-balance it on top of the structure. Blocks are positioned to support other blocks in building the structure. (Wikipedia.org, 2011)

Connectivity Within Work Relationships

Connectivity, or the variable quality of connection, between the child and youth care professional and their colleagues and supervisors was evident in the data as a condition that influenced the **Balancing** process. Connectivity was compromised of connection and disconnection in participants' work relationships.

Connection. Some child and youth care professionals explained connectivity as connecting or feeling connected, through communication with their colleagues and supervisors. They described communicating verbally, and in written form, their need for help, support, direction, information, and mentorship. Open and active communication (e.g., feedback, support, accessibility) within their immediate working relationships met professionals' reported needs. Professionals described connection as feeling confident in their coworkers' capabilities and being able to take their concerns to colleagues and supervisors. As a child and youth care professional explained, the exchange of communication with their team created confidence in service continuity with the adolescent: "Most helpful was my team; my immediate team members because I could depend on them to follow through with getting the information and connecting." [INT-01]

As an aspect of the connectivity condition influencing the **Balancing** process, connection figured prominently in the data as an influencing concern experienced by supervisors. I discuss and provide evidence of how child and youth care professionals were influenced by connectivity in regards to disconnection within their working relationships later in this section. Supervisors explained how they supported child and youth care professionals during encounters with suicidal adolescents. For example, they

created opportunities to debrief encounters child and youth care professionals had with suicidal adolescents:

So I said, “Let’s get off complex and let’s find a place to sit and go and grab maybe a picnic basket.” I don’t know, “we’ll grab something and go sit in a park.” I didn’t want to be in a restaurant. I wanted people to be able to do whatever it was they needed to do and that’s actually what we did. We grabbed some food and just went over to the park and we had a really good two-hour chat. [SUP-02] And then maybe if I’ve talked with them after they’ve done an assessment and it was questionable, we’ll generally meet the next day or the day after just to do another debriefing. [SUP-04]

In addition to creating opportunities for debriefing, supervisors described monitoring child and youth care professionals’ interactions with the suicidal adolescent and stepping in when they were concerned about the professionals taking on too much responsibility for the adolescent’s life. To illustrate, a supervisor explains how they discuss their concerns with a child and youth care professional:

When I see workers who really are taking it on too much themselves, who I can tell, I can, I’d like to believe I can see in staff when, yeah, they’re taking responsibility for whether or not a youth is going to choose to end their life and being able to just name that. So when I’m hearing language from them, just being able to stop the conversation and say, “You know, I just heard you say you know, ‘not on my watch’. We need to talk about that. You know? We need to address what you’re saying there about your responsibility.” Sort of trying to support

them in recognizing you know, where the limit is, right? Of how much we can do.

[SUP-01]

Supervisors interrupting the professional's interaction with the adolescent and addressing their concerns may also result in the child and youth care professional being relieved of their duties. In such instances, connection may be the supervisor recognizing the child and youth care professional's need for the supervisor to step in and respond to the adolescent. For example, a supervisor explained trying to support a professional over the phone in assessing the adolescent's suicidality, and needing to send the professional home as the professional was overcome with emotion:

And then as I walked through them through that [suicide risk assessment tool] the youth worker started crying on the phone. So I had to call a supervisor at three in the morning to have them go down to the [program] to help out that youth worker, 'cause we had to send that youth worker home. [SUP-03]

While supervisors and colleagues may serve as points of connection for child and youth care professionals, their influence can also lead to disconnection.

Disconnection. Disconnection was identified as an aspect of the connectivity condition that influenced child and youth care professionals in the **Balancing Proximity and Perimeter** process. Several professionals explained their efforts to share with their colleagues or supervisors concerns about the encounter with a suicidal adolescent and receiving limited, or a complete lack of response or support. Despite supervisors identifying how they created opportunities for connection, from the perspective of child and youth care professionals, there was a need for more communication and follow up by supervisors after their encounter with a suicidal adolescent. Disconnection influenced the

property *Being With* discussed in Chapter Four as the relational connection between the child and youth care professional and the adolescent may be severed based on the authority of the supervisor. As one professional explained, “My team leader didn’t have the time of day and thought I shouldn’t waste a minute on this one [adolescent].” [CYC-03] Supervisors were highly influential on professionals’ practice as they were viewed as the authority and person to whom they reported. Child and youth care professionals explained they worked within a hierarchical structure in which communication and information travelled upwards. The hierarchical reporting structure influenced connectivity between the professional and their supervisor, and between the professional and the adolescent:

I always go to my supervisors. I always go up the ladder. The chain of command for me wherever I’m at. That’s what I do.

Researcher - Do they tell you where they take it? Or what happens next?

No. No. Not often. Often what happens is that it gets reported and then it’s out of my hands. They’ll report it to the ministry, things like that. But it’s out of my hands. [CYC-02]

The severing of the relational connection while *Being With* distanced the child and youth care professional from the adolescent. Once the professional reports the encounter to their supervisor, the adolescent is “out of my hands.” [CYC-02] The authority ascribed to supervisors reinforced the position of child and youth care professionals along the proximity – perimeter continuum such that professionals did not sustain their relational connection. As one professional explained, she/he experienced frustration and lacked

confidence to continue in relational proximity with the adolescent after a directive from her supervisor:

I wasn't allowed to have anything to do with her. And I was just quite frustrated but I didn't know where to go with it. I didn't have the confidence to see her anyways. I didn't have the confidence that anybody in administration higher up would back me up on that. [CYC-04]

Professionals conveyed they felt isolated and alone, and at times, had no one that would support, or "back up" their decisions. Disconnection occurred when supervisors or colleagues failed to recognize child and youth care professionals' expertise. One professional explained longing to being heard or valued within their work relationships: "So I would wish they would hear my expertise, because when I say something I'm talking from a gut feeling of something." [INT-01]

In addition to not being heard or valued for their expertise, professionals' practice of *Being With* adolescents during encounters was not necessarily supported by their supervisors. Child and youth care professionals focused on their relational proximity and connection with the adolescent especially during encounters where they perceived other supports and outside resources were limited. However, relationships characterized by the practice of *Being With* were not always aligned with supervisor's expectations:

The help that wasn't there was terrible. The only thing that I had to rely on with him is my relationship with him. Bottom-line that's what it all comes down to. It's the only thing. Isn't that something? And the team leader's saying "No. Shouldn't have a relationship like that with him." [CYC-03]

Professionals attempted to connect through communication with their colleagues and supervisors to elicit support for adolescents in their care. Out of the information they garnered through the mental health literacy practices of *Detecting* and *Appraising*, they shared their opinions and concerns by *Flooding the Zone*. As identified previously, professionals want their expertise to be valued such that connectivity with their work colleagues becomes a condition that influenced how professionals realized mental health literacy practices during their encounters. Child and youth care professional's practice of *Flooding the Zone*, coupled with others sometimes viewing the adolescent's suicidality differently had devastating consequences:

I've had situations where I've sent an email in the middle of the night, saying like this youth is unwell, I've seen him on the overnight, he's not doing good, and he needs to be assessed, and this actually happened in [month] and he had a meeting with [counsellor] the morning of the next day. And I sent her an email knowing this, and to the [mental health counsellor], like he needs to be, like he needs to be assessed, and needs to be "pinked", you know, certified. And then I got a response back like "Oh I talked to him he was clear, and he said that he's been taking his [medication] from the doctor." Of course he's saying this 'cause, you know, 'cause he'd want to get back in the house... And a week later he committed suicide. [INT-01]

Child and youth care professionals may have different perspectives than their supervisors on what an adolescent needs and the type of care to be provided. Professionals' experience of disconnection and not being heard by their supervisor influenced their practice of *Being With* the adolescent. In some encounters, child and

youth care professionals were specifically directed by their supervisors not to see the adolescent. One professional struggled with this direction and brought the situation to his/her colleagues who informed the professional his/her employment was at risk if she/he continued to see the adolescent:

We do case conferencing so I brought it up there. And that's when I was told don't, don't go over – don't do it and don't see her if they tell you not to see her because you won't keep your job. [CYC-04]

Supervisors may disconnect child and youth care professionals from the adolescent by directing them to no longer work with the adolescent. Connectivity also intersects with the micro condition of arousal as professionals experience intense emotions when informed by a supervisor they did not take the appropriate action during the encounter.

As a result, professionals may question their capabilities:

They cancelled my [life skills] class the following week and we all had to have a talk about that and talk about boundaries and roles and it was huge. It was major [laughter]. Terrifying. Terrifying. Well, because you know, as a practitioner I don't want to do any harm. I never want to do any harm. And I felt like oh – have I done harm? That's sort of how I felt. Oh, have I harmed somebody by doing this? Has my inexperience harmed him by talking about it? Is he maybe going to think about it more? [CYC-02]

While some child and youth care professionals explained they were cut off from contact with the adolescent and not heard by their supervisors, one professional described disconnection even when his/her supervisor had created an opportunity for discussion and debriefing. Disconnection, for this professional, was explained as the supervisor

normalizing the encounter with the suicidal adolescent and thus not validating the professional's emotional experience:

I just wish the tone was a little bit different sometimes like when I was getting clinical counselling and talking about it as far as saying like, I think sometimes 'cause you're immersed in that sort of stuff, or you do it so much that it's just like normalized. Like for me, like when I was at that second one with [youth's name] like I was just like a little bit like shocked and like my [supervisor] was just, she's so good at what she does, she's so calm about it in meetings and like she's just really like direct with it. And like part of me was just like a little bit I guess, I was still in shock, but not. And so I wish they would just, yeah. I don't know. It's just the tone sometimes. [CYC-06]

Disconnection, as an aspect of connectivity, was comprised of professionals' not feeling heard, not being valued for their expertise, being directed to end contact with the adolescent, or experienced as emotions invalidated by their supervisors. Connectivity interplayed with the condition of professionals' arousal and influenced professionals' practices of *Being With*, *Flooding the Zone*, *Detecting*, and *Appraising*.

Policies

Policies refers to guidelines or protocols either prescribed by the child and youth care professionals' employer or agreed upon amongst services within a community. Policies pertaining to suicide were often made available to professionals in written form as part of a larger group of documents outlining procedures employees were to follow in a variety of situations. Child and youth care professionals and supervisors explained policies were comprised of various steps the professional was to enact should they

encounter a person who was suicidal, or a situation where a person has attempted suicide.

For example, some professionals were instructed by an agency policy to enact the

following steps during an encounter with a suicidal child or youth:

1. Is the child or youth's life in immediate danger?
2. Stay with the child/youth to ensure safety.
3. Arrange transport to the hospital.
4. If safe transport is not available, phone 911 for ambulance/police assistance.
5. Inform the parents/guardians.
6. Inform child/youth's therapist, social worker. [DOC-03]

The presence of a policy outlining steps for professionals to enact during an encounter with a suicidal adolescent was a condition that influenced the **Balancing** process. To illustrate, step one in the above policy document is aligned with child and youth care professionals' *Appraising* practice, and step two coincides with professionals' practice of *Watching*. Policies, then, became part of the process and influence professionals' practices in the situation.

Child and youth care professionals explained policies were helpful or unhelpful conditions, which have an impact on their practice. As one professional explained, the presence of a policy created confidence they were undertaking correct action in the encounter:

So one thing I think for me because I am a 'P and P' [policy and procedure] person, I value that piece because for me that gives me that sense of if anything happens, the policies and procedures are there in writing and it's clear to me of how I'm to proceed in this situation if I come across a situation like a suicidal

situation our policy and procedures state that we need to follow this way. Like you know, step by step and then follow that. And that gives me peace of mind that I'm doing my job correctly because I'm following procedure. Or at least that's a guideline for me to follow and if I didn't have that then I don't know where things would, would go, right? So, so I think that's, that's an important piece that we need to have. [INT-01]

The presence of a policy outlining the steps the professional is to take during encounters with suicidal adolescents provided "peace of mind." [INT-01] The professional also alluded to the policy providing a predictable pathway through the encounter: "...if I didn't have that then I don't know where things would, would go, right?" [INT-01] However, not all professionals found the presence of a policy helpful in their encounters with suicidal adolescents.

Policies may not necessarily be applicable across encounters and may provide the professional with limited information. For example, one professional explained the policy available to him/her from the employer was directed only towards situations where the child or adolescent had attempted suicide:

Researcher - Was there a specific policy around what you were supposed to do if you encounter a suicidal kid?

Ask the questions.

Researcher – That's what it said?

Yeah. I remember that it was a stupid thing [laughter]. Follow the suicide protocol was all in place for if a child attempted.

Researcher – Oh. Okay.

So if you went in and they're hanging from the door, whatever, there was a specific you know, what you had to do.

Researcher – But there wasn't anything to tell you –

Not if they were sort of threatening, no.

Researcher - Threatening or thinking about?

Here's some possible questions to ask. Well, here's questions. You could ask these questions.

Researcher – But then nothing to tell you what to do next?

Well then you could phone your supervisor and get guidance that way, or if there's a mental health worker, you could phone them. If they're working with a suicide prevention worker you could phone them. So there's all these "coulds", "you could" or "you could do this" or "you could do that" or "you could do the other". But no specific, it was only if one, if there was an attempt in progress what you needed to do. Don't leave them hanging. Go call the [emergency]. That's not helpful. [CYC-07]

As a micro condition, policies impacted child and youth care professionals' mental health literacy practices directly. Professionals followed steps outlined in policies regarding what questions they were to ask the adolescent and who they needed to contact. Policies, then, influenced the practices of *Appraising*, *Watching*, and *Flooding the Zone*.

Suicide Education

Child and youth care professionals' mental health literacy practices within the **Balancing Proximity and Perimeter** process were influenced by their participation in pre- and in-service education programs. Pre-service programs in schools of child and

youth care provided professionals with foundational skills in counselling and interpersonal communication: “I think like the [child and youth care] program helped me a lot too, just with the basic fundamental like counselling skills.” [CYC-06] Pre-service programs additionally emphasized the importance of creating a relationship with children and adolescents. Professionals, in turn, focused on relationship building during their encounters with suicidal adolescents and explained relationships as being foundational to their practice. The following two quotations are examples of how professionals concentrated on their relationship with the adolescent during the encounter:

But I’ve just come to realize that I am going to count on what I’ve been trained and my experience and that is how I will practice. And if that’s – I know the outcome. I can count on knowing that when I’ve waived and gone the way they tell me to, it blows up, ‘cause without relationship you have nothing and that’s what I was taught in child and youth care and I will stand by that. [CYC-03]

I thought, “Okay I’ll go to the grassroots of child and youth care and just build a relationship with him.” [CYC-08]

The emphasis on relationship building and providing students with counselling skills in pre-service programs was a condition that influenced child and youth care professionals’ mental health literacy practice of *Being With*. While *Being With*, professionals listened, attended to the adolescent’s needs, and engaged in a relational connection with the adolescent.

Professionals also explained drawing upon systems theory in their practice with suicidal adolescents. Systems theory provided professionals a view of the adolescent as situated within the context of their family, school, and community. One child and youth

care professional explained how she/he used systems theory to understand the points where the adolescent's resilience may be enhanced:

And I mean the school of child and youth care gives foundational information. I mean they're teaching systems, right? And we're looking at the individual, the family, the school, the community. We know that the stronger the link between the child and his family the child and his school, the child and his community, the stronger the kid. We've got more resilience, right? So I mean those are just basic you know theoretical frameworks we know to look at. [CYC-03]

Professionals were also informed in pre-service programs the limits of confidentiality and their ethical obligation to report if an adolescent is suicidal as illustrated in the following quotation:

My counselling classes, communication classes, I guess that's where I've learned it from. Like hurting someone, hurting yourself, or someone's hurting you. It's a fairly broad I guess, guideline but I guess that's where I learned and if they tell you something along those lines then you have to tell somebody. [CYC-06]

A systems approach viewing the adolescent in the context of their family, school and community, together with the obligation of informing others if the adolescent is going to hurt themselves were elements of pre-service education that influenced child and youth care professionals' mental health literacy practice of *Building Supports*. Professionals engaged and informed influential others in the adolescent's life based on knowing the limits of confidentiality and adopting a systems approach in their work.

Professionals explained that specific suicide education within child and youth care pre-service programs was provided sporadically: "We went through suicide in

psychology class... we went through it in the child and youth care program, bits and pieces, here and there.” [CYC-02] Educators in schools of child and youth care also explained the topic of suicide historically was not formally taken up in core child and youth care courses. The knowledge and skills provided in child and youth care pre-service programs were viewed by educators as foundational to practice, yet attention to specific issues, such as suicide, were limited. Recent changes to curriculum to incorporate topics such as mental health in the past few years have occurred as one educator explained:

The core courses really were you know, about working with individuals, working with families, working with groups, understanding child and youth care theory development, like theories, developmental and change theories that will assist child and youth care practitioners. You know, all the helping skills, and stats and research. All of the various, but there really wasn't enough focus on some of those issue-based topics. So substance abuse and mental health were two that we realized practitioners really are working in the context of those settings specifically, but even when they're you know, in a, say a community setting, or residential setting, they, they're always addressing those issues. [ED-01]

In the above quotation, the educator explained professionals were likely to address issues that were not taken up in child and youth care pre-service education in practice. As another educator explained, professionals working in the field of child and youth care, students, and pre-service program advisory committees communicated a need for child and youth care programs to specifically address suicide and mental health in curriculum:

Basically it was folks, they were saying we want more information about this [suicide], students saying we want more information in our classes, sites [e.g., community agencies] saying it would be helpful if you did this, or our advisory committee saying it would be helpful if we prepared our students. [ED-02]

In response to the identified need, recently educators created and implemented curriculum that addressed the topic of suicide within some pre-service child and youth care programs. Content pertaining to suicide was focused on “knowing some of the signs and symptoms and what exactly is the process for referring kids, supports to their community” [ED-02]. Students in some pre-service programs were also exposed to exploring attitudes around suicide, risk and protective factors, and how to ask someone if they are thinking of suicide. One educator explained his/her pedagogical approach to teaching child and youth care students to ask about suicide:

I say, “I’d like you to all stop and turn to your neighbour and I’d like you to ask the question.” And I say, “Don’t make it too flowery, right?” And so I say, “You know, ask them ‘Are you thinking of killing yourself?’” and many of them go “Oh-oh.” And so they do. I say “And I want you to ask it, you know, in an empathic and serious way. Right? And sit with that and then I want you to reflect and talk about how that felt.” So we do that and reflect in the large group about that and students often share that that’s the most terrifying moment for them and that has happened over the years. I haven’t varied on that strategy because that’s been so helpful in provoking, arousing the emotionality that comes with “Okay now I have to do something about this.” You know? Or what does this mean? Or I feel uncomfortable or it brings back that myth that if I say the word that I’m going

to, you know, actually have somebody thinking they're suicidal when they're not.

[ED-01]

Knowing the “signs” [ED-02], or “risk factors” [ED-01], and asking the adolescent about suicide had implications for professionals’ practice of *Detecting* and *Appraising*. Some professionals learned through pre-service programs various criteria or factors, which educators then linked to suicidality. Such signs influenced what professionals observed in the adolescent, or essentially, professionals’ practice of *Detecting*. To illustrate further, one educator explained, “using mental health examples to highlight particular symptoms that they will really want to go ‘Oh, that’s a red flag. I need to pay attention to that.’”[ED-04] Following *Detecting*, professionals learned to ask the adolescent about their suicidality which led to the practice of *Appraising* such that professionals discerned and categorized the adolescent’s level of risk for death by suicide. Some students in pre-service child and youth care programs learned to categorize an adolescent’s suicidality by risk level and respond based on the level assigned:

So they do that and come to assess whether somebody’s in immediate danger, sort of high risk, medium risk, low risk. With all levels of risk there is some form of intervention, going from, you know, make a phone call, try and get the adolescent crisis response unit here to get help this minute. Get an ambulance or drive them to hospital, right, if they’re high risk and in the moment and so that’s the place.

[ED-01]

Professionals learned in pre-service programs to respond by *Flooding the Zone* after categorizing the level of suicide risk. As discussed in Chapter Four, *Flooding the Zone* refers to the practice of notifying others of the adolescent’s suicidality and referring

the adolescent to other professionals. For example, an educator explained students in child and youth care pre-service programs “need to be able to figure out who needs to be involved, who needs to be talked to, and who needs to be brought together to deal with the issue.” [ED-03] Pre-service education in child and youth care programs influenced professionals’ mental health literacy practices throughout the **Balancing** process. There was evidence professionals realized the practices educators taught during their encounters with suicidal adolescents.

Professionals and educators distinguished between pre-service programs and workplace experiential learning such that child and youth care programs provided foundational skills and knowledge, and the “real training comes on the job.” [ED-01] One professional explained they did not feel they were prepared for encounters with suicidal adolescents during their pre-service program for the realities of practice:

I don’t really think that I felt really prepared. I feel like, yeah they, we had all these talks in class about your roles and professional boundaries and that. But I think when you’re actually in a situation it gets really blurry. [CYC-02]

The knowledge transfer and application of pre-service education to practice with suicidal adolescents was challenging for some professionals. When additional suicide education resources were available for self-study, some professionals explained they had limitations on their time and were not able to take advantage of such resources:

Like I have, I have found this material [refers to binder containing practice guidelines document] and have not read it because it’s too busy with you know, I mean when I go into a situation and go, “Oh my gosh. I have a kid that could die

today”, I don’t have time to read about it. I’m drawing on me. I’m relying on what I can do right now, you know? [CYC-03]

Resources and ongoing in-service suicide education may, or may not, be made available to child and youth care professionals in their workplace. In some situations, no in-service education options are available despite working with a population of adolescents who may be suicidal:

Well I mean first of all there should be, if this is information that I’m finding and I’m dealing with kids who could be suicidal and families that don’t have knowledge, why is there no training for me? There is not training dollars in [employer] at all. None. None. [CYC-03]

Education, as a condition influencing the **Balancing** process, may support various mental health literacy practices child and youth care professionals in my study realized in their encounters with suicidal adolescents. However, when working in the field, some professionals may not feel adequately prepared to work with suicidal adolescents, and have limited opportunities for ongoing in-service education or time for self-study. Education intersected with other influencing conditions in the process. As I will discuss later in this chapter, in regards to macro conditions in the **Balancing** process, accreditation required employers to provide in-service education to employees.

Experience

Child and youth care professionals understood their encounter with the suicidal adolescent in the context of their previous personal and professional experience. The experience condition interplayed with other conditions (e.g., arousal) and influenced their mental health literacy practices. Some professionals had personal experience with suicide

with friends, family members, or their own experience of suicidality. One child and youth care professional who had personal familiarity with suicide stated she/he “thought about myself and when I was in that situation”, [CYC-01] and drew on his/her personal experience to understand the adolescent’s needs from her/him during the encounter: “Like just hearing that they were saying, what I went through as well, like they definitely solidified what I already thought was what they needed.” [CYC-01]

One child and youth care professional’s *Detecting* and *Appraising* practices were influenced by his/her personal experience. The professional explained they felt “triggered and panicky” when they shared their appraisal of the adolescent’s suicide risk and “it was not taken seriously” by colleagues. [CYC-02] The professional conveyed their prior experience of hearing their own child fluctuate between killing himself and “joking” entered into how she/he categorized the adolescent’s suicidality:

So there’s was all these like check, check, checks, checks. So I have the feeling that they felt from it that it was just a big joke. And even though he was saying to them “Oh, I’m just joking” ‘cause my [child] would say stuff like that. My [child] would say you know, one minute he was killing himself and the next he’s it’s just a big joke, you know? [CYC-02]

The professional’s personal experience, then, was a condition that intersected with the condition of connectivity within work relationships. The professional experienced disconnection with his/her colleagues who believed the adolescent was not serious about suicide.

Child and youth care professionals who had previous experience with suicide in other situations and relationships anticipated how they would respond to a suicidal

adolescent. The thoughts and emotions professionals experienced in previous circumstances influenced how their perception of the present encounter. For example, one professional explained she/he anticipated feeling nervous when encountering a suicidal adolescent:

I've had other encounters with it I guess, before like with friends, or with other kids that I've worked with but they didn't necessarily disclose to me. Like they had already attempted I guess. So I guess I would've always thought I would be a little bit, I guess, nervous when someone had told me 'cause I find it a really big deal I guess of someone wanting to end their life. [CYC-06]

Experience also contributed to the professional gaining confidence over time.

Professionals were able to explain how responding to situations involving suicide changed from their initial encounter based on the knowledge and confidence they derive from each situation:

Just every time I, every time I go through it I just, I gain a little more knowledge and a little more confidence so that I'm – like the first time a student came to me and said that she was feeling this way I was a blank. I didn't know what to say to her. And so every time I've gone through it I've learned a little more. [CYC-04]

And you know, based on experiences, I'll probably do okay. So I have that self-confidence now I guess, that I'm not going to go into panic stations. [CYC-07]

But I know that over the years, it's kind of become part of the work. So it's not as high anxiety that it used to be for me. Like you used to hear "suicide" and be like "Oh my God. We've got to care take." And it's become part of the job and so you become a little more comfortable working with youth that are suicidal. [SUP-03]

Professionals' emotional experience of feeling confident or nervous based on prior experiences demonstrates the intersection between the condition of experience and the condition of arousal.

Arousal

Child and youth care professionals' conveyed encounters with suicidal adolescents created feelings of physical and emotional arousal. Professionals described emotions such as "fear", "panic" and "helplessness". As one supervisor explained, "as soon as one of the kids use the 'S' word, which is what I call it, people panic." [SUP-04] Child and youth care professionals' arousal, in some encounters, stemmed from feeling suicide was beyond their capabilities or preparation. They feared that the adolescent would die:

You feel like – you don't feel prepared. You don't feel like you have all the answers. You don't know what to do and God forbid you say or do the wrong thing and they commit suicide, how will you live with yourself? You know? So as a practitioner, it is a frightening thing. [CYC-02]

Professionals' feelings of being inadequate or overwhelmed were influenced by the context of the encounter and their interactions with the adolescent. Some experiences of arousal could be overcome in situations where the professional felt they could respond to the adolescent, whereas other encounters proved to increase the professionals' arousal to the point of experiencing paralysis:

I viewed it as just overwhelming. It was, you know, I was out of my depth. With her it was, at the beginning, I definitely felt like I was totally out of my depth but because I was able to do what I was able to do, it felt okay. But the next time was,

a boy that came into the office and he said “I just want to let you know I’m going to kill myself tonight but you’re not going to know when and you’re not going to know how.” And I can remember my heart beating like crazy going “Oh Frigg. Now what?” And you know, and I was on the night shift and it’s like “Crap.”

[CYC-07]

Because she would, she’d write the letters, right? Like, you know, like “Nobody loves me. The only good thing about my life is that [professional’s name] is there so I’m sorry [professional’s name] and you can have my things but I’m jumping off the bridge.” You know, like one letter was really bad. And then she disappeared and so it was like did she jump off the bridge? And so we were quite scared. [CYC-05]

Child and youth care professionals attempted to dissipate their aroused emotions and move into a state of comfort and calm. In order to mitigate the aroused state, professionals took up *Appraising* practices attempting to discern the adolescent’s risk level for suicide, while trying simultaneously *Being With* the adolescent and attending to their needs. As one professional explained, arousal shifted professionals’ practice along the *Rules of Engaging* continuum:

Just I was trying to be comfortable with it, ‘cause I guess it’s a normal feeling to have. So yeah, I just was basically asking him really open-ended questions and just I guess just making sure what level he was at with it. Or what like, if he was just thoughts with it, like ideation, or if he had plans to, or if he’s tried to, or if he’s told anybody else. I was asking really sort of plain questions and just trying to remain calm and just ask him if he needs anything or just ask him what I could

do or what he needs me to do right now, or like if we needed to pull over. [CYC-06]

The description in the above quotation illustrates how the aroused condition of the professional influences how mental health literacy practices are realized during the encounter with the adolescent. The professional tried to be comfortable, asked questions to categorize the level of suicidality, tried to remain calm, and attend to the adolescent's needs. As a condition influencing the **Balancing** process, arousal impacted the activity of the professional during the encounter.

At the intersection of arousal and mental health literacy practices, or *Rules of Engaging*, some professionals often made decisions regarding the adolescent's suicidality based on "gut feeling" or intuition. Professionals "tuned in" [INT-01] to their bodies in order to recognize the physical and emotional indicators of arousal. As one child and youth care professional explained, the experience of physical and emotional arousal during the encounter may have more influence on their practice than suicide education:

And to be honest with you, I just, it's a gut, it's just a feeling that I get. It's just an intrinsic, like. I just know: a knowing of it. I. And of course I've had some training in some suicidology. Like I've been to a conference and I've read up on it, but it's just really, just the experience. Just being in it, and knowing, and feeling it out. I don't know how to explain it.

Researcher – Are you able to tell me more? You say "gut." What does that feel like?

What it feels like is a clear indication. Like it's just coming from like, where it's like you're into my intuition. And it's like this kid is serious. And it just, I think I feel like it's arousal that you get from it, that you, it's a different kind of arousal when you get this kid is just bullshitting, right? It's just a different feeling and emotion and you tap into it. Like I think when you're in tune with your body and your body knowledge and how it reacts to things then you have a clear message of what that feels like. [INT-01]

Some professionals explained they experienced a physical and emotional arousal in response to the encounter with the adolescent. For example, one professional described engaging in the practice of *Watching* the adolescent for several hours until someone arrived to relieve him/her. After the colleague took over the *Watching* practice, the professional explained how arousal influenced his/her response to other adolescents in his/her care:

I immediately made him [colleague] sit at the [adolescent's] door. I had to disengage. It was, I was just mentally just a basket case and I went down and I think became very mother-like to the boys. Not child-care like. It was "You're in your rooms right now. And get in there. And get to sleep. And just I don't want to talk to you. I don't want anything. You just need to settle and I'm going to clean this mess up." And I just focused on cleaning the mess. I mean at that point I'm in their faces. They settled and then I just spent the time cleaning up. And I was like shaking. [CYC-07]

The professional disengaged with the suicidal adolescent, was physically shaking, and mentally a "basket case". The condition of arousal influenced the professional's practices

along the proximity – perimeter continuum such that when the professional stopped *Watching*, she/he moved entirely away from the adolescent, was in a heightened state of arousal, and took up a directive stance with other adolescents in the program.

Arousal also influenced some child and youth care professionals' practices of *Being With* and *Detecting*. Professionals were concerned about how they developed and maintained a relational connection with the suicidal adolescent while simultaneously asking them questions about their suicidality:

Maybe this is a time we could actually get in and talk to him. Okay I'm going to go talk to him today. I'm going to make a – I'm going to show up. See what happens. You know? I mean it's always like that. But that's a very tough place and, and then what questions do I ask? What will offend him? What will he respond to? You know? Exhausting trying to get in there with this type of kid.

[CYC-03]

During the **Balancing** process, professionals negotiated mental health literacy practices along the proximity – perimeter continuum. Arousal, such as feeling exhausted and worried about asking the adolescent questions, permeated the process and influenced professionals' experience of the encounter.

Child and youth care professionals were emotionally aroused further when faced with the absence of supports and resources during the encounter with the suicidal adolescent. Some professionals explained they experienced emotions of being “helpless”, “isolated”, or “overwhelmed” when they engaged in the practice of *Flooding the Zone* and found no further help for the adolescent. For example, one professional stated she/he felt “left out there, floundering” [CYC-04] when no resources were made available.

Another professional explained his/her experience of not being able to implement additional supports:

Mental Health Act he was going to have him committed and all but he had certified. So he had signed. You have to have 2 signatures. The doctor signed, the psychiatrist wouldn't sign 'cause he hadn't attempted anything. So they wouldn't, they wouldn't have him committed anywhere. So that's what we were facing. So in the cells he was just screaming like a mad animal in there. And I just, it's like, there's nothing I could do here. You're so out of control. [CYC-03]

Professionals explained physical and emotional arousal as engaged in various mental health literacy practices. Professionals experienced panic, isolation, and feeling out of control. *Appraising*, *Being With*, *Watching*, *Detecting*, and *Flooding the Zone* were all influenced by the condition of the child and youth care professionals' aroused state during the encounter with a suicidal adolescent.

In this section I identified and explained the micro conditions influencing the **Balancing Proximity and Perimeter** process during child and youth care professionals' encounters with suicidal adolescents. The micro conditions consisted of the professionals' arousal, education, connectivity within work relationships, policies, and experience. In the following section, I explain the macro conditions influencing the **Balancing** process.

Influencing Macro Conditions

Macro conditions are those that are situated at a distance from the individual child and youth care professional (Corbin & Strauss, 2008), yet interplay with micro conditions in impacting the **Balancing** process in various ways. Corbin and Strauss (1990) posit "the

analysis of a setting must not be restricted to the conditions that bear immediately on the phenomenon of central interest” (p. 11). My analysis included considering broader conditions which influence child and youth care professionals’ mental health literacy practices. Macro conditions influencing the **Balancing** process consisted of the availability and accessibility of mental health resources, perspectives of the role of child and youth care professionals in providing care to suicidal adolescents, and the implementation of an accreditation process for community agencies funded by government bodies. How professionals realized mental health literacy practices during their encounters with adolescents was swayed by macro conditions. In the following section, I will describe and explain the macro conditions that were generated during analysis of the data.

Availability and Accessibility of Mental Health Resources

In Chapter Four I explained how child and youth care professionals enacted the mental health literacy practice *Flooding the Zone* during the **Balancing** process. When *Flooding the Zone* professionals sought out resources and professional supports for the adolescent and moved towards establishing a perimeter around the adolescent. The availability and access points for mental health resources within the system of care influenced how professionals enacted the practice of *Flooding*. Professionals explained they learned ways to navigate the mental health system in order for the system to respond to the adolescent. For example, a child and youth care professional explains how she/he learned to expedite access to help for the adolescent through removing her/himself from the intervention and deferring to the police:

I feel like it's more secure to call cops and have them take her, and you know what? To be honest with you, hospital [staff] will see them faster as opposed I'm coming in. And I notice a lot of times when I come in with the individual and, if I start to talk for the individual, they don't even, they don't want to hear it. The triage nurse is like "No. They can speak for themselves." They're really rude like that. And they're like "No. They can speak for themselves" and then they'll be talking to the individual. They don't want the workers to be with them. [INT-01]

Availability of mental health resources within the community additionally influenced child and youth care professionals' mental health literacy practices. In some communities, mental health resources were sparse. The situation was compounded when adolescents did not meet the eligibility requirements for the services that were present.

Flooding the Zone, then, became challenging for professionals as they navigated the system trying to find help for the adolescent. The limited availability and inaccessibility of mental health resources for an adolescent led to the professional taking up highly restrictive measures to protect the adolescent from harm:

With this kid when he went psychotic there was no help for him. There was no help for him. I mean I advocated with the doctor to give him medication which the doctor – they get pissy with him. They're annoyed because he's so obnoxious when he's like that. And he is. He truly is. And doctors don't like addicts and they don't like mental illness. In our town it's really apparent. Its like don't have the time of day for it. There is no adolescent psych. unit. There is only an adult psych. unit. They didn't want him. The one in [city name] that's the adolescent psych. unit, you have to be functioning. You have to want to do their program. He's not

going to do that. He's in crisis. So the only, the doctors wouldn't take him in the hospital and give him a shot and knock him out for the night, so he had to go in the cells. [CYC-03]

Child and youth care professionals described a mismatch between what was available in the mental health system for adolescents, and what they viewed the adolescents actually needed. As participants within the system of care, child and youth care professionals co-constructed the mismatch between *Flooding the Zone* with services that do not necessarily meet the adolescent's needs and interrupting the practice of *Being With*. For example, in the previous quotations, professionals opted to access service through the police to expedite care at the hospital or to lock up adolescents when no other options are available or accessible. One professional explained they attempted to obtain services for an adolescent through the justice system in the absence of adequate mental health care:

Well the only thing good that can come of jail is that the forensic programs are better. That's – and I mean we were actually planning to get him, you know, a bit of you know, some juvenile time before he turned 19 so he could get some help. I mean we tried to work that even. Like we were doing anything we could to get him the help. It wasn't available. [CYC-03]

The absence of available mental health services was an influencing condition on professionals' practices with adolescents. Professionals may resort to extreme measures and lock adolescents in facilities designed for people engaged in criminal behaviour rather than mental health care facilities.

Even when services specific to suicide intervention are offered in the community, professionals encountered challenges. The interplay between the micro condition of

policies and the macro condition of availability and accessibility of mental health resources was apparent when professionals followed prescribed guidelines for *Flooding the Zone* in contacting services and the identified service was unable to, or delayed, in responding. One child and youth care professional explained in the following exchange how she/he adhered to the protocol of notifying the crisis response workers of the adolescent's suicidality and the service was busy:

Researcher – And so you called them [crisis workers] and?

And they're busy. [laughter]

Researcher – You got a busy signal?

Someone called me back and they said it's, "We're short staffed, we're busy today. Can you just hang onto her until we can get there?"

Researcher – Hang onto her?

Until they can come, until they can come to the school, so probably a couple of hours.

Researcher – Couple of hours. Had you contacted them before?

Yes, I had contacted them before and they had connected her with [mental health services] but this day they were super busy and they couldn't respond right away. And because I was there with her, they just wanted me to watch her until they could respond. [CYC-04]

The condition of mental health resources thus influenced the child and youth care professional's mental health literacy practice during the encounter with the adolescent. The professional attempted to follow the protocol by *Flooding the Zone* and eliciting the help of designated service providers, yet was left *Watching* the adolescent as the service

was too busy to respond. The following quotation illustrates further the condition of mental health services influenced how professionals responded to suicidal adolescents:

I mean I like to say in the way the system is how we pass the buck. Like we – I’m very guilty of this too - because for the longest time, I didn’t know what to do or the system isn’t really set up for the way that I see that this needs to be dealt with. So, and say I’m dealing with thirty kids, so I would typically say; “I don’t want you to go. I know this great suicide outreach worker.” You know? And hopefully maybe that will be something. [CYC-01]

The presence of a service in the community devoted to suicide care may, or may not, be viewed as advantageous by child and youth care professionals. The service may be too overwhelmed to respond expeditiously, or professionals may refer the adolescent to “pass the buck” as illustrated in the above quotation.

Child and youth care professionals explained the services that were available also lacked continuity in their involvement with the adolescent or ensuring communication between the professional and the services. For example, services changed, did not communicate with the child and youth care professional, or the adolescent’s file was moved to different workers. The condition of mental health services intertwined with the professionals’ arousal as feelings of frustration was identified. As the following quotation illustrates, the interplay of the conditions influenced how the professional communicated with the adolescent; that is, the professional withheld information from the adolescent:

I think but from the time she got there to the time she left there was about 7 different social workers involved with her. Yeah. “Oh no that one’s left. Your file’s getting transferred to this person and they’ll call you.” And they didn’t, so I

would call them. And you know, I started off and, as this was happening, I would not tell her. I'd get frustrated. I'd make the phone calls. "Come on you guys. Somebody's got to, you know, give me some information. What the heck's happening?" [CYC-07]

The availability and accessibility of mental health resources was a condition that influenced the **Balancing Proximity and Perimeter** process for child and youth care professionals. Professionals explained they resorted to police involvement to expedite or obtain services when other options were unavailable or inaccessible. Even when identified suicide intervention services existed in the community, at times they were unavailable to the adolescent. The structure of mental health services additionally impacted professionals' mental health literacy practices by moving professionals away from relational proximity towards creating a perimeter due to the lack of continuity of service and reciprocal communication between providers and child and youth care professionals.

Role of Child and Youth Care Professionals

Child and youth care professionals distinguished their role from other helping professionals, which in turn influenced their mental health literacy practices. In Chapter Four, I discussed the property *Being With* as a mental health literacy practice professionals realized during encounters with suicidal adolescents. While *Being With*, professionals explained they functioned in their role as situated in-between the adolescent and other professionals (e.g., psychiatrist, mental health clinician, suicide intervention worker, nurse) and relied upon their relational connection with the adolescent as defining their role. As a condition influencing the **Balancing** process, the role of child and youth

care professionals in the mental health system of care was viewed as separate and apart from professionals with higher qualifications or from alternative disciplines. As one child and youth care professional explained, they experienced their role as devalued (i.e., not taken seriously) based on the roles and credentials of other professionals:

I wasn't really honestly taken very seriously, right? Because you're sitting with all these you know, you're sitting with the professional people, right? Who, the psychiatrist, the doctors, the school counsellor who had probably her Master's in psych counselling, you know? Right? So it was they, I don't think it's, it wasn't always my experience but in this case it was "we're the professionals", right?

[CYC-08]

Educator participants also delineated the role of child and youth care professionals as different from other professionals (e.g., psychiatrist, counsellor). Child and youth care professionals took up mental health literacy practices such as *Flooding the Zone* partially in response to directions and teachings from others. Educators in pre-service programs explained child and youth care professionals' role with suicidal adolescents as alerting others and following the identified protocol, and supporting the adolescent while help from others is accessed. The following quotation illustrates an educator's perspective on role of child and youth care professionals:

... to notify people within whatever the system is. So if it's in the school you'd want to be contacting the vice principal, the principal, the school counsellor, whoever your supervisor is and having a conversation with them about it. ...Make sure you're clear on what the protocol for your school is, so do they, is there an agency within that district that they connect with to deal with, to get extra support

for a young person who's suicidal and what's the, what's the process for contacting them or what information are you expected to get yourself. And if you're not sure and haven't had specific training in terms of what to look for, just identifying that the person's suicidal and then getting them some help. And then letting them know that you're, that they're not alone and that you're going to try to make sure that they, that whatever assistance they need to help them cope or manage will be made available to them. [ED-02]

The perception of child and youth care professionals as those who notify others and stay with the adolescent until others more skilled can respond was a condition that influenced professionals' mental health literacy practices. Professionals may adjust their position on the continuum between relational proximity and perimeter based on such understanding of their role. As one child and youth care professional explained, adolescents may seek out connection and share information about their struggles, and the professional must balance hearing the information with knowing their role in relation to other professionals:

But I just find that kids are drawn to me. They just open up to me. They find me easy to talk to and sometimes you hear stuff you don't want to hear. What are you going to do with that information? So today I can deal better with that information. I'm not so afraid of that information just because it's not my role. It's not my role. I'm not a counsellor. I'm not hired as a counsellor so I have to be careful with that. [CYC-02]

When ***Flooding the Zone*** with other professionals to protect and support the adolescent, child and youth care professionals explained they might lose contact and be unaware of

the outcome. Professionals were left not knowing what happened to the adolescent, thus reinforcing their role as temporary until others can intervene:

I don't know whatever happened to him. There is no continuity there for me to know whatever was the outcome of that in the end, 'cause it's not my role. [CYC-02]

Child and youth care professionals explained their role as distinct from other service providers during encounters with suicidal adolescents. They experienced others devaluing their expertise and were directed by educators and policies to notify and inform others. Child and youth care professionals' role was to stay with the adolescent until others (e.g., counsellors) could provide help. The construction of their role was subsequently reinforced, as child and youth care professionals were left not knowing what happened to the adolescent after others undertook care.

Agency Accreditation

The **Balancing Proximity and Perimeter** process was indirectly influenced by the condition of accreditation of publicly funded agencies. In 1999, an accreditation policy was implemented in the province of British Columbia as a quality assurance measure for community social service agencies (Ministry of Children and Family Development, 2011). Guidelines are established through accrediting bodies for employee professional growth and development (Commission on Accreditation of Rehabilitation Facilities [CARF], 2011). For example, agency policies are required to be reviewed annually with employees: "So we're required by CARF standards to review policies every year, annually. And we have to keep track of which staff attended and had the review." [SUP-01]

Changes are also being implemented in the hiring practices of agencies. Through accreditation, guidelines are beginning to be established for employees to possess particular credentials and qualifications:

It's expecting that line workers will all have an undergraduate degree and that supervisors will all have their Master's. And so those expectations are slowly sort of like being, yeah, are coming into the agencies. [ED-05]

The accreditation process additionally requires agencies to create policies specific to their client population. In circumstances where agencies provide service to populations where suicide may be a concern, accrediting bodies identify the need for the agency to establish a policy as to how employees will respond:

So in some agencies it's a drop in, it's a very casual relationship with the client, or a very soft relationship. It's a family drop in, it's a teen drop in, and so they're must less likely to have specific guidelines around this. Other agencies, I'm thinking not even the residential agency, but agency that does lots and lots of family counselling and they have a program for children who've been sexually abused, and they have lots of clients who have higher suicide risks. And so in that agency they have really clear protocols around managing suicide risk and they do a lot of training about it. [ED-05]

At the macro level, the requirement for agencies to be accredited was a condition that influenced child and youth care professionals in the **Balancing** process. Agencies were required to create policies for practice with suicidal persons and it was compulsory that such policies were reviewed on a regular basis. The conditions of accreditation, education, and policies all intersect, as professionals are required to possess credentials

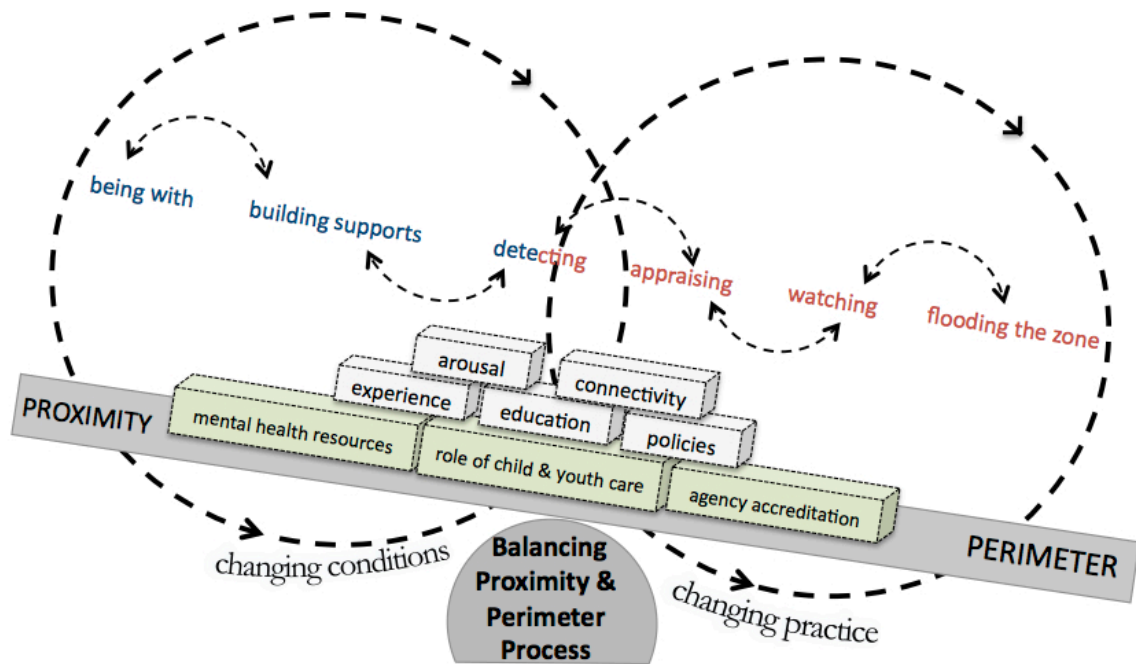
from pre-service education programs and policies are established to inform professionals how they are to respond to suicidal adolescents.

In this section I identified and explained the macro conditions that influenced the **Balancing** process. The availability and accessibility of mental health resources in the community, the perceived role of child and youth care professionals, and the requirement for community agencies to be accredited were all macro conditions in the process. In the following section I describe the consequences or outcomes of professionals' responses to their encounters with suicidal adolescents.

Consequences within Balancing Proximity and Perimeter Process

The consequences of one mental health literacy practice can support or hinder another literacy practice being used in the interaction, or alter conditions within the process. In this section I identify and explain the consequences that were part of the **Balancing** process. Corbin and Strauss (2008) explain "conditions and subsequent action are more likely to bounce off of one another like billiard balls, leading to consequences that one cannot always predict in advance" (p. 91). By analyzing the interplay between mental health literacy practices, or *Rules of Engaging*, and the conditions occurring within the process, consequences were identified that were unforeseen by professionals. Consequences and conditions co-vary with each other and with professionals' mental health literacy practices. In Figure 5 I have identified the consequences of "changing conditions" and "changing practice" within the **Balancing Proximity and Perimeter** process. I positioned the consequences near the tipping point of the proximity-perimeter continuum to illustrate how "changing conditions" and "changing practice" may be

Figure 5. Consequences within Balancing Proximity and Perimeter Process



outcomes of child and youth care professionals' mental health literacy practices. The consequences thus feed back into the larger **Balancing** process. In Chapter Six I will explain the circles with dashed lines and arrows, which represent the sub-processes of circling care and circling defensively, and the tension within the **Balancing** process that influences the teetering of the continuum. In the present Chapter, I initially explain how professionals in my study changed their practice as a consequence of the process. Secondly, I describe the consequential shifts of conditions within the process.

Changing Practice

Changing practices of child and youth care professionals were the result of the relationship between their actions and conditions within the context of their encounters with suicidal adolescents. Child and youth care professionals' movement along the proximity-perimeter continuum, and thus the timing of various practices taken up by

professionals was the result, in some contexts, of both their prior experience with situations involving suicide and their relational connection with the adolescent.

Movement towards more directive practices, such as *Appraising*, may be quickened as a consequence of the professionals' experience:

So you're kind of you know, doing gentle suicide assessment, but to me it was like I was just meeting this kid so I can't just throw that right in there. So it was a little windy road that I took as opposed to a direct approach that I probably would take now, but at that time it was the first one, person that I had face to face in this situation. [CYC-07]

The mental health literacy practice of *Flooding the Zone* may also change as a consequence of the professionals' prior experience with particular service providers within the mental health system. One professional explained how she/he changed his/her practice of *Flooding* based on his/her experience with hospital staff. The professional perceived the staff as unhelpful in restricting the suicidal adolescent from leaving the hospital. As a consequence, the professional called the police from the hospital emergency room for their assistance:

And I've had situations where I'm chasing them down at the hospital. And the hospital won't do anything about it. They're like "Yup, like you have to call the police." And that's frustrating as a professional 'cause I had to literally do that and call the police at the emergency room to arrest an individual that was very, very unstable, but she wouldn't comply with staying and she was taking off on me all the time. And that was, that was a learning moment for me that next time it's just call the police and have them take them. [INT-01]

The professional explained a change in practice in both the current encounter and in future encounters with adolescents whereby the professional shifted from seeking support at the hospital for the adolescent, to having the adolescent escorted by police.

The mental health literacy practice of *Being With* was comprised of professionals listening, being present and engaged with the adolescent during the **Balancing** process. The outcome or consequence of listening was often a movement into other mental health literacy practices, such as *Detecting* whereby professionals began to look for warning signs the adolescent was thinking of suicide in the conversation. *Detecting* had consequences for the practice of *Being With* such that professionals struggled with being distracted when looking for signs:

That's one thing that it can happen I guess you just have to, I guess you just have to be present. Like I was recognizing that I was like a little bit distracted as well like, 'cause like he started talking about heaven. And I was like "Heaven?" 'Cause I'm not religious, right? And I was like "what?" Like heaven? And I was like "what is he talking?" You have to be really present I think and not try to be in your own head as well like and that's the main key I guess I've been learning is just to, just be with them. [CYC-06]

Consequences of child and youth care professionals' practice of *Flooding the Zone* include changes to which mental health service providers are accessed by professionals. When faced with inadequate mental health resources, professionals may change their role. For example, a professional explained there was no mental health supports available in the community for the adolescent, and service providers who were identified by the community as experts in mental health and suicide were unavailable. As

a result, the professional changed his/her *Flooding the Zone* practice and role in the community by engaging in a study on adolescent suicide. The absence and unavailability of resources was viewed by the professional as an opportunity for him/her to become a community resource to others:

I put it together and I make it available to, I'll become the specialist and people can call on me then. You know, I only got one other person in my office but you know, I mean if you want this binder [practice guidelines document], here it's really got good information. I've highlighted, you know, I'll give you a summary. Whatever. I can take it to our district service providers' monthly meeting and say, "My study is on adolescent suicide. This is my way to communicate this out into the community by doing it at district service providers' meeting." [CYC-03]

Professionals' practices altered in various ways as an outcome of their actions and the conditions occurring within the **Balancing** process. They moved back and forth along the proximity-perimeter continuum, adjusting their mental health literacy practices in response to the practices themselves and the co-varying conditions. Conditions, as discussed in the following section, also shifted as a consequence of the interactional process.

Changing Conditions

Child and youth care professionals in their encounters with suicidal adolescents sought out support and direction from colleagues and supervisors during the **Balancing** process. The condition of connectivity within work relationships led to consequences for the professional during the encounter, and for future encounters. Specifically, the meaning professionals ascribed to the experience of disconnection, and how supervisors

respond to the professional, potentially constructed further disconnection. For example, a professional explained how she/he expressed a need for support, which was unmet by his/her supervisor and consequentially, his/her decision not to seek support in the future:

I just felt I needed to express what I needed to express and then I felt I didn't get the supports and so that kind of like prepares you for the next time. Its like, "don't do it." Like don't ask for the support 'cause you might not get it. Do you know what I mean? Like it kind of gave me a bad taste in my mouth like when I ask, when I gave out this information, I didn't get the support I needed so why should I do it in the future because I don't feel I get it. [INT-01]

As an outcome of disconnection, the professional forecasted isolation and withdrawal in future encounters with suicidal adolescents. Such a consequence thus influenced the condition of connectivity in working relationships for the present, and future.

A consequence of disconnection for another professional resulted in seeking support further up the hierarchy of authority. The professional and his/her immediate supervisor disagreed on how to respond to the suicidal adolescent, yet the professional maintained and solidified their position: "I went over her head to the higher ups and I'm going to continue doing what I know is right. I don't get badgered by supervisors."

[CYC-03]

For another professional, challenging the supervisor's perceptions of their role and seeking out support from higher authorities was not an option. Rather, as a consequence of being informed she/he stepped out of his/her role by the supervisor, she/he learned his/her "place":

Now that said, I'm a much different person today about being aware of my boundaries, roles and that sort of thing. And if I do have concerns about kids for one reason or another, I'll go to the supervisor, or I'll go to the right place that's, and I won't take it upon myself to do all the investigating. [CYC-02]

Disconnection may also lead to the professional questioning their role as a helping professional in their current place of employment. As a condition that influenced the **Balancing** process, the role of child and youth care professionals within the system of care was perceived by some professionals as devalued, temporary, and served to notify and refer the adolescent to other service providers with greater expertise. When one professional challenged the perception of their role with the adolescent in the context of their relationship with their supervisor, challenging resulted in the professional feeling uncertain about their practice as a whole: "You know, I mean I started to question my own practice and going, 'Okay. Not my practice.' I questioned my belonging in the system." [CYC-03]

Conditions that influenced the **Balancing Proximity and Perimeter** process included professionals' education and the presence or absence of policies or protocols that outlined steps the employer expected professionals to enact when encountering adolescents thinking of suicide. During some encounters, the absence of suicide education and policies became clear to professionals and supervisors. In response to the absence of such conditions, supervisors created and implemented program-wide policies and education for all employees:

The program director, asking what kind of training [program name] has had on assessing youth for suicide, have they been taught a risk assessment and [director]

realized they hadn't so we developed a training session to teach the workers there how to do a risk assessment, and the protocol to follow in [program name] which should be everywhere. [SUP-03]

The consequence of implementing of such policies or assessment practices may be a technical or mechanistic approach to suicide intervention whereby the professional experiences pressure to follow specific sequential steps when they encountered a suicidal adolescent. For example, professionals' mental health literacy practices of *Appraising*, *Detecting*, *Watching* and *Flooding the Zone* in various ways intersected with the conditions of policies and education. That is, professionals were directed or educated to respond to adolescents with specific actions. Consequentially, professionals explained an obligation to recall and implement all the steps they had learned:

I might forget something integral. I don't know. I feel like in some sense there is a lot of pressure... So I guess a problem is that I might feel like I might forget a certain aspect of like the process or something. [CYC-06]

Consequences in the **Balancing Proximity and Perimeter** process included changes to professionals' mental health literacy practices and changes to conditions. Professionals' practices of *Being With*, *Detecting*, *Appraising*, *Watching*, and *Flooding the Zone* all shifted in various ways in response to each other and the conditions. Conditions also changed and were impacted by other conditions and professionals' practices.

Chapter Summary

Conditions within the **Balancing Proximity and Perimeter** process influence how Child and Youth Care professionals realize the mental health literacy practices of *Being With*, *Building Supports*, *Detecting*, *Appraising*, *Watching*, and *Flooding the*

Zone. Conditions influence movement along the proximity-perimeter continuum during professionals' encounters with suicidal adolescents. In this chapter I identified and explained the five following micro or individual-level conditions that influence the **Balancing** process: (a) connectivity; (b) arousal; (c) education; (d) experience, and (e) policies. The three macro conditions, or conditions located within the larger context, found to be influencing the **Balancing** process included: (a) availability and accessibility of mental health resources; (b) the perceived role of child and youth care professionals, and (c) accreditation requirements for community agencies. Consequences within the **Balancing** process included changing conditions and changing practice. In Chapter Six, I integrate the theory of the **Balancing Proximity and Perimeter** process and explain more fully the two sub-processes, circling care and circling defensively. I clarify how mental health literacy practices, or the properties of the category, **Rules of Engaging**, are located within each sub-process and describe how the **Balancing** process is comprised of tension and fluidity.

Chapter 6

Findings 3:

Towards a Theory of Balancing Proximity and Perimeter

In this chapter I outline a theory of the **Balancing Proximity and Perimeter** process which I generated from analysis of the data. The theory is an interpretation that explains how child and youth care professionals realize mental health literacy practices during their encounters with suicidal adolescents. The **Balancing** theory I present is interpretive such that the emphasis is on understanding rather than causality (Charmaz, 2006). That is, the **Balancing Proximity and Perimeter** process provides an understanding of patterns and connections, not a prediction of professionals' practices. In this third findings chapter, I begin with a discussion on the process of integrating the theory within grounded theory research design. Secondly, I present a model depicting the **Balancing Proximity and Perimeter** process and describe the core category and its two sub-processes, circling care and circling defensively. Lastly, using a narrative vignette, I illustrate and present the theoretical storyline of the **Balancing** process.

Theory Integration

Grounded theory is “the generation of emergent conceptualizations into integrated patterns, which are denoted by categories and their properties” (Glaser, 2002b, p. 23). Furthermore, “...theories present arguments about the world and relationships within it” (Charmaz, 2006, p. 128). I have entitled the integrated pattern I present in this chapter, the **Balancing Proximity and Perimeter** process. As Charmaz suggests, the **Balancing** theory is an argument I am introducing about how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents. The

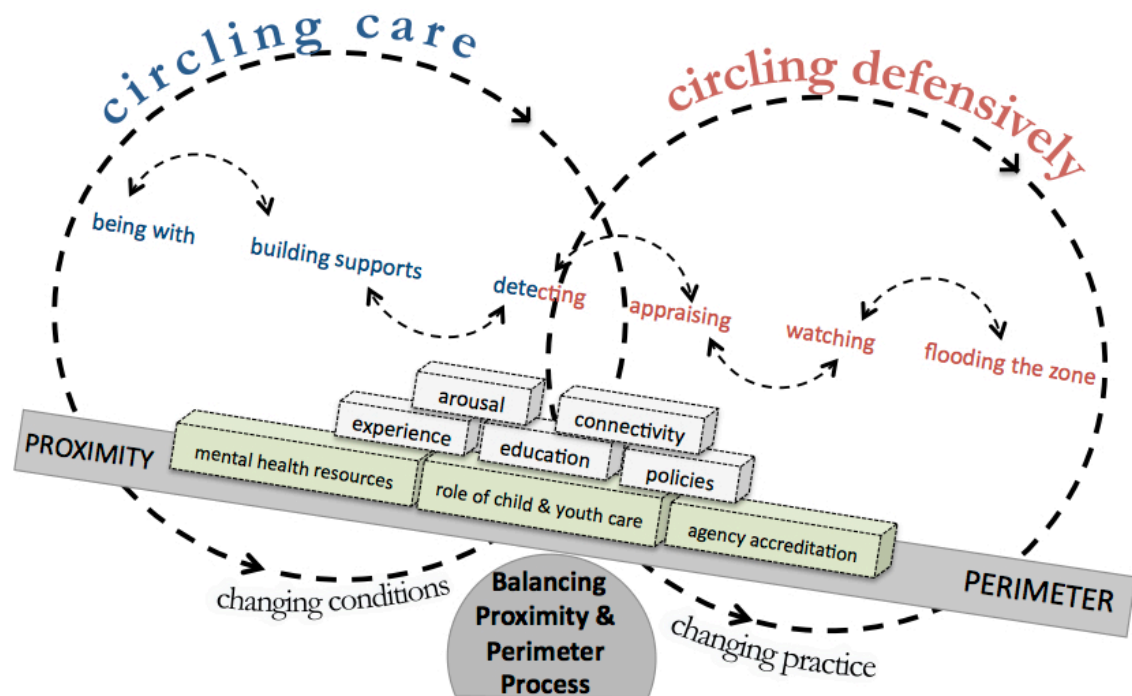
pattern in the **Balancing** process is comprised of two sub-processes, circling care and circling defensively, the category *Rules of Engaging* and its six properties (see Chapter Four), and the conditions and consequences intersecting and influencing actions and interactions within the process (see Chapter Five). The **Balancing Proximity and Perimeter** process is an “ongoing action/interaction/emotion taken in response to situations, or problems” (Corbin & Strauss, 2008, pp. 96-97). The child and youth care professionals in my study realized particular actions, or mental health literacy practices, in response to the situation with the suicidal adolescent. Although the elements of the pattern within the **Balancing** process are similar across situations, changing conditions within the context lead to professionals making adjustments to their actions and interactions (Corbin & Strauss, 2008). In presenting my theory of the **Balancing Proximity and Perimeter** process I intend to impart the following:

Theories flash illuminating insights and make sense of murky musings and knotty problems. The ideas fit. Phenomena and relationships between them you only sensed beforehand become visible. Still, theories can do more. A theory can alter your viewpoint and change your consciousness. Through it, you can see the world from a different vantage point and create new meanings from it. (Charmaz, 2006, p. 128)

While altering viewpoints and changing consciousness may be a lofty goal, I believe the **Balancing Proximity and Perimeter** process offers new insights into the complexities and phenomena of Child and Youth Care professionals’ practice with suicidal adolescents. Through this new vantage point, it is my hope that professionals,

supervisors, educators, policy-makers, and researchers may garner new understanding of mental health literacy practices.

Figure 6. Model of the Balancing Proximity and Perimeter Process



The Balancing Proximity and Perimeter Process

I identified the **Balancing Proximity and Perimeter** process as the core category from the data. The core category is “the concept that all the other concepts will be related to” (Corbin & Strauss, 2008, p. 104) and “is intended to name the Central Phenomenon of the study” (Scott, 2004, p. 120). A visual representation of the theoretical model is presented in Figure 5, which depicts two sub-processes, circling care and circling defensively. The diagram depicted in Figure 6 is the “integrated story that the data tells” (Lempert, 2007, p. 260). Cutting across the two sub-processes is the sub-category, **Rules of Engaging**, and its respective properties (e.g., **Being With**, **Watching**) explained previously in Chapter Four. Unlike previous mental health literacy research where researchers enter the study with a preconceived conceptualization of mental health

literacy, I generated the current theory directly from participants and related documents. Grounding the **Balancing** theory in the data provides a contextualized understanding of child and youth care professionals' mental health literacy practices during encounters with suicidal adolescents.

Balancing

The term “balance” may refer to an even distribution of weight, steadiness, or a state of equilibrium whereas “balancing” denotes the action of arranging or adjusting the parts of something *in an attempt to achieve* equilibrium (Dictionary.com, 2011). As child and youth care professionals in their encounters with suicidal adolescents are often off-balance (e.g., while engaging in various practices along the proximity-perimeter continuum), the term “**Balancing**” conveys fluidity and tension in the process as if the professional is on a teeter-totter without a fixed centre.

The stances child and youth care professionals are **Balancing** in my study consist of two contrasting positions, proximity and perimeter, which are located at opposite ends of the continuum in Figure 6. Movement occurs along the proximity-perimeter continuum during child and youth care professionals' encounters with suicidal adolescents based on which mental health literacy practice was realized, and how the practice intersects with other practices, conditions and consequences. Many professionals may move along the continuum from left to right, whereas others may begin with practices located at different points on the continuum (e.g., begin with *Appraising*). The starting point on the continuum is highly contextualized. For example, a professional may be aware the adolescent is suicidal from communication with the adolescent's peer and begin

immediately with *Appraising* by asking questions to determine the adolescent's risk for suicide.

As professionals progress through the encounter, the process is characterized by tension as they adjust their position on the continuum trying to move towards a state of **Balancing**. Tension is derived from proximity and perimeter being opposing states in the process. For example, child and youth care professionals may engage in practices (e.g., *Being With*) that position them in close relational proximity to the adolescent. In proximity, professionals are energetically engaged, connected, physically close, and actively listening to the adolescent's concerns. In contrast, child and youth care professionals in a perimeter state may enact practices (e.g., *Flooding the Zone*) in which the adolescent is referred to another, often unknown, service and the relational connection with the child and youth care professional is interrupted and may be severed entirely. In some situations, as a consequence of the interplay between these practices and various conditions, professionals may find themselves situated at one end of the continuum despite their best efforts in **Balancing** or achieving equilibrium. For example, a child and youth care professional attempted to refer the suicidal adolescent to mental health services (i.e., *Flooding the Zone*); however, because mental health resources were unavailable the professional's practice shifted to the proximity end of the continuum:

So what am I doing? What am I to do with all this, you know? It's terrible. The help that wasn't there was terrible. The only thing that I had to rely on with him is my relationship with him. Bottom-line that's what it all comes down to. It's the only thing. [CYC-03]

Child and youth care professionals may also find that the adolescent will not collaborate, or move with them in adopting particular mental health literacy practices:

It was really awkward because you know, we had what I thought was a really good relationship. And you know the boyfriend was sitting in front of the door so she wouldn't run away because she didn't want to talk about it. She refused to talk about it. She wouldn't even say "yes" or "no" when I asked her if she had a plan. She closed up. [CYC-04]

The above quotation illustrates how the **Balancing Proximity and Perimeter** process is interactional. That is, the adolescent also influences the mental health literacy practices realized by child and youth care professionals. The adolescent "closed up" when the professional enacted the practice of *Appraising*. The professional tries to achieve **Balancing** with his/her relational proximity to the adolescent (e.g., "We had what I thought was a really good relationship") and establishing a perimeter by appraising risk (e.g., "I asked her if she had a plan"). The **Balancing** process then, may include the professional attempting to find the middle ground.

The middle ground. Balancing may be described as finding the middle ground along the continuum. One educator described a need for child and youth care professionals to know "how to manage the middle ground and how to negotiate uncertainty and ambiguity and contradictions" [ED-03] during encounters with suicidal adolescents. The contradictions within the **Balancing Proximity and Perimeter** process require professionals to realize mental health literacy practices with different aims simultaneously, or negotiate movement between practices. The following quotation

illustrates movement between multiple mental health literacy practices (e.g., *Being With*, *Flooding the Zone*) at opposite ends of the proximity-perimeter continuum:

Then setting up, setting a safety plan out with that youth and having the relationship with the youth in order for them to be able to be comfortable coming to you saying, “I’m not feeling so good.” And then, them being able to talk about that and referring them to the proper supports. [SUP-03]

Having a relationship with the adolescent and referring the adolescent to other supports are actions located within the practices of *Being With* and *Flooding the Zone* respectively. *Being With* positions the professional in close relational proximity, whereas *Flooding the Zone* positions the professional on the perimeter as others become the care providers and the child and youth care professional may no longer be involved with the adolescent. The contradictions in the **Balancing Proximity and Perimeter** process may require professionals to manage the middle ground between their relationship with the adolescent and perimeter practices (e.g., *Flooding the Zone*), which may interrupt or jeopardize their connection. As one child and youth care professional explained, establishing a perimeter (e.g., having the adolescent arrested) requires balancing uncertainty in their relationship with the adolescent:

Because we’ll sit in the [emergency] room forever and like for hours, and then you know, not be seen. But if the cops arrest them and take them in they are seen right away. Yeah, so there’s a huge difference there and I don’t know. Like that of course affects the relationship with the client because they can think that you’re, you know, against them or taking them in. But for the most part I think they know. They know that you’re trying to help them. ‘Cause I’ve never had a

backlash from a youth saying “Oh you did this to me.” It was more like they look at it [as] you helped them. So that’s the good part about it. [INT-01]

The **Balancing** movement along the proximity-perimeter continuum situated professionals’ practices within two sub-processes: circling care and circling defensively. The sub-processes are depicted as overlapping in Figure 6 to illustrate how professionals were attempting at times to balance their position on the continuum. For professionals, **Balancing** involved enacting mental health literacy practices within circling care that maintained their relational proximity to the adolescent while ensuring practices within the sub-process of circling defensively were taken up to make sure the adolescent was safe from harm.

Circling Sub-Processes

The core category, **Balancing Proximity and Perimeter** process was comprised of two “circling” sub-processes. The **Balancing** process was “...broken down into sub-processes. Sub-processes are also concepts; they explain in more detail how the larger process is expressed” (Corbin & Strauss, 2008, p. 101). Some participants in my study mentioned “circling” directly and indirectly when they described their encounters with suicidal adolescents. That is, the concept of circling is well grounded in the data. For example, a supervisor explains how circles of care are used to support the adolescent and their family:

So we need that circle of care to be, all of us to be able to stand tall so we can, we can support that youth and family, you know? That, and sometimes it might be a real small [circle] because there’s not a lot happening, but we know they’re there and they know we’re there. [SUP-04]

Circling was realized in two distinct ways: circling care, and circling defensively (see Figure 6). Circling denotes movement and actions that repeat themselves more than once, or are revolving. Circling defensively may depict actions such as surrounding, fortifying, enveloping, or providing cover. Circling is viewed as taking up a defensive or protective position. Alternatively, circling care is characterized by connectivity and relational proximity with the adolescent. In the following section I elaborate and distinguish further between the sub-processes of circling defensively and circling care.

Circling defensively. I identified circling defensively in the data during analysis as a sub-process comprised of several mental health literacy practices realized by child and youth care professionals in their encounters with suicidal adolescents. As depicted in Figure 6, the practices of *Appraising*, *Watching*, and *Flooding the Zone* were located within the circling defensively sub-process. The goal of such practices revolved around the protection of the adolescent from suicide. Professionals assessed the “threat”, determined the “risk”, monitored the “watch”, and called for additional supports. The practice of *Detecting* is situated at the crossroads between the two sub-processes. As discussed in Chapter Four, child and youth care professionals enacted *Detecting* by listening for clues or warning signs for suicide. Thus, in the circling defensively sub-process, *Detecting* served as an *alert* to the threat of suicide.

In grounded theory research, memos are used to elaborate processes and actions (Charmaz, 2006). I provide two examples below of early analytic memos I wrote during the analysis that crystallized the early identification of the circling defensively sub-process. The memos are comprised of both participants’ words and my own reflections. Memos represent my developing ideas and insights that arose during data collection and

analysis (Charmaz, 2006), and are a narrative tool used to conceptualize the data (Lempert, 2007). While such early memos are presented as “messy and incomplete, with undigested theories and nascent opinions”, providing them in the present chapter serves to illustrate how circling defensively earned its way into the **Balancing** theory (Lempert, p. 249).

November 21, 2010: Circling defensively conveys a sense of surrounding something as a means of protection. Several codes could fit under this category including negotiating responsibility between services, building a support network, accessing emergency services, exchanging information, following, getting ‘eyes on’, and working with family or peers. While it appears the intention is to create ‘circle of care’ as the supervisor [SUP-04] describes it, I experience it as I read the transcript more as a defensive strategy. Participants’ choices of words thus far such as: safe, protection, monitoring (checking in), and the phrase “not on my watch” all convey this as a defensive strategy. All of the information gathering (e.g., the youth’s history, mental health diagnosis, teaching skills, knowing precipitating factors, knowledge of the youth’s service history) is all about assessing “risk” or the enemy we could call “death” or “suicide” (see for example SUP-04 who referred to the “S-word”). Knowing the risk level is part of the defensive strategy, just like knowing the enemy in a war situation. This may also be described as ‘setting a perimeter’ perhaps.

Some Child and Youth Care professionals also talked about “protecting vs. betraying.” Perhaps they are identifying the need to distance themselves (betraying) in order to protect (perimeter). It seems like stepping back (surrounding) as opposed to sitting in the middle, or being with the youth.

November 27, 2010:

Memo in Response to Quotation From Transcript

“Yes. We actually had ‘constant attention.’ So when a child has either made a threat of suicide or we see a real change in behaviour, you know the typical things of just holding back, just a real change in behaviour, has maybe said something to one of the other kids and the indicators of suicide, we’ll ask psychiatry for an assessment and if it’s quite severe, if it’s deemed to be severe then the psychiatrist will put them on ‘constant attention.’” [SUP-02]

This quotation typifies the response of professionals to suicide. There are set indicators to watch/listen for (e.g., changes in behaviour, verbal ‘threats’). It is interesting that the verbal communication regarding suicide or suicidal thoughts is viewed as a *threat*. The meaning attributed to these comments/behaviours follows notions of risk, which in turn invites a (emergency) response to protect. *Protection* is enacted by the supervisors/CYC professionals by maintaining physical proximity (e.g., eyes on, constant attention, suicide watch, checks/monitoring, following, etc. They are following the policies,

which also indicate a linear response (e.g., “if you hear suicide ideation, do step one”).

The reinforcement of this response to a threat comes as well from the psychiatrist who identifies the risk (e.g., “severe”) associated with the threat and then defines the response (watching).

“Constant” may be defined as “unvarying in nature,” “steadfast” or “fixed.” The uniqueness of the individual, the fluidity of suicidality, the dance of relationship may be lost when a “fixed” way of being with a youth is enacted.

“Attention” may be defined as “care,” “attending to someone” or “a courteous act indicating affection.” It is also defined as “the cognitive process of selectively concentrating on one aspect of the environment while ignoring other things.” In this case the affection, care, and attending to the youth appears to be lost, and the concentration is focused on the identity of the person as solely “suicidal.” The psychiatrist does not direct care, but directs monitoring or how the adolescent is watched.

Following the defensive theme, attention may also be defined as “a motionless erect stance with arms at the sides and feet together, assumed by military personnel...” (Synonyms.net, 2011). This is interesting in terms of the encounter that [SUP-02] shares where the worker on “constant attention” was sitting in the youth’s room

“watching” while the youth went to sleep, perhaps motionless as she/he watched.

Circling defensively captures an element of the **Balancing Proximity and Perimeter** process where child and youth care professionals are surrounding the adolescent, defending them from the harm of suicide, monitoring their movements, and accessing emergency services for supports. The memos above illustrate the developing relationships between the practices taken up by professionals and the identification of the sub-process circling defensively from my early codes in the analysis.

Circling care. Circling care included mental health literacy practices that created and maintained relational proximity with the adolescent. Participants discussed providing a “circle of care” [SUP-04] or ways of expressing care to the adolescent:

When he’s sad or he’s going through something then, you know, I let him know that I care about what he’s thinking. [CYC-01]

You can’t force them to do anything. They are set upon doing their own.

However, what can we do? What can we draw on here? We can let him know he’s cared about and supported. [CYC -03]

I’m like, “I care about what you do. I find you fascinating!” And they’re like,

“Really? I’m fascinating?” [CYC -01]

As part of the **Balancing Proximity and Perimeter** process, circling care was comprised of connection and relationship with the adolescent. The care expressed through the practices of *Being With* and *Building Supports* addressed the adolescent’s isolation:

You just had a sense that to me sort of sitting there talking to her and spending a lot of time just asking a question and listening to long, long, long answers that this

is a child that didn't feel that anybody had really spent that time listening to her.

[CYC-07]

As discussed above, *Detecting* was positioned in Figure 6 within both sub-processes of both circling care and circling defensively. In circling care, *Detecting* arose within the process of listening and connecting with the adolescent as the professional began interpreting content in their interaction as warning signs or clues for suicidality.

Child and youth care professionals in the **Balancing Proximity and Perimeter** process realized various mental health literacy practices situated along the proximity-perimeter continuum. Balancing in the process encompassed tension between the two sub-processes, circling care and circling defensively, as practices realized within the sub-process had contradictory aims. Professionals, then, were required to negotiate the middle ground, move back and forth along the continuum. The theoretical storyline in the following section will further illustrate and explain the **Balancing** process.

The Theoretical Storyline

A vignette depicting a child and youth care professional's encounter with a suicidal adolescent will illustrate the theoretical story of the **Balancing Proximity and Perimeter** process. Drawing upon my comparative analysis of the twenty-two incidents described by the nineteen individual participants in my study, I've constructed the following vignette to demonstrate the theoretical storyline of **Balancing**. As Corbin and Strauss (2008) suggest, "the theoretical scheme should be able to explain most of the cases" (Corbin & Strauss, 2008, p. 113). While the specific details of the story may differ

across incidents, "...participants should be able to recognize themselves in the story that is being told" (Corbin & Strauss, 2008, p. 113), such that the mental health literacy practices enacted by professionals, the sub-processes of circling care and circling defensively, and the conditions and consequences impacting the **Balancing** process, are all familiar elements for child and youth care professionals in their encounters with suicidal adolescents. The elements of the **Balancing** process will be identified throughout the vignette, which is narrated in first person, yet is a compilation of participants' shared experiences. For example, properties of the category *Rules of Engaging* (e.g., *Detecting*) are identified throughout the vignette. Additionally, the conditions I identified and explained in Chapter Five that are depicted in the vignette are acknowledged by capitalization (e.g., EDUCATION).

Vignette. *I had an encounter with a suicidal adolescent last week at the group home where I work as a child and youth care professional. The adolescent had been staying with us for a while, so like I was taught to do in my child and youth care degree, I had focused on building a relationship with him over time. EDUCATION Just before bedtime I observed him walking down the hall of the residence and punching the wall. I told him not to punch the wall and he turned around and said, "Watch it or I'll punch you!" He went into his bedroom and shut the door. I knew something was wrong with him [Detecting] so I asked my colleague to support me while I spoke with the adolescent. CONNECTIVITY We knocked on his door and asked him to come out and talk with us. He complied, but seemed quite agitated. [Detecting] He started saying "I don't care anymore." I asked him "What's going on? Why are you so angry?" He kept saying "I don't care anymore" and "I can't do this anymore." I thought his statements about not*

caring anymore might be a warning sign that he was suicidal [Detecting] so I kept asking him questions about his day and why he was angry. I knew he recently started taking antidepressant medication. [Detecting] I made sure I spoke in a calm voice and tried to be present as I listened to him. [Being With] He then asked if his best friend, who was another resident at the group home, could talk with us. I knew his friend was emotionally stable and would be a great support to him. My colleague went and asked his friend to join us. [Building Supports] The adolescent told his friend he was having a “crappy” day and began to share about his experience earlier in the day of running into a family member in the community. He then said he didn’t want to live and that he was going to jump off the bridge. His friend expressed concern for him and said, “I don’t want you to die, man.” I felt scared when I heard him say he was going to jump off the bridge. AROUSAL He was presenting so differently than his usual self. I have never seen this behaviour from him before. [Detecting] I felt in my gut that this kid is really serious and not just wanting attention. [Appraising] AROUSAL I signalled to my colleague to go notify our supervisor. CONNECTIVITY I knew that the group home had developed a policy recently pertaining to situations involving suicide as the agency was going through the accreditation process. ACCREDITATION The policy outlined the questions employees were asked when an adolescent said they were suicidal. POLICIES I followed the policy and asked the adolescent about his plan to jump off of the bridge. He said there were plenty of bridges around that he could jump off of. [Appraising] Following the policy further, I asked him about his level of pain. He stood up quickly and said “I can’t do this anymore” and immediately bolted out of the room and out the front door of the residence. I knew from a workshop I attended on suicide EDUCATION that he was at

high risk for suicide [**Appraising**] because he wasn't being collaborative, so my colleague and I followed him outside, trying to chase him down. [**Watching**] The adolescent started walking into oncoming traffic and we're following him. I use my walkie-talkie to notify our supervisor, who in turn calls 911. [**Flooding the Zone**] I give the supervisor a description of what he's wearing and his location as we're following him. The adolescent sees that we're following him. [**Watching**] Thankfully the walkie-talkie has a good range and we are able to maintain contact with our supervisor.

CONNECTIVITY The police pull up beside us and I get in their car. My colleague returns to the group home while I drive with the police, following the adolescent. He ends up circling back around the block to the group home and my supervisor lets us know that he's back. CONNECTIVITY We drive to the group home and the adolescent is sitting on the porch. I noticed he was calm and compliant. [**Detecting**] He seemed to be in a calm state where he's given up so that told me he's really suicidal. [**Appraising**] The police began talking with him. [**Flooding the zone**] He turned to me and said, "Why did you call them? You're the only one who could help me." I felt sad when he said this statement, but I knew that he needed help beyond my expertise and it wasn't my role to help him if he was suicidal. He needed a psychiatrist or mental health clinician. ROLE OF CHILD AND YOUTH CARE I told him I cared about him and wanted him to have the help he needed. [**Being With**] The police arrested him under the Mental Health Act and the police told us that he would likely be staying at the hospital overnight. I knew from my previous experience EXPERIENCE that if he was arrested and brought into the hospital by police that he would likely be able to see a psychiatrist earlier than if I brought him to the hospital myself. MENTAL HEALTH RESOURCES Overall it kind of

worked out because I was able to maintain contact with my colleague and supervisor throughout the whole encounter. But I think next time I definitely would contact the police sooner so they could arrive before the adolescent left the group home so they could arrest him and take the adolescent to the hospital right away.

The child and youth care professional depicted in the vignette realized various mental health literacy practices during their encounter with the suicidal adolescent. The vignette also illustrates the professional's movement back and forth along the proximity-perimeter continuum, with various conditions often influencing how the movement occurred. Features of the **Balancing Proximity and Perimeter** process are clearly evident in the vignette. For example, the professional's experience of tension between *Being With* and *Flooding the Zone* is epitomized in the adolescent's statement: "Why did you call them? You're the only one who could help me." Returning to my earlier discussion in the present chapter regarding the concept of balancing, the professional strives to balance the opposing states of proximity and perimeter: being with and in relationship versus protecting the adolescent from the perceived risk of suicide by establishing a defensive perimeter. **Balancing**, then, is the often-unrealized quest for balance and the movement along the proximity-perimeter continuum between, and in-between circling care and circling defensively.

Chapter Summary

In the present chapter I outlined the theory of the **Balancing Proximity and Perimeter** process to explain how child and youth care professionals realize mental health literacy practices in their encounters with suicidal adolescents. I presented an integrated model of the theory and explained the two sub-processes circling care and

circling defensively. I created and presented a vignette based on incidents shared by participants in my study to illustrate the theoretical storyline and how various practices and conditions impact the **Balancing** process.

In the following chapter, I provide an overview of my study and situate my theory of the **Balancing Proximity and Perimeter** process within the literature. Implications of the **Balancing** process and recommendations for future research are discussed in Chapter Seven.

Chapter 7

Discussion, Implications and Conclusions

In this final chapter I offer implications and conclusions of how child and youth care professionals realize mental health literacy practices during their encounters with suicidal adolescents. Following an overview of my dissertation as a whole, I situate the **Balancing Proximity and Perimeter** process arising from my research within the relevant literature and present the broader implications of the theory for child and youth care practice, for pre- and in-service education, and for mental health literacy research. Lastly, I present the boundaries of my research and provide recommendations for future research. My study, I believe, extends current conceptualizations of mental health literacy and offers insights for professionals, educators in schools of child and youth care, and for the larger mental health system of care for suicidal adolescents.

Dissertation Overview

In a review of the literature, the need to extend current conceptualizations of mental health literacy was informed by the emerging field of New Literacies (see New London Group, 2000) including critical literacy theory and social literacy theory. The review also identified a gap in understanding the interactional context between child and youth care professionals and suicidal adolescents, and the mental health literacy practices taken up by professionals in such encounters. Further, a review of the literature made visible the absence of suicide content in pre-service programs across a range of disciplines, how current in-service suicide education programs are aligned with traditional notions of literacy and literacy development, and adolescents' help-seeking preferences for informal and relational resources. The literature review illuminated the

need for research specifically geared towards helping professionals in the field of child and youth care who often hold positions in close proximity to suicidal adolescents (e.g., residential care) yet are not designated as traditional, formal mental health resources (e.g., psychiatrists, psychologists, school counsellors). A review of mental health literacy research identified the current conceptualization of mental health literacy is primarily derived from dominant views of mental health and mental illness, and traditional notions of literacy. Qualitative research is needed to deepen our understanding of mental health literacy as a contextualized social practice.

My study used constructivist grounded theory methodology to answer the following broad research question: How do child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents? The analysis of the rich data gathered from a variety of sources led to the identification of the core category, **Balancing Proximity and Perimeter** process, as an explanation and interpretation of how professionals realized mental health literacy practices. In the following section I situate my theory within the relevant literature including how my findings of the two sub-processes, circling care and circling defensively, and the associated actions/interactions, or mental health literacy practices, relate to existing ideas and research.

Situating the Balancing Proximity and Perimeter Process Within the Literature

My theory of the **Balancing Proximity and Perimeter** process is affirmed by, and affirms, findings within the existing literature. The concept of balancing has been taken up in the literature pertaining to practice with suicidal adolescents. For example, Stanley, Manthorpe and Gillespie (2008) examined how physicians balanced adolescents'

need for confidentiality and self-determination with the needs and concerns of their parents. The researchers found physicians chose various approaches to managing and negotiating engaging adolescents in treatment and reassuring parents while protecting confidentiality. One physician in Stanley et al.'s study described the process as "a bit murky" (p. 95). The **Balancing** process, for child and youth care professionals in my study, also held a murky quality in its fluidity, uncertainty, and dynamic process.

Professionals grappled with similar challenges as physicians in Stanley et al.'s study in balancing their proximal relational engagement with following pre-established agency policies or instruction within their pre-service program that directed professionals to break the adolescent's confidentiality and potentially interrupt or harm the relationship:

Sometimes I wish there could be some sort of reform with confidentiality rules, like 'cause it does sort of suck. Like, once someone tells you something so personal and then you have to go tell like people... I just wish there was some other way of breaking confidentiality or something. [CYC-06]

The proximity-perimeter continuum lies at the heart of the **Balancing** process.

Professionals take up particular mental health literacy practices, and by doing so they shift and move along the continuum. While some professionals may achieve balance in the process, more often practices were unbalanced as I previously described in Chapter Six.

Theoretically, the **Balancing Proximity and Perimeter** process may have some similarities to the philosophical underpinnings of Dialectical Behaviour Therapy (Linehan, 1993). Dialectical Behaviour Therapy [DBT] was originally developed for the treatment of suicidal individuals and Borderline Personality Disorder (Linehan, 1987).

The traditional exclusive focus within the therapeutic relationship on change was found to be ineffective as clients experienced such focus as invalidating (Miller, Rathus, & Linehan, 2007). Therapists, then, “had to figure out how to hold both acceptance and change in the therapy simultaneously” (Miller et al., p. 38). Acceptance of pain and the wish to change are opposing forces the therapist and the client seek to balance during the therapeutic process (Miller, Glinski, Woodberry, Mitchell, & Indik, 2002). Dialectical dilemmas, or polarized positions, are targeted throughout therapy and a synthesis between extremes is sought.

Aspects of the **Balancing** process are also polarized; that is, mental health literacy practices taken up by professionals during encounters with suicidal adolescents may be situated at either extreme of the continuum. Similar to the challenge of holding change and acceptance simultaneously for DBT therapists, child and youth care professionals experience a dialectical tension in holding the opposing forces of proximity and perimeter together during encounters with suicidal adolescents. It is this tension that characterizes the **Balancing Proximity and Perimeter** process and surfaces the two sub-processes, circling care and circling defensively.

The Two Sub-Processes: Circling Care and Circling Defensively

I identified circling care and circling defensively as two sub-processes within the **Balancing Proximity and Perimeter** process. As discussed in Chapter Six, circling care was comprised of child and youth care professionals’ mental health literacy practices that positioned the professional in close, relational proximity to the adolescent, whereas practices taken up within the sub-process circling defensively situated the professional in a defensive position, protecting the adolescent from harm. Overlap between the sub-

processes were generated from the data such that the professional moved back and forth along the proximity-perimeter continuum, realizing practices within either sub-process. For example, one professional explains how s/he shifted back and forth between the practices of *Being With*, located within the circling care sub-process, and *Appraising*, within the circling defensively sub-process:

...definitely relationship building. So I think we need to be human, have a human experience with them and kind of have a conversation with them, and not make it so much about getting through this task, you know, of assessing, but just being present with them. But also coupled with you gotta be quick on how you can get through all those things. Like you know, in a quick time turnaround of like assessing, and deciding what action, you know, what course of action you're going to be taking with this individual but without losing the part of like, the relationship with them. [INT-01]

In the above quotation, the professional explains s/he takes up the practice of *Being With* by “having a human experience” and “just being present” while simultaneously is trying to be “quick” in “assessing”, or what I’ve termed *Appraising* practice. The need to balance the practices is evident in his/her statement: “but without losing the part of like, the relationship” as s/he acknowledges the practice of *Appraising* may be a threat to the relationship with the adolescent.

Such findings are affirmed by Sun, Long, Boore, and Tsao’s (2006) grounded theory study investigating the nursing care of patients at risk of suicide. In Sun et al.’s study, the theory generated from the findings, “safe and compassionate care via the channel of the therapeutic relationship” (p. 684), married the activities of providing

protection with maintaining a therapeutic relationship. Nurse participants took up protection activities within a framework of care. When nurses separated providing protection from care, patients in Sun et al.'s study felt they were being controlled rather than protected and cared for. Although adolescents' perspectives on how professionals realized mental health literacy in their encounters were not the focus of my study, when practices within the sub-processes of circling care and circling defensively were separated, professionals explained how adolescents voiced they did not necessarily feel cared for in their interactions. For example, one professional described referring an adolescent to mental health services, or circling defensively. The adolescent said that s/he did not believe that would help (e.g., "there was no point") as s/he had already spoken with other service providers and "nothing had changed". [CYC-04] Despite the adolescent's reluctance, the child and youth care professional continued with the referral to other supports without the adolescent's collaboration.

Caring actions and defensive actions also were identified in Sun, Long, Huan, and Chiang's (2009) grounded theory study examining strategies used by Taiwanese families to care for a relative who was previously suicidal. Actions taken up by families included "guarding the person day and night" and "creating a nurturing environment" (p. 547). Families took up such actions concurrently. Guarding actions were comprised of constant observation and ensuring safety, whereas nurturing actions were related to conveying care and support, fostering tranquility, and reawakening hope. In nurturing, families provided the relative with an emotionally warm environment and ensured they were able to just "be there" for the person so they did not feel alone (p. 549). The actions realized by family members in Sun et al.'s study affirm the sub-processes that were generated in

my study of circling care and circling defensively in the **Balancing Proximity and Perimeter** process. Families, taking a similar role to the child and youth care professionals in my study, realized actions that were both caring or nurturing, and guarding or defending. However, a central difference was that many child and youth care moved back and forth between the sub-processes along the continuum unlike family members who took up caring and guarding as concurrent projects. At times professionals engaged in practices simultaneously within circling care and circling defensively, yet some professionals' practices were situated solely within circling defensively.

Being With

I discussed above how the **Balancing Proximity and Perimeter** process was comprised of two sub-processes, circling care and circling defensively. The practice of **Being With** was realized as part of the sub-process circling care whereby professionals situated themselves in relational proximity to suicidal adolescents. In Chapter Four I explained the aspects of **Being With** practice including how professionals engaged with adolescents energetically (e.g., body language, tone of voice), actively listened to the adolescent, and verbally communicated empathy and care.

In the proximity-perimeter continuum and related sub-processes within the **Balancing Proximity and Perimeter** process, the practice of **Being With** is located at one end of the continuum and often taken up by the professional early in the encounter. As discussed in Chapter Four, **Being With** may be set aside as other practices are realized, or professionals may return to **Being With** when other practices, such as **Flooding the Zone**, are ineffective (e.g., no mental health resources available).

Current scholars in suicidology suggest therapeutic engagement and collaboration must continue throughout the entire encounter. For example, within Jobes' (2010) Collaborative Assessment and Management of Suicidality [CAMS] approach, the suicidal person participates fully in the assessment of risk for suicide and coauthors their treatment plan. The CAMS approach emphasizes the formation of a clinical alliance and a collaborative relationship between clinician and patient (Jobes, 2006). The alliance essentially becomes a partnership, where the clinician and patient join together as "allies" to fight against suicide (Michel, 2010, p. 13). In this fight, suicide becomes personified or an externalized object to battle for both the professional and the adolescent. Jobes (2006) illustrates in the CAMS approach how the therapist shifts their body position from sitting in front of the client, to sitting side-by-side. This change figuratively positions the helper and helpee as allies. Such a position is in contrast to how some child and youth care professionals located suicide within the adolescent. For example, professionals in my study identified the adolescent as "risk" (e.g., "This kid is high risk" [CYC-03] or "He's a high risk" [CYC-06]). Externalizing suicide as an entity for the professional and adolescent to battle may support the practice of *Being With* as the professional and adolescent are aligned and joined together.

The notion of collaboration and joining together may be related to Rootman's (2009) discussion of health literacy being dependent upon the degree of fit between care provider and patient. The degree of fit between the adolescent's goals and the goals of the professional during the encounter may influence the extent to which the practices are collaborative and the strength of the relational bond between them. Further, collaboration while realizing practices within the sub-process of circling care positions mental health

literacy between professional and adolescent as a “relational act” (Giroux, 1987, p. 15). Such positioning of literacy is congruent with empowerment elements of critical literacy theory. As the professional realizes the practice of *Being With*, the adolescent gains confidence and connection while sharing their unique story.

In the present study, child and youth care professionals shifted to defensive practices rarely in collaboration with the adolescent. For example, one professional called the police without the adolescent knowing. When they arrived, the adolescent said to the professional, “Why did you call for them? You’re the only one who could help me.” [INT-01]. Another child and youth care professional described applying an assessment tool, and the adolescent becoming increasingly angry and starting to retract his/her suicidal statement when the professional tried to create a safety plan by *Flooding the Zone*. This action was, apparently beyond what the adolescent felt s/he needed. Findings suggest the absence of full collaboration between professionals and adolescents throughout the encounter. Child and youth care professionals may be fighting suicide; however, adolescents may not be their allies in the battle.

The practice of *Being With* may be similar to findings from Sun et al.’s (2006) grounded theory study examining nursing care of suicidal patients. Part of nursing care for participants in the study encompassed an ability to “‘be there’ with suicidal patients – in their humanity, physically, emotionally, in their presence and in time” (p. 688). Family members also tried to “be there” with a formerly suicidal relative in providing care and nurturing in Sun et al.’s (2009) grounded theory study. Family members in the study listened to their relative, ensured they did not feel alone, and used nonverbal actions to convey care. Similarly to *Being With*, the experience of *being met* by mental health

professionals was described in Talseth, Gilje and Norberg's (2001) phenomenological study. Talseth and colleagues examined relatives' experiences of care for an adult family member who was suicidal. The experience of "being met" was comprised of relatives feeling respected, understood, consoled, comfortable, relieved, and listened to (p. 253). Relatives experienced being seen as a human being through face-to-face contact and presence. Talseth et al. found that *being met* was central to creating hope for relatives.

The related concepts of ***Being With***, 'being met', or 'being there' thematically encompass Martin Buber's (1970) idea of I-Thou relationships characterized by authentic presence and "the offer of one's 'total being' to another" (DeWitt & Baldwin, 2000, p. 48). Part of offering one's being to another is the professional relating openly and totally with the individual (Miller, DeWitt, & Baldwin, 2000). Such *being* is congruent with White's (2007a) description of child and youth care practice whereby the professional brings "oneself fully to the therapeutic relationship" (p. 225), Harris' (2011) depiction of her child and youth care work with adolescents as "making myself visible and available" and "meeting them where they're at" (p. 53), or Begoray and Banister's (2007) recommendation for "reaching teenagers where they are" in adolescent girls' sexual health education (p. 24). Child and youth care professionals' practice of ***Being With*** during encounters with suicidal adolescents is affirmed by various ways of *being* in relationship portrayed in the literature.

As professionals bring themselves fully to the encounter and the relationship by ***Being With***, other ways of knowing may be realized as a part of their engagement with the adolescent. For example, drawing on the work of Noddings and Shore (1984), *intuitive knowing* is difficult to analyze. The authors suggest intuition is separate from

intuitive *feeling*, as the latter is more of a capacity that reveals and allows us to be moved and spoken to by the world. Feelings are intertwined with the meaning and value we place on our experiences (Artz, 1994). In clinical practice with children and adolescents, psychiatric mental health nurses defined intuition as “knowledge based on a strong feeling, sense, or perception, but not necessarily based on objective evidence” (Rew, 1991, p. 112). Nurses described multiple incidents where they acknowledged and acted on intuitive knowing regarding clients’ past experiences or future behaviours. One of the examples offered by a psychiatric nurse in Rew’s study involved staying with an adolescent even though he denied needing any help, and later finding out he was suicidal. Intuitively, beyond the objective evidence at hand, the nurse knew differently and stayed with the adolescent.

Hollingsworth, Dybdahl, and Minarikto (1993) offered the term, “relational knowing” to portray the ways of knowing teachers valued and relied on within educational settings (p. 8). The authors suggest teachers *know relationally* through their pedagogical care of students. Similar to child and youth care professionals’ *Being With*, Hollingsworth and colleagues conceptualized teachers’ relationships with students were characterized by a process of personal and emotional engagement with a reliance on intuition. Building on Hollingsworth et al.’s ideas, Webb and Blond (1995) viewed relational knowing as “the interaction of the knowledge of two persons that happens when they are in-relation” (p. 614). Furthermore, Webb and Blond focus on knowledge as re/constructed, dynamic, and involves both the mind and the body. Relational knowing requires physical, mental, and emotional engagement, characterized by holistic caring. Knowledge is not derived at a detached distance, rather, knowing emerges out of

connection. Minick (1995) established the relationship between knowledge and caring in a study with thirty critical care nurses. The nurses' narratives revealed caring as allowing early recognition of patient problems. Engagement was described as nurses' *involved stance* which heightened their perceptions and improved assessment skills.

Professionals' practice of *Being With* is also similar to the concept of the therapeutic alliance or therapeutic relationship within the relevant literature. As the basis of the therapeutic process, alliance is comprised of empathy, attachment, listening, openness, and respect (Michel, 2010). As discussed above and in Chapter Four, child and youth care professionals' practice of *Being With* included expressing empathy and care, listening and being present energetically. There is a strong association between the therapeutic alliance and adolescents' participation in the process of psychotherapy (Karver, Shirk, Handelsman, Fields, Crips, Gudmundsen, & McMakin, 2008). Further, Hawley and Garland (2008) found a significant association between the therapeutic alliance and outcomes (e.g., decreased symptoms, increased self-esteem) for adolescents using community-based services. *Being With* does not necessarily mean avoidance or absence of more directive practices by professionals. While the need for collaboration across the encounter was demonstrated earlier, the presence of more structured practices (e.g., *Appraising*) may not necessarily harm the alliance between professional and adolescent. For example, adolescents in a residential treatment program described a good relationship with professionals who cared for them as encompassing care and understanding along with establishing clear expectations (Manso & Rauktis, 2011). Thus, as a mental health literacy practice, *Being With* is a practice that child and youth care professionals could hold throughout the encounter with a suicidal adolescent.

Building Supports

The practice of *Building Supports* within the **Balancing Proximity and Perimeter** process included the collaborative engagement of peers and family members with the adolescent and child and youth care professional. Peers and family members became an extension of the dyad interaction between the professional and adolescent. Peers became involved in the interaction in some encounters by informing the professional of their concern for their friend, taking their suicidal friend to see the professional, or participating in the conversation with the adolescent and professional. Both the child and youth care professional and the adolescent informed family members of the adolescent's suicidality. *Building Supports* collaboratively leveraged existing relationships in circling the adolescent with care. The practice of *Building Supports* may have implications for suicidal adolescents.

For male adolescents with a history of suicide attempts and poor peer relations, parent relationships served as the most consistent protective factor in mitigating the risk of future attempts on their lives (Kidd, Henrich, Brookmeyer, Davidson, King, & Shahar, 2006). Further, relational connections with peers and parents were reported by adolescent participants in Bostik and Everall's (2007) study as helpful in overcoming suicidality. Relationships with parents provided adolescents with care, support and acceptance. Close friendships, peer groups, and romantic relationships also provided adolescents in Bostik and Everall's study with emotional support and opportunities to communicate their experiences. Family and peer support were also found to be associated with decreased suicidality amongst African American adolescents in Washington, DC, though peer

support had less impact in situations where the adolescent had higher levels of depression (Matlin, Molock, & Tebes, 2011).

Returning to the literature reviewed in Chapter Two on adolescent help seeking, adolescents preferred informal sources of help including family, friends, and partners (Booth et al., 2004; Burns & Rapee, 2006; Ciarrochi, Wilson, Deane & Rickwood, 2003; Gilchrist & Sullivan, 2006; Jorm, Wright, & Morgan, 2007). The child and youth care professionals' practice of *Building Supports* then, may be highly effective in supporting the suicidal adolescent in the **Balancing Proximity and Perimeter** process.

Detecting

Child and youth care professionals read the signs and looked for clues for suicide during the **Balancing Proximity and Perimeter** process. Educators viewed knowing the signs of suicidality as part of the role of child and youth care professionals in encounters with suicidal adolescents. Professionals observing and noticing pre-conceived indicators for suicidality in adolescents realized *Detecting* as a practice. They entered the encounter with expectations: "Whether that's in their drawings or the way in which they aren't sleeping properly, you know, all the signs you'd expect." [ED-02] Discussion and lists of warning signs are well documented in the literature. For example, clinical-researchers with the American Association of Suicidology [AAS] (n.d.) developed the mnemonic "IS PATH WARM" as a way of remembering warning signs for suicide (see Table 10).

In-service suicide education, as reviewed in Chapter Two, also emphasizes looking for warning signs (Quinnett, 2007) and risk alerts (LivingWorks Education Inc., 2007). Identifying warning signs suggests professionals can detect suicidality, and

Table 10

Warning Signs for Suicide

IS PATH WARM?	
I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Changes

therefore must engage in a practice of *Detecting*. Furthermore, warning signs exist as externalized indicators of suicidality across populations, contexts, and history. In an apparent hidden quest for determinacy, child and youth care professionals in my study gathered information and listed the signs of suicidality:

She had high-risk behaviour. There were a lot of the suicidal signs. At that time there was no direct talking about it to me anyways of like “I wanna kill myself”, like “I feel hopeless kind of discussion”. But she had high risky behaviour: sex without protection, she was cutting. [CYC-01]

As illustrated in the above quotation, professionals’ focus on warning signs draws their attention to negative behaviours (e.g., “risky behaviour”, “sex without protection”, “cutting”). Such focus provides the professional with a limited and pathologizing view of the adolescent and is incongruent with current best practice guidelines that invite professionals to *detect* protective factors as well. For example, Ashworth (2001) suggests professionals consider adolescents’ perceptions of being cared for and supported by

others alongside identifying the presence of risk factors (e.g., history of abuse, substance abuse).

The lists of signs for professionals to detect during encounters with adolescents shift the focus of the professional from the unique subjective experience of the individual to a view of the generalizable and observable. Such shift in gaze also re-positions professionals as experts, rather than giving this role to the adolescent:

In the exploration of patients' inner experience, the patients should be considered the experts on their own history; they are the keepers of their rich personal inner world, which has been shaped by their own individual biography. (Michel, 2010, p. 21)

White (2009) suggests "multiple risk factors for youth suicide exist and they interact in complex ways making it impossible to describe a singular profile of a 'typical' suicidal youth" (para. 10). Seeking the typical or suicide script for professionals in my study may supersede listening to what is unique: "Cause every individual is unique, but the kinda the script is the same in a way, you know?" [INT-01] If, as Michel (2010) suggests above, adolescents become the experts in the encounter, the professional-adolescent roles change from provider-recipient to recipient-provider; that is, the emphasis shifts. The child and youth care professionals take on the primary role of recipient of the suicidal adolescent's story, experiences, and understanding of their suicidality. The adolescent is empowered to share their knowledge and the professional joins with them in the knowing of their unique experience. Drawing upon critical literacy theory, scholars suggest when roles shift to give learners more power, they are able to voice their experience and concerns, and critically engage with their living conditions (New London Group, 2000).

A shift in roles during the encounter then, provides new opportunities for the suicidal adolescent to gain awareness and understanding of their experience.

Appraising

Categorizing or classifying the adolescent's risk level for suicide characterized child and youth care professionals' *Appraising* practice. Some professionals relied on assessment tools provided by their employers to assess the adolescent's risk for suicide. Professionals in my study asked the adolescent questions (e.g., "Do you have a plan?") and checked the appropriate box on the assessment tool according to the adolescent's response. How professionals realized the practice of *Appraising* emulates various clinical guidelines for suicide risk assessment. For example, Ashworth (2001) provides a "risk assessment matrix" in which children and youth are determined to be at mild, moderate, or high/imminent risk for suicide depending on a number of variables (e.g., ideation, immediacy of plans, previous attempt) (p. 38). Determining a risk level by using assessment tools or matrices may be counter to what adolescents need. In a recent study exploring adolescents' experience of nurses conducting a suicide risk assessment, adolescent participants described the importance of having one consistent therapist over time and a trusting relationship with the professional (Murray & Wright, 2006). Findings also suggested the first step in assessment is to establish such a relationship with the adolescent, and show genuine interest in their story. The researchers recommend professionals use open-ended questions and adopt a curious stance when communicating with adolescents for assessment purposes.

Child and youth care professionals in my study often realized the practice of *Appraising*, not by open-ended questioning and listening to the adolescents' story as

Murray and Wright (2006) recommend, but by engaging in a mechanistic, question-answer format. As one professional explained, “It’s like a whole bunch of, it’s a good 2 pages... with like thirty questions or something like that.” [CYC-06] *Appraising* was a practice that treated the adolescent as an object (e.g., “we were doing the assessment on him” [CYC-06]). At the point of realizing the practice of *Appraising* in the **Balancing Proximity and Perimeter** process, the scale tips in favour of circling defensively.

Shneidman, reminds professionals to focus on the adolescents’ story:

Our kind of treatment, psychotherapy and so on should address the person’s story, his/her narrative, not the demographic, nosological category of this or that fact. It says, “Please tell me who you are... what hurts?” Not, “Please fill out this form... and give me samples of your body fluids.” (Shneidman, 2001, as cited in Leenaars, 2011, p. 231)

While the purpose of *Appraising* is to categorize the risk level of suicidality for the adolescent, there are conflicting findings in the literature regarding the effectiveness of the practice. For example, Stathis, Litchfield, Letters, Doolan and Martin (2008) compared levels of agreement between professionals in the assessment of suicide risk for adolescents incarcerated in youth detention centers. Stathis and colleagues found a lack of consensus in the level of risk assigned to adolescents by professionals. While one group of professionals, the detention centre’s Suicide Risk Assessment Team [SRAT] placed eleven adolescents at high risk; the same group of eleven adolescents was subsequently assessed by another group of professionals, (i.e., The Mental Health Alcohol Tobacco and Other Drugs Service [MHATODS]) who determined eight of the original 11 adolescents were not suicidal. The SRAT was comprised of service

coordinators, caseworkers and psychologists, whereas the MHATODS were clinicians supervised by a psychiatrist. Though the lack of consensus may be a result of different assessment tools used by each professional group or disciplinary location, Stathis et al.'s study illuminates the murkiness of *Appraising* practice in accurately categorizing risk.

However, other studies have demonstrated consistency in evaluating suicide risk. For example, Karver, Tarquini and Caporino (2010) examined judgments of suicide risk of helpline counsellors for adolescents. Using realistic clinical profiles of adolescents who may be at risk for suicidality, the researchers found that the helpline counsellors had a high rate of agreement regarding the classification of risk and correctly identified future suicidality for 80% of the adolescents.

Clearly the difference between Stathis et al.'s (2008) study and Karver et al.'s (2010) study is the assessment of risk of *actual* adolescents versus the assessment of risk for profiles created for research purposes. The time and energy professionals expend on assessment tools, calculating risk, and asking "like thirty questions" [CYC-06] may, or may not be worthwhile in predicting the adolescent's future suicidal behaviour. The complexities of suicidality may not be easily moulded into a high, medium, or low risk level. Suicide is not merely a matter of immediately present circumstances. It also does not have a simple cause. It is usually the culmination of life events, and it has a developmental history" (Michel & Valach, 2010, p. 70). Furthermore, such *Appraising* practices that only provide a surface-level understanding may leave adolescents "impersonally processed" (Michel & Valach, p. 67). For example, one Child and Youth Care professional explained how she/he realized the practice of *Appraising*: "There's five questions, if they get three out of five, they're medium risk. If they get four out of five

they're high risk." [CYC-04] This action additionally shows the professional behaving as a technician, applying a routine method of assessment to the adolescent's subjective experience.

Superficial understanding does not account for the complexities and contextualized location of suicidality. Literacy practices such as evaluating or what I have termed *Appraising*, are situated within a social context and are embedded within relations of power and cultural practices (Street, 1995, 2009). In a recent study exploring how suicide was discursively formulated within an adolescent suicide education program, Morris (2010) found that power was manifested by a helper in the assignment of suicide risk of the suicidal person. That is, the adolescent becomes labelled and recognized as a suicide risk: "They're medium risk." [CYC-04] *Appraising*, then, may be an exercise of power, and position the child and youth care professional as both a technician and expert in identifying the adolescent as at risk.

Watching

During encounters with a suicidal adolescent, child and youth care professionals in my study engaged in the practice of *Watching* adolescents (see Chapter Four). The *Watching* practice was comprised of surveillance, observation or physically following the adolescent to maintain "eyes on." Many professionals were following a direction or implementing an agency policy when they watched the adolescent, and at times, *Watching* became a structured, time-sensitive activity (e.g., checking on the adolescent every 15 minutes while they are sleeping).

The concept of watching a person who is suicidal has been taken up in the literature. Similar to findings in my study, watching is described in the literature using a

variety of terms including “constant observation” (Alland, Gallagher, & Henderson, 2003; Fletcher, 1999; Vrale & Steen, 2005; Wheatley, Waine, Spence, & Hollin, 2004), “formal observation” (Manna, 2010), “special observation” (Horsfall & Cleary, 2000), or “suicide watch” (Junker, Beeler, & Bates, 2005). The various terms refer to “high levels of observation, with some degree of removal of freedom and/or belongings, with the aim of preventing suicide” (Fletcher, 1999, p. 9). For example, in Junker and colleagues’ study the researchers describe a suicide watch within a correctional setting to encompass the following mechanisms: (a) constant surveillance using closed-circuit TV; (b) rounds conducted by nursing staff, every 15 min; (c) rounds by correctional staff, every 15 min; and (d) direct observation (pp. 22-23). The suicidal person’s fellow inmates, who had completed an education program on observation skills, conducted direct observation. While at first glance it may be unusual to utilize the person’s fellow inmates as observers, such practice may be equated to families providing follow up care to suicidal persons as described above in my review of Sun et al.’s (2009) study. Family members in Sun and colleagues’ study also provided observation. To further illustrate the mechanisms of observation, three different levels of observation are recommended by the Clinical Resource and Audit Group [CRAG] (2002; see Table 11).

Tradition underpins the practice of observation. In a review of the literature from 1996 to 2009, Manna (2010) found a significant gap in the literature providing empirical evidence of the effectiveness of the practice of observation. A barrier to research evaluating observation identified by Manna may be the legal and ethical implications of withholding a practice that may be life saving. Despite the paucity of clear evidence supporting observation practices, litigation concerns are well founded. For example, a

Table 11

Description of Progressive Levels of Observation

Level of Observation	Description
General	The staff on duty should have knowledge of the patients' general whereabouts at all times, whether in or out of the ward.
Constant	The staff member should be constantly aware of the precise whereabouts of the patient through visual observation or hearing.
Special	The patient should be in sight and within arm's reach of a member of staff at all times and in all circumstances.

(CRAG, 2002, p. 2).

recent United States Court of Appeals ruling held a nurse and the nurse's employer partially to blame for an inmate's death by suicide for not initiating close monitoring based on the inmate's affirmative response to suicide ideation ("Suicide Risk," 2011).

The potential for blame for an adolescent's death by suicide emerged from the data in my study as an aspect of the practice of *Watching*. In Chapter Four, I discussed participants' explanations that they did not want the adolescent to die when they were responsible (e.g., "I was very concerned that we might lose her on our watch" [SUP-01]).

Policies, as identified in Chapter 5, were a condition that influenced how child and youth care professionals in my study take up observation, or *Watching*. A discourse analysis of a special observation policy for nurses within an inpatient psychiatric facility illuminated the power such policies have over patients and nursing practices such that "it is unlikely that either the patient or the nurse has the actual power to resist the observation prescription, or to re-negotiate it" (Horsfall & Cleary, 2000, p. 1295). Child and youth care professionals in my study also assumed they had little influence or power in how the practice of *Watching* was performed. As I presented in Chapter Four, one

professional followed the observation policy above all else: “I really had to pee, [laughter] but part of the protocol is do not leave the student alone.” [CYC-04]

Universal procedures for observation or watching a suicidal person displaces the expertise and decision making of the professional who is in closest relational proximity to the person and neglects the uniqueness and individuality of the person contemplating ending their lives. Child and youth care professionals in my study shifted between circling care and circling defensively, when taking up practices such as *Watching*. Despite being in physical proximity to the adolescent while *Watching*, professionals were less engaged in relational proximity. The practice of constant observation may end up creating distance between nursing professionals and patients (Alland et al., 2003), can be paternalistic and can be an activity that interferes with the formation of therapeutic relationships (Bouic, 2005).

Similar to the **Balancing Proximity and Perimeter** process, the dynamic between observation for control and safety, and observation for therapeutic relations was identified in Vrale and Steen’s (2005) content analysis examining how nurses perform constant observation of patients. Participants in the study described monitoring the patient’s movements to control against self-harm, while also showing interest and care, creating hope, offering conversation about everyday life and discussing with the patient that patient’s experience of constant observation. Vrale and Steen found that nurses described moving together with the patients as like a “dance” while “...at the same time allowing space between the partners” thus balancing “between control and therapeutic aspects” (p. 517).

Nurses' need to balance observation with engagement was also recommended by Mackay, Paterson, and Cassells (2005) when working with persons who present a risk for violence or aggression. Using in-depth unstructured qualitative interviews, Mackay and colleagues investigated the practice of observation by nurses with potentially aggressive patients. Participants described observation in terms of procedure (e.g., nurse implementing institutional policy to maintain patient within arms' reach), and role and skills (maintaining safety, intervening, de-escalation and management of aggression, assessing, communication, and therapy). That is, observation for the nurse participants in Mackay et al.'s study was comprised of more than watching: "Observations also allowed the opportunity to be with, spend time with, and help the patient – the very process of the procedure allowing 'one to one' care for those thought to be most in need of it" (p. 469). Observation of suicidal persons may be reconceptualised as a process of engagement to refocus professionals on the interpersonal relationship with the patient, exploring the suicidal person's experience, and attending to their needs for emotional and physical security (Cutcliffe & Barker, 2002, p. 619). Child and youth care professionals' mental health literacy practices then, within the **Balancing Proximity and Perimeter** process may be best realized as concurrent practices; that is, circling care and circling defensively become simultaneous or intertwined. While some participants in my study realized such practices concurrently, practices such as *Watching* were often viewed by participants as distinct, stand-alone activities. As a stand-alone activity, professionals are situated at the defensive perimeter, rather than in relational proximity with adolescents in their care.

Increasing child and youth care professionals' autonomy and/or engagement in multidisciplinary decision-making regarding the practice of *Watching* may be beneficial

for both professionals and patients. However, such a shift would require a change in how child and youth care professionals' role is perceived, by the professionals themselves, as well as by educators and other mental health care providers. Participants in my study were not only directed by policy in realizing the practice of *Watching*, they were also instructed to perform *Watching* by other mental health professionals.

We can put them on special attention with the understanding that we will, we remain with them until a psychiatrist can place them on constant attention. So although special attention means a check every 15 minutes, if I'm a supervisor and I have a large concern for maybe if you were my youth, I'd put you on special attention but I would still keep you in my face until I could get psychiatry. What often happens is the psychiatrist, it's a matter of a telephone call, will give the verbal order for constant attention and then come in and either dismiss it or continue it. But a constant attention must be directed by psychiatry. [SUP-02]

Child and youth care professionals, as evidenced in the above quotation, did not have decision-making power or influence in the implementation of the practice of *Watching*, nor did they critically question the practice. Stevenson and Cutcliffe (2006) suggest the discourse surrounding observation practices such as *Watching* hold implicit and taken-for-granted assumptions about risk and power relations. The discursive statements of "constant attention" or "suicide watch" discussed by child and youth care professionals serve, in part, to re/produce the suicidal person as risky, dangerous, and in need of being monitored within a special space (e.g., "keep you in my face"). Opportunities for professionals to question critically and examine the practice were limited. Child and

youth care professionals were clear on who directs *Watching*, and how the practice is realized during encounters with suicidal adolescents.

Creating opportunities for shared decision-making regarding how *Watching* is realized may change practice for both professionals and adolescents. For example, Kettles and Paterson (2007) conducted a small pilot study to examine the introduction of more flexible observation guidelines where nursing staff within a psychiatric setting were given more autonomy to decide a patient's level of observation, rather than only following an observation procedure directed by a physician. Initially, nurses in the study were reluctant to make decisions as to the level of observation; however, results of the study indicated a shift to towards multidisciplinary team decision making or nursing decisions regarding patients' needs for observation. Patients were on high levels of observation (e.g., special observation or constant observation) less frequently or for shorter periods of time. Kettles and Paterson suggest "staff time is better spent in engagement and therapeutic intervention than sitting in corridors watching patients from a specified distance" (p. 379). *Watching*, as Cutcliffe and Barker (2002) suggest, may be best realized as an aspect of *Being With* or engagement, rather than a technical and formal procedure of observation.

Flooding the Zone

Critically questioning the notion of suicide prevention, Szaz (1986) suggests prevention implies coercion, and policies aimed at preventing suicide are paternalistic towards the client. Although Szaz specifically identifies that his ideas are specific to practice with adults, the practice of *Flooding the Zone* taken up by professionals in my study had coercive elements. In Chapter Four I explained the practice of *Flooding the*

Zone whereby child and youth care professionals notified other professionals, service providers, police, or school personnel of the adolescent's suicidality. Directives provided via policies, supervisors, or instruction in pre- and in-service programs to call and inform others compelled professionals to respond by ***Flooding***:

Mental health professionals, however, are expected to prevent suicide: If they are psychiatrists, they have the duty to commit the "patient"; if they are psychologists, social workers, nurse practitioners, or lay therapists – who are not (or not yet) licensed, or even required, by the state to commit – then they are expected to make an appropriate referral to a physician... to forcibly prevent the patient's suicide. (Szaz, 1986, p. 807).

Even though child and youth care professionals did not have the legislated capacity to commit adolescents to psychiatric care, professionals were aware ***Flooding the Zone*** might lead to forcible confinement. In some encounters, child and youth care professionals reported that adolescents were arrested under the *Mental Health Act* and admitted to the hospital, or confined to jail when an appropriate psychiatric facility was unavailable. One professional reported the outcome of the practice in the latter incident as "horrible", "terrible", and "tragic" for the adolescent. [CYC-03] ***Flooding the Zone*** may support the professional establishing a defensive perimeter around the adolescent however, hidden within such practice is an element of coercion.

Flooding the Zone also positioned child and youth care professionals in my study as referral agents or negotiators with service providers within the mental health system who were perceived to hold the knowledge and expertise to intervene. In Chapter Four, I discussed how professionals explained how they notified others of the adolescent's

suicidality, referred the adolescent onto services as they did not want to “hold the responsibility” [INT-01], and were informed by designated mental health service providers to not be “mucking about in it” with the suicidal adolescent [ED-02].

Salhani and Charles (2007) examination of inter-professional dynamics between child and youth care professionals and other professions in a residential setting affirms participants’ explanations of *Flooding* in my study. Salhani and Charles found that child and youth care professionals “were most often left out of discussions and decisions and were, indeed, the least often consulted group” (p. 13). While it was recognized amongst all inter-professional team members child and youth care professionals had the most influence with the adolescents in the residential setting, from a hierarchical standpoint, child and youth care professionals were located at the bottom. Furthermore, participants in Salhani and Charles’ study described their role as merely to convey information: “Overall, the child and youth care workers felt that they were expected to act as mere conveyors of the type of information required by the outside professionals rather than having anything important to offer as professionals themselves” (p. 15). Such findings are similar to professionals in my study who perceived their role as referral agents, or what I have termed, professionals *in-between* (see Chapter Four and Chapter Five). However, some child and youth care professionals in my study used the opportunity when waiting for other professionals to become involved to develop relationship and connection with the adolescent. In *Being With*, professionals valued the relational proximity and viewed this position as something they had to offer: “The only thing that I had to rely on with him is my relationship with him. Bottomline, that’s what it all comes down to.” [CYC-03]

Implications of the Balancing Process

The **Balancing Proximity and Perimeter** process provides “an abstract theoretical understanding of the studied experience” (Charmaz, 2006, p. 4) of how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents. Cooney (2011) suggests a grounded theory may be viewed as credible if feedback from participants indicates the **Balancing** process made sense and explained their situation with suicidal adolescents. Furthermore, for the **Balancing** process to fit, the theory must be generated “from diverse data from multiple perspectives of the social setting in the given substantive area” (Baker, Norton, Young & Ward, 1998, p. 548). In my study, data were collected from professionals across a range of locations in the field of child and youth care, supervisors at youth-serving agencies, educators found in schools of child and youth care, and documents (e.g., agency policies, assessment tools) provided to me by participants. Opportunities were afforded child and youth care professionals, educators, and supervisors to provide feedback throughout the research process and during a research presentation I provided at a child and youth care conference (Ranahan, 2011). Research participants and presentation attendees recognized the **Balancing** process in their encounters with suicidal adolescents in practice. For example, in the post-presentation discussion, conference attendees shared personal stories of encounters with suicidal adolescents and voiced how they recognized the **Balancing** process in such encounters. Statements such as “Oh, I did that too”, or “That totally makes sense to me” were affirmations of how the theory was relevant and fit with their experience. Such criteria for evaluating grounded theory studies leads to my discussion in this section regarding the implications of the theory for child and youth care practice, for

pre- and in-service suicide education, and for the burgeoning field of mental health literacy.

For Practice

The **Balancing Proximity and Perimeter** process holds several implications for child and youth care professionals' practice with suicidal adolescents. Professionals' mental health literacy practice of *Being With* in the **Balancing Proximity and Perimeter** process is aligned well with the relevant literature on engaging effectively with suicidal adolescents. *Building Supports* also emphasizes collaboration and support as adolescents are joined with the professional in decision-making and informing others who are in existing relationships with the adolescent. The challenge for child and youth care professionals resides within the tension between such practices and practices that are situated on the continuum towards perimeter. Child and youth care professionals' work with suicidal adolescents needs to be characterized by collaboration and relational proximity throughout the encounter even when taking up practices such as *Appraising* or *Watching*. As discussed above, Jobes (2006, 2010) suggests that a suicidal person participate fully in assessing their risk of suicide and the subsequent planning therein. *Watching* may also be reconfigured to focus on aspects of *Being With* rather than objective, and relationally distant, observation.

In Chapter Five I discussed several conditions influencing the **Balancing Proximity and Perimeter** process that impact how child and youth care professionals realize mental health literacy practices with adolescents. Conditions such as community agency policies or connectivity with supervisors can greatly contribute to the tension inherent in the **Balancing** process. Policies are articulated as numbered steps or a set

method to follow during an encounter with a suicidal adolescent. That is, policies require professionals to engage with the adolescent in a procedural, mechanistic manner. While certainty in such situations may be desirable by the agency or professionals themselves, the complexities of suicide and thus the practices professionals must take up when encountering suicidal adolescents do not translate well into specific steps. The theory of the **Balancing** process and the tension therein implies professionals must grapple with uncertainty and be “able to work in the gray” [ED-03]. Policies for practice with suicidal adolescents may be well advised to emphasize the characteristics of an inter-relational, reflective process, rather than only the specific steps. As White (2007b) suggests, professionals need “[q]ualities of curiosity, collaborative meaning-making, joint knowledge construction, and ethical engagement” to work effectively in situations involving suicide (p. 213). Such approaches would be congruent with what may be envisioned as *critical* mental health literacy practices. Professionals would be called upon to question, examine, and transform their practice rather than adhering to policies with blind compliance.

I noted above the condition of connectivity additionally influenced the practices of professionals in the **Balancing Proximity and Perimeter** process. Supervisors often directed professionals’ practice and thus their location along the proximity-perimeter continuum. The direction not only influenced which practices were taken up by the professional, but also contributed to the tension within the process as some professionals felt invalidated or disconnected with their supervisor’s direction. Within the **Balancing** process then, professionals may not always feel empowered or trusted in making decisions, which may (again) lead to a lack of collaboration with the suicidal adolescent

and/or regimented following of policies without critical examination. Collaboration must then extend beyond the two-way interaction between the child and youth care professional and the suicidal adolescent, to include the supervisor who may be viewed as holding a stake in the **Balancing** process.

For Education

Suicide content in pre- and in-service education for child and youth care professionals and other service providers, if present at all, has predominantly focused on knowledge of risk factors or warning signs, suicide assessment to determine level of risk, and referral resources (see Chapter Two). Suicide educators may be contributing to the **Balancing Proximity and Perimeter** process by constructing the role of child and youth care professionals as merely technicians who ask standardized questions and apply assessment tools. Some educators in my study explained these professionals' role with suicidal adolescents as alerting others, following the identified protocol, and supporting the adolescent while help from others is accessed. Such instruction co-constructs how professionals realize mental health literacy practices with adolescents as the professionals become the detectors of warning signs, the appraisers of risk, and the initiators of a flood of referrals.

What is clear in the **Balancing** theory is that professionals' mental health literacy practices in the event of encountering a suicidal adolescent are contextualized, situational and complex. To illustrate, in one encounter the professional engages an adolescent in a discussion, finds out she/he are suicidal, follows agency policy by escorting the adolescent to the hospital, experiences the hospital personnel as unhelpful as the adolescent leaves without care, and phones the police who arrest the adolescent under the

Mental Health Act in the parking lot of the hospital, at which point the adolescent is admitted. The complexities of such an encounter are not adequately delineated in the classroom where the focus may be on lists of warning signs or steps to apply in assessing risk. White and Morris' (2010) recent study with suicide educators illuminated such complexities in real life situations. Educators in the study "acknowledge[d] that final, universal or singular explanations of suicide were impossible" (p. 2191). The challenge then, for suicide education curriculum is to support students' learning of the ambiguous and indeterminate nuances of encounters with suicidal adolescents.

Further, the finding within the theory of the child and youth care professional being constructed as the professional *in-between* must be challenged by educators as it may render them powerless during encounters. It is worthwhile to return to examine further an adolescent's statement reported by a professional in my study: "Why did you call for them? You're the only one who could help me." [INT-01] The review of the adolescent help-seeking literature supports the adolescent's statement. That is, adolescents prefer informal supports where they are accepted, relationally connected, and trusted. Child and youth care professionals' role may be reconceptualized within pre- and in-service education as existing within, and interconnected to, the broader health care field. For example, the World Health Organization defines health as "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2007). The definition identifies the link between physical health and mental health, and encompasses social well-being. How we define such concepts influences curriculum (Novitzky, 2009), and consequentially, professionals' practice. If educators continue to define and locate health expertise within particular disciplines (e.g.,

mental health belongs to psychiatric nursing or psychology), child and youth care professionals will continue to be the professional *in-between*.

Curriculum, then, within pre- and in-service programs should be redesigned to adopt approaches that would explore the complexities of practice with suicidal adolescents and be informed by extended notions of mental health literacy. For example, students could have opportunities to participate in interdisciplinary conversations about practice with suicidal adolescents. Banister and Begoray (2004) described using nonstructured focus groups to create conversations and a nonthreatening environment as a strategy to improve health education for adolescents. The researchers also used free writing, role playing, and body tracing as strategies to create awareness and understanding of behaviours. Such strategies within suicide education curriculum would advance professionals' understanding across disciplines and create awareness of how various conditions (e.g., role of child and youth care professionals, arousal, policies) influence their mental health literacy practices.

Hoskins and White (2010) may also inform new pre- and in-service suicide education approaches based on their research with professionals located within child protection contexts. The researchers identify various learning activities that are designed to develop students' skill of attending to the context of practice. Hoskins and White recommend educators "provide students with opportunities to cultivate the skill and art of seeing more than what meets the eye, to read below the surface, and to do this while developing a working relationship" (p. 41). The same strategies should be provided within suicide education curriculum, inviting students to take up a critical perspective on mental health literacy and examine the practices they enact during encounters with

suicidal adolescents. For example, students may be encouraged to “read below the surface” of assigning a level of risk to an adolescent’s suicidality while *Appraising* by inviting students to ask various questions such as (a) how might labelling the adolescent as ‘high’ risk influence my interaction?; (b) how might my application of the label ‘high’ risk impact the responses of others?; (c) what meaning to I attribute to ‘high’ risk, versus ‘low’ risk and why?; or, (e) what additional knowledge may I need beyond the assigned risk level? Critically attending to the often hidden aspects of *Appraising* practice by encouraging students to consider to the questions above would deepen students’ understanding of the complexities of practice with suicidal adolescents.

Further, suicide education curriculum would benefit from incorporating elements of critical literacy including shifting the roles of teachers and learners or suicide experts and professionals in-between. I identified professionals’ experiences, both work-related and personal, within the **Balancing** process as influencing conditions on their mental health literacy practices. Thus, students’ prior knowledge and ways of knowing may be acknowledged and used within the learning context. Reliance on expert knowledge (e.g., guest speakers from suicide-specific services) in the classroom may also be re-examined as the roles shift and students are empowered to question and collaborate with each other. Mental health experts as guests in the classroom may be invited as participants rather than the *keepers* of knowledge. Such strategies are congruent with a view of knowledge production as a “relational act” (Giroux, 1987, p. 15) and the emergence of a “critical consciousness” (Freire & Macedo, 1987, p. xiii) whereby students are aware of the power relations and sociocultural reality that shapes practice with suicidal adolescents. For example, students may be encouraged to question the underlying assumptions of risk,

watch, warning signs, safety, or assessment within the **Balancing Proximity and Perimeter** process. Reconceptualizing mental health literacy may support such educational advances in pre- and in-service programs.

For Mental Health Literacy

I identified and illustrated in the review of the literature presented in Chapter Two the reliance on quantitative research approaches to measure participants' mental health literacy as they read abstract vignettes depicting persons experiencing mental health concerns as classified under the *Diagnostic and statistical manual of mental disorders* (APA, 1994). As well I discussed how current conceptualizations, and subsequently dominant research approaches (e.g., Jorm et al., 1997) of mental health literacy are situated within traditional notions of literacy. That is, mental health literacy is viewed as a measurable attribute of individuals that can be acquired as a neutral set of competencies. By way of definition and measurement, persons are determined to be at some point on a continuum from mental health literate to illiterate. In the present study I extend current research on mental health literacy in the following three ways: (a) deepening and extending understanding of mental health literacy through qualitative research; (b) reconceptualising mental health literacy as a social practice and process; and (c) extending current mental health literacy research to include child and youth care professionals as a population of interest.

First, by using a grounded theory approach, the meaning of mental health literacy practices was derived directly from the data. That is, participants identified and explained how they realized mental health literacy practices during encounters with suicidal adolescents rather than testing participants against a pre-conceived notion of mental

health literacy. Certain actions (e.g., *Being With*) were consistently described in the data as practices that may be included in reconceptualising mental health literacy. However, in contrast to current attributes of mental health literacy (e.g., knowledge of mental disorders), such literacy practices are very difficult to assess. For example, *Being With*, “being met” (Talseth et al., 2001, p. 253), or “reaching teenagers where they’re at” (Begoray & Banister, 2007, p. 24) are ways of *being* and engaging that are qualities of the interaction itself. Deepening our understanding of mental health literacy practices from the perspectives of participants broadens what may be included as *literacy*, and in turn, expands the scope of what may be required of professionals and needed by adolescents in the interaction.

Secondly, I considered current reconceptualizations of literacy as a relational act and set of social practices (Barton & Hamilton, 2000; Street, 1995, 2009) that are comprised of activities, actions and interactions within a specified context (Prinsloo & Baynham, 2008). A grounded theory approach to inquiry allowed me to construct a theoretical explanation of mental health literacy as a social process (Charmaz, 2006). Thus, the context, influencing conditions, and actions/interactions embedded in mental health literacy practices realized during encounters were able to be identified from the data. I reconceptualised mental health literacy to be understood as a process and social practice rather than simply an observable attribute located within individuals. Considering mental health literacy *practices* allowed me to explore the patterns of activity around the literacy event (i.e., an encounter with a suicidal adolescent) and link the practices to the broader conditions at play (Street, 2003). For example, current conceptualizations of mental health literacy include knowledge of professional help

available (Jorm et al., 1997). Participants in my study referred the adolescent to service providers, or enacted what I termed *Flooding the Zone. Flooding*, as an aspect of the larger social process, was linked to various conditions (e.g., policies, availability of resources) that intersected with the professionals' knowledge of help available. That is, rather than a set of standalone attributes, mental health literacy is a situated set of social practices influenced by a variety of conditions.

Lastly, child and youth care professionals were found in my study to be often situated as in-between professionals (see Chapter Four and Chapter Five). That is, professionals who refer the adolescent on to other service providers assumed that the latter possess greater expertise or hold the more important role in the mental health system of care as a key provider of services to suicidal adolescents. I discussed in Chapter Two that mental health literacy research has so far focused on several other groups of professionals (e.g., psychiatrists, psychologists, physicians, nurses). My study extends current research by focusing specifically on child and youth care professionals as the population of interest and I begin the academic conversation of how mental health literacy matters to child and youth care practice.

Boundaries of the Study

The use of constructivist grounded theory method proved effective in identifying how child and youth care professionals realize mental health literacy practices during encounters with suicidal adolescents. The theory of the **Balancing Proximity and Perimeter** process was generated directly from the data. This process may not have materialized if I had chosen to rely on pre-conceived conceptualizations of mental health literacy to guide my observations and analysis. Additionally, the mental health literacy

practices (e.g., *Being With, Detecting*) within the **Balancing** theory may not have developed during analysis if I had asked child and youth care professionals to define and explain their encounters in regards to mental health literacy as defined by Jorm et al. (1997) or CAMIMH (2007). Providing child and youth care professionals and supervisors with a current conceptualization of mental health literacy may have framed their encounters with suicidal adolescents in an alternate way. For example, as knowledge of mental disorders is an aspect of existing definitions of mental health literacy, professionals may have focused their responses on relaying information about the adolescent's mental health diagnosis. By inviting participants to inform me of their encounters with suicidal adolescents, the mental health literacy practices were generated directly from the data.

Findings from my study are limited of course to the concepts, categories, properties, conditions and consequences that I identified in the data I collected. Findings are further limited in regards to the data provided by the sample of participants and available documents. Although I endeavoured to follow a theoretical sampling strategy to elaborate categories and identify variation within categories by including data from a range of sources, I acknowledge that findings may be limited by the availability and accessibility of participants. For example, some professionals may be hesitant to discuss their encounters with suicidal adolescents due to self-blame for an adolescent's death by suicide, or a fear of judgment by others. Further, professionals may not define an experience as one involving suicide if they were uncertain of the adolescent's intent to die, and the frequency of encountering situations involving suicide in child and youth care practice is unknown. As I discussed in Chapter One, child and youth care

professionals practice in a range of settings and contexts with varied populations which may, or may not, influence the likelihood of encountering a suicidal adolescent.

As a constructivist grounded theory researcher, I grappled with how my presuppositions and location (see Chapter One) may have been imported into the research. Following Charmaz (2006), I practiced reflexivity, querying my interpretations alongside the interpretations of those that participated in my study. I cannot say for certain that assumptions beyond my awareness, and therefore outside of my practice of reflexivity did not enter into the analysis. What I have constructed is “an interpretive rendering” of how mental health literacy practices are realized by child and youth care professionals in their encounters with suicidal adolescents (Charmaz, 2006, p. 184). Thus findings are limited to how I interacted with and interpreted comparisons in the data during analysis (Charmaz, 2006).

Despite my efforts to follow grounded theory methodology and the guidance of expert grounded theorists I consulted throughout the research process, procedural or conceptual errors may have occurred as a reflection of my relative novice researcher status. Suddaby (2006) suggests that researchers are required to “develop a tacit knowledge of or feel” for applying grounded theory procedures (p. 639). I recognize that developing a “feel” for the research process and grounded theory strategies will necessitate further experience; however, readers returning to the research procedures I presented in Chapter Three and the presentation of my findings will find I clearly demonstrated that I attempted to be reflexive, be informed by scholars in grounded theory, and follow grounded theory methodology to ensure the credibility of my work.

Avenues for Future Research

As a relatively new field of study, opportunities for further mental health literacy research abound. My research adds to this emerging field through a grounded theory approach, focusing on an under-researched population of professionals, and expanding notions of mental health literacy to include literacy as a situated, contextualized, and active social process. Future studies that continue to explore mental health literacy from a contextualized and interactional view are needed.

[Mental] health literacy includes more than word recognition, reading comprehension, and numeracy. The existing measures and screenings do not fully grasp the concept of health literacy in terms of language, context, culture, communication, or technology. Thus, we do not yet possess a measure that takes into account the full set of skills and knowledge associated with health literacy. Furthermore, potential confounders, such as text anxiety, distress due to illness, or cognitive deficits secondary to disease, are not taken into account when measuring health literacy. (Mancuso, 2009, p. 87)

The intersections of context, culture, communication, technology or confounders are not taken up in current mental health literacy research where the focus, for example, continues to be on testing individuals' declared knowledge of mental disorders as indicated by the *Diagnostic and statistical manual of mental disorders* (APA, 1994). Mancuso (2009) suggests we do not have a measure that can negotiate the complexities of health literacy, and by extension, mental health literacy.

I suggest that perhaps a fixed measure of mental health literacy is gratuitous. Measuring mental health literacy as an individual attribute provides a one-dimensional view on the concept and misses hidden literacy practices, such as *Being With*. The practice of *Being With* may be central to child and youth care professionals' care for suicidal adolescents, however "...these 'ways of being' are typically not conducive to being counted and measured" (White, 2007a, p. 238). Further, practices within circling care may be easily hidden or overtly avoided as Webb and Blond (1995) suggest: "Too difficult to analyze or categorize, impossible to put a number on, caring is disregarded" (p. 611). An avenue, then, for future research includes a focus on the experiential and qualitative elements of mental health literacy: that which is immeasurable and yet vital to practice with suicidal adolescents.

Further, much more research is needed with respect to the specific content area of how mental health literacy is realized in practice for professionals and the children, adolescents, and parents involved. As mental health literacy is interactional and relational, the voices of the suicidal adolescents need to be heard. Future investigations into adolescents' and their families' mental health literacy practices and their experiences of care by child and youth care professionals are needed. Such inquiry would afford the opportunity to examine how robust the theory **Balancing Proximity and Perimeter** process is with respect to encounters between child and youth care professionals and suicidal adolescents.

As an influencing condition on the **Balancing Proximity and Perimeter** process, the intersection of pre- and in-service education and mental health literacy is an additional area for future inquiry. Specifically, we need to investigate how mental health

literacy, as a contextualized, situated social practice, might be enhanced in pre- and in-service suicide education. Research of this nature would provide an opportunity to design and evaluate a curriculum framework for enhancing mental health literacy within pre- and in-service programs.

Following this, further research on how mental health literacy practices are realized by participants (e.g., family members, adolescents, professionals, service providers) in the context of practice situations involving suicidal adolescents may illuminate more fully the influences of power relations embedded within the sociocultural context of mental health literacy. This would assist in further determining political elements of mental health literacy that may be helpful in supporting professionals, adolescents and family members in providing care. Such inquiry may also support the development of critical perspectives on mental health literacy.

Chapter Summary

Charmaz (2006) suggests theories offer “insights and make sense of murky musings and knotty problems” and “[p]henomena and relationships between them you only sensed beforehand become visible” (p. 128). My theory of the **Balancing Proximity and Perimeter** process deepens our understanding of how mental health literacy practices are realized during encounters with suicidal adolescents. In my experience as a child and youth care professional and educator, I have encountered students, children, adolescents, and, at times their parents, who are struggling with their own suicidality or the suicidality of someone they love. I have found such encounters challenging and complex with little room for *right* answers. Despite reading extensively and adhering to practice guidelines and agency protocols in my child and youth care practice, murkiness

remained. Such murkiness in child and youth care practice with suicidal individuals was the impetus for my study.

The **Balancing Proximity and Perimeter** process provides new insights into practice with suicidal adolescents, and in turn, can inform pre- and in-service suicide education. The **Balancing** theory illuminates the tension and the forces implicated in the proximity-perimeter continuum, and furthers our understanding of how mental health literacy practices are taken up by professionals during encounters with suicidal adolescents. Thus, the **Balancing** theory provides a way of seeing practice and suicide education from “a different vantage point” (Charmaz, 2006, p. 128). With this different view, fresh approaches to practice, to suicide education, and to conceptualizing mental health literacy may be realized.

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University
of Victoria

Appendix A:

Letter of Permission for Third Party Recruitment:

Schools of Child and Youth Care/Child and Youth Care Association

Patti Ranahan
Faculty of Education
University of Victoria
PO Box 3010 STN CSC
Victoria BC V8W 3N4

Date (_____)

Dear (association/school name):

I (Patti Ranahan) am conducting a research project entitled “Child and Youth Care Professionals’ Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study.” The purpose of this research is to investigate Child and Youth Care professionals’ mental health literacy practices in situations involving adolescent suicide.

Over the last decade the concept of *mental health literacy* has emerged, initially defined by Jorm et al. (1997) as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (p. 182). Beyond knowledge and beliefs about mental disorders, Jorm and colleagues identified “knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking” as part of mental health literacy (p. 182). The proposed study builds on the present notions of health literacy as situated, relational, and contextual practice in exploring Child and Youth Care professionals’ mental health literacy practices in their interactions with suicidal adolescents.

I am interested in interviewing Child and Youth Care professionals who have encountered situations involving adolescent suicide and request your assistance with participant recruitment. Involvement in the research is voluntary and everything that is shared is confidential.

Your involvement in this participant recruitment for this research would involve: 1) distributing a recruitment poster through email to notify Child and Youth Care alumni members and/or members of the Child and Youth Care Association of BC about this research study. The recruitment poster and email notice will be provided by the researcher, Patti Ranahan, who will be the contact person for the research study.

Please sign below to indicate your support of this research study and your agreement to provide assistance with participant recruitment as indicated above and return in the self-addressed stamped envelope to the researcher.

NAME (print)

SIGNATURE

DATE



Appendix B:

Letter of Permission for Third Party Recruitment: Youth-Serving Agencies

Patti Ranahan
 Faculty of Education
 University of Victoria
 PO Box 3010 STN CSC
 Victoria BC V8W 3N4

Date (_____)

Dear (*agency name*):

I (Patti Ranahan) am conducting a research project entitled “Child and Youth Care Professionals’ Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study.” The purpose of this research is to investigate Child and Youth Care professionals’ mental health literacy practices in situations involving adolescent suicide.

Over the last decade the concept of *mental health literacy* has emerged, initially defined by Jorm et al. (1997) as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (p. 182). Beyond knowledge and beliefs about mental disorders, Jorm and colleagues identified “knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking” as part of mental health literacy (p. 182). The proposed study builds on the notions of health literacy as situated, relational, and contextual practice in exploring Child and Youth Care professionals’ mental health literacy practices in their interactions with suicidal adolescents.

I am interested in interviewing Child and Youth Care professionals who have encountered situations involving adolescent suicide and request your assistance with participant recruitment. Involvement in the research is voluntary and everything that is shared is confidential. A summary report of the research findings will be provided to your agency at the conclusion of the study.

Your involvement in this participant recruitment for this research would involve: 1) putting up a recruitment poster in your agency office(s); 2) through email, notifying Child and Youth Care professionals who are employed by your agency about this research study; and 3) if needed, provide agency guidelines or policy information relevant to the research study. The recruitment poster and email notice will be provided by the researcher, Patti Ranahan, who will be the contact person for the research study.

Please sign below to indicate your support of this research study and your agreement to provide assistance with participant recruitment as indicated above and return in the self-addressed stamped envelope to the researcher.

 NAME (print)

 SIGNATURE

 DATE



Appendix C:

Letter of Permission for Third Party Recruitment: Online Community

Patti Ranahan
 Faculty of Education
 University of Victoria
 PO Box 3010 STN CSC
 Victoria BC V8W 3N4

Date (_____)

Dear Editor, International Child & Youth Care Network:

I (Patti Ranahan) am conducting a research project entitled “Child and Youth Care Professionals’ Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study.” The purpose of this research is to investigate Child and Youth Care professionals’ mental health literacy practices in situations involving adolescent suicide.

Over the last decade the concept of *mental health literacy* has emerged, initially defined by Jorm et al. (1997) as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (p. 182). Beyond knowledge and beliefs about mental disorders, Jorm and colleagues identified “knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking” as part of mental health literacy (p. 182). The proposed study builds on the present notions of health literacy as situated, relational, and contextual practice in exploring Child and Youth Care professionals’ mental health literacy practices in their interactions with suicidal adolescents.

I am interested in interviewing Child and Youth Care professionals who have encountered situations involving adolescent suicide and request your assistance with participant recruitment. Involvement in the research is voluntary and everything that is shared is confidential.

Your involvement in this participant recruitment for this research would involve: 1) distributing a recruitment poster through email to notify members of the International Child & Youth Care Moderated Email Discussion List about this research study. The recruitment poster and email notice will be provided by the researcher, Patti Ranahan, who will be the contact person for the research study.

Please respond via confidential email to the researcher, Patti Ranahan, at pranahan@uvic.ca to indicate your support of this research study and your agreement to provide assistance with participant recruitment as indicated above. Thank you!

Appendix D: Recruitment Poster



Attention all Child & Youth Care Professionals!

You are invited to participate in this very exciting UVIC research study...

Research Aim

To listen and learn from you while you share your experiences with suicidal adolescents in your Child & Youth Care practice. The goal is to recruit participants who have completed a diploma or undergraduate Child & Youth Care program, on a first come - first serve basis. The researcher, Patti Ranahan, will contact all volunteers.

Participant Criteria:

- You are a Child & Youth Care professional
- You have completed a diploma/Bachelor's degree program in Child & Youth Care
- You have encountered a suicidal adolescent(s) in your practice

Your role in this study would require you to:

- Sign a consent form to participate in this study
- Participate in a 1:1, confidential 1-2 hour recorded interview with Patti Ranahan - researcher and PhD student at the University of Victoria
- Be available for a one hour follow-up interview if needed

All interviews and interview locations will be prearranged based on your availability and comfort with the location.

Participant Next Steps...

Please send a confidential e-mail to Patti Ranahan if you are interested in participating in this study.

I look forward to hearing from you soon ☺

pranahan@uvic.ca



Appendix E:

Child and Youth Care Professionals Letter of Invitation to Participate

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are being invited to participate in a study entitled, Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study that is being conducted as a personal interest study and to meet the requirements of my doctoral degree in Educational Studies.

I am a graduate student with the University of Victoria's Faculty of Education, Department of Curriculum and Instruction. I can be reached by confidential e-mail at:

Patti Ranahan
Email: pranahan@uvic.ca

The purpose of this research project is to understand Child and Youth Care professionals' mental health literacy practices when encountering a young person at risk of dying by suicide. This information will assist in:

- Understanding the process of how Child and Youth Care professionals provide direct services to suicidal adolescents,
- Developing further understanding of mental health literacy through qualitative inquiry,
- The identification of barriers and opportunities for furthering Child and Youth Care professionals' responses to suicidal adolescents and access to information that supports providing care,
- Enhancing mental health curriculum in Child and Youth Care pre-service programs.

This research is particularly important to the enhancement of Child and Youth Care professionals' responses to young people at risk for suicide that will facilitate more awareness of their decisions, which can result in positive outcomes in the provision of care. Your perceptions will provide the theoretical foundation for future mental health curriculum development and knowledge translation.

If you volunteer to participate in this research study, you will be asked to sign a consent form, which indicates your agreement to participate in an audio-recorded interview with Patti Ranahan for 1-2 hours. You are also asked to participate in a follow-up audio-recorded one-hour interview to clarify your interview data.

Your participation in this research study must be completely voluntary. If you decide to participate, you may withdraw at any time without consequence or explanation. If you withdraw from the study your data will not be used in the analysis. It is possible; depending on the number of volunteers responding to the recruitment request, that not all interested individuals will be able to participate in the study as participants are accepted, on a first come, first serve basis. All interested participants will be contacted.

Your personal confidentiality and the confidentiality of your data are very important components of maintaining ethical standards in this research. All of the data will be coded and personal identifiers including participant names will be removed from the analysis and documentation of this data. Data from this study will be disposed of by the deletion of computer files, shredding of paper documents and the destruction of audiotapes.

It is anticipated that the results of this study will be shared with the University of Victoria dissertation committee, Grounded Theory Club members who are comprised of academic scholars in Grounded Theory, youth-service providers and educators within Schools of Child and Youth Care in BC. At no time will personal identifying information be shared with others. If you desire a copy of the final documentation of this study, a copy will be available to you upon request.

There are no known or anticipated risks to you by participating in this study, other than the inconvenience of attending the 1-2 hour interview and one-hour follow-up interview session. In the unlikely event that you experience stress in response to the interview, you will be offered assistance in accessing counseling supports.

If you have any questions or concerns about the ethical approval of this study, you may contact the Supervisor of the Dissertation Committee, Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca, or the University of Victoria Human Research Ethics Board, 250 472-4545 or e-mail ethics@uvic.ca.

Should you be interested in participating in this study, please send a confidential email to the researcher, Patti Ranahan, (pranahan@uvic.ca) with a contact phone number where you can be reached.

Thank you very much for considering your participation in this study.

Appendix F: Child and Youth Care Professional Recruitment Email Script

Dear _____

My name is Patti Ranahan. I am a doctoral student in Education, Curriculum and Instruction, at the University of Victoria and teach in Child and Youth Care programs at Vancouver Island University. As part of completing my doctoral dissertation I am conducting a study entitled “**Child and Youth Care Professionals’ Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study.**”

I am interested in understanding the practices of Child and Youth Care professionals who have encountered suicidal adolescents in providing direct service to young people. As suicide is a leading cause of death amongst adolescents, understanding professionals’ responses to young people at risk of suicide may lead to positive outcomes and enhance current mental health education.

Please find attached to this email a (Letter of Permission/Recruitment Poster/Letter of Invitation) for more information.

Sincerely,

Patti Ranahan
Faculty of Education
University of Victoria
PO Box 3010 STN CSC
Victoria BC V8W 3N4
pranahan@uvic.ca

Appendix G:

Child and Youth Care Professional/Supervisor Telephone Script

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You have indicated an interest in participating in a study entitled "Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents. The purpose of this research project is to understand the practices of participants who have encountered young people at risk of dying by suicide.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used in the research and be subsequently destroyed by the researcher.

The potential benefits of your participation in this research include an opportunity to reflect on your practice, contribute to the current state of knowledge pertaining to professionals' practice with suicidal adolescents, and further awareness of the role of Child and Youth Care professionals in the prevention and early intervention of mental health concerns.

There are no known potential risks to you by participating in this research. In the unlikely event that you experience stress in response to the interview, you will be offered assistance in accessing counselling supports.

If you agree to voluntarily participate in this research, your participation will include ongoing informed consent, and participation in an individual audio recorded interview lasting 1-2 hours in a location of your convenience. An additional follow up one-hour interview may also be required. If you are interested in participating in the research, we can set up an appointment to meet at your convenience to discuss the research process and answer any further questions you may have, and obtain consent.

Appendix H: Child and Youth Care Professional Participant Consent Form



Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are invited to participate in a study entitled “Child and Youth Care Professionals’ Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study” that is being conducted by Patti Ranahan.

Patti Ranahan is a graduate student with the Faculty of Education in the Department of Curriculum and Instruction at the University of Victoria and you may contact her if you have further questions by e-mail at pranahan@uvic.ca.

As a graduate student, I am required to conduct research as part of the requirements for a doctoral degree in Educational Studies. It is being conducted under the supervision of Dr. Deborah Begoray. You may contact my supervisor at 250 721-7847 or email dbegoray@uvic.ca.

Purpose and Objectives

The purpose of this research project is to understand the practices of participants who have encountered young people at risk of dying by suicide in their professional role as a Child and Youth Care worker. The study will be guided by the following research question: What characterizes Child and Youth Care professionals’ mental health literacy practices in their interactions with suicidal adolescents? The goal of this inquiry is to generate a useful and understandable theory of Child and Youth Care professionals’ mental health literacy practices in their interactions with suicidal adolescents. Developing a theory, grounded in the direct experiences of participants such as you, can be viewed as the first step to informed Child and Youth Care practice and enhanced mental health educational approaches for Child and Youth Care professionals. Informed practice can also lead to positive outcomes for young people at risk of dying by suicide.

Importance of this Research

Research of this type is important because approximately one million people in the world die by suicide every year, and amongst a third of developing and developed countries young people as a group are at the highest risk of suicide. Child and Youth Care professionals often work with young people who are vulnerable to suicide and have a role in prevention and early intervention of mental health concerns. This research may also inform Child and Youth Care mental health curriculum.

Participants Selection

You are being asked to participate in this study because you are a key informant for the study. You are a **Child and Youth Care professional** who has encountered an adolescent at risk of suicide in your practice, are currently providing direct service to adolescents in your professional role, and have completed a diploma or Bachelor’s degree in Child and Youth Care.

What is involved

If you agree to voluntarily participate in this research, your participation will include one 1-2 hour interview, and one follow up 1 hour interview. The interviews will be audio taped and the researcher will make a transcription. Participants' interview data will be summarized and any identifying information will be removed. Then the summary will be shared with a group of educators in Child and Youth Care who have an interest in discussing Child and Youth Care professionals practice with suicidal adolescents.

Inconvenience

Participation in this study may cause some inconvenience to you, including the time it may take for you to participate in the interviews and arranging childcare if you are parenting.

Risks

There are no known or anticipated risks to you by participating in this research. In the unlikely event that you experience emotional discomfort or stress in response to the interview, you will be offered assistance in accessing counseling supports. You may also choose to stop the interview at any time to take a break or reschedule for an alternative time.

Benefits

The potential benefits of your participation in this research include an opportunity to reflect upon and articulate your experiences of encountering suicidal adolescents in their practice. It may also help to expand our understanding of the relationship between education and practice and contribute to the development of mental health curriculum.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be used only if you provide explicit permission. If you do not give your permission for your data to be used, it will be destroyed.

On-going Consent

To make sure that you continue to consent to participate in this research, I will review this participant consent form at the beginning of each interview.

Anonymity

In terms of protecting your anonymity, your name and any other identifying information will be removed from any written papers. Your name will never be used in any presentations, discussions, or printed material from the study.

Confidentiality and Disposal of Data

Your confidentiality and the confidentiality of the data will be protected. All of the information will be kept in a locked filing cabinet for 5 years after the study is finished. After that time all information will be destroyed. Electronic files will be deleted and the computer hard drive will be destroyed when the computer is no longer in use. Paper files will be shredded.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: summary report to educators in schools of Child and Youth Care, summary report to youth-serving agencies who assisted in participant recruitment upon completion of the study, to write my doctoral dissertation, publish articles in professional journals, present the findings at professional meetings, and as examples in my teaching activities.

Contacts

Individuals that may be contacted regarding this study include Patti Ranahan at pranahan@uvic.ca, or Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.



Appendix I: Supervisor (Respondent to Initial Recruitment)

Letter of Invitation to Participate

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are being invited to participate in a study entitled, Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study that is being conducted as a personal interest study and to meet the requirements of my doctoral degree in Educational Studies. As a **Supervisor** within a youth-serving agency, YOU can provide key information for this study.

I am a doctoral student with the University of Victoria's Faculty of Education, Department of Curriculum and Instruction. I can be reached by confidential e-mail at:

Patti Ranahan
Email: pranahan@uvic.ca

The purpose of this research project is to understand Child and Youth Care professionals' mental health literacy practices when encountering a young person at risk of dying by suicide. This information will assist in:

- Understanding the process of how Child and Youth Care professionals provide direct services to suicidal adolescents,
- Advancing the field of mental health literacy through qualitative inquiry,
- The identification of barriers and opportunities for furthering Child and Youth Care professionals' responses to suicidal adolescents and access to information that supports providing care.

This research is particularly important to the enhancement of Child and Youth Care professionals' responses to young people at risk for suicide that will facilitate more awareness of their care decisions, which can result in positive outcomes in the provision of care. Your perceptions will provide the theoretical foundation for future mental health curriculum development and knowledge translation.

If you volunteer to participate in this research study, you will be asked to sign a consent form, which indicates your agreement to participate in an audio-recorded interview with Patti Ranahan for 1-2 hours. You are also asked to participate in a follow-up audio-recorded one-hour interview to clarify your interview data.

Your participation in this research study must be completely voluntary. If you decide to participate, you may withdraw at any time without consequence or explanation. If you withdraw from the study your data will not be used in the analysis. It is possible; depending on the number of volunteers responding to the recruitment request, that not all interested individuals will be able to participate in the study as participants are accepted, on a first come, first serve basis. All interested participants will be contacted.

Your personal confidentiality and the confidentiality of your data are very important components of maintaining ethical standards in this research. The Child and Youth Care professional who identified you as a potential participant will not be informed of your choice to participate in the study. All of the data will be coded and personal identifiers including participant names will be removed from the analysis and documentation of this data. Data from this study will be disposed of by the deletion of computer files, shredding of paper documents and the destruction of audiotapes.

It is anticipated that the results of this study will be shared with the University of Victoria dissertation committee, Grounded Theory Club members who are comprised of academic scholars in Grounded Theory, youth-service providers and educators within Schools of Child and Youth Care in BC. At no time will personal identifying information be shared with others. If you desire a copy of the final documentation of this study, a copy will be available to you upon request.

There are no known or anticipated risks to you by participating in this study, other than the inconvenience of attending the 1-2 hour interview and potential one-hour follow-up interview session. In the unlikely event that you experience stress in response to the interview, you will be offered assistance in accessing counseling supports.

If you have any questions or concerns about the ethical approval of this study, you may contact the Supervisor of the Dissertation Committee, Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca, or the University of Victoria Human Research Ethics Board, 250 472-4545 or e-mail ethics@uvic.ca.

Should you be interested in participating in this study, please send a confidential email to the researcher, Patti Ranahan, (pranahan@uvic.ca) with a contact phone number where you can be reached.

Thank you very much for considering your participation in this study.



Appendix J: Supervisor Participant Consent Form

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are invited to participate in a study entitled "Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study" that is being conducted by Patti Ranahan.

Patti Ranahan is a graduate student with the Faculty of Education in the Department of Curriculum and Instruction at the University of Victoria and you may contact her if you have further questions by e-mail at pranahan@uvic.ca.

As a graduate student, I am required to conduct research as part of the requirements for a doctoral degree in Educational Studies. It is being conducted under the supervision of Dr. Deborah Begoray. You may contact my supervisor at 250 721-7847 or email dbegoray@uvic.ca.

Purpose and Objectives

The purpose of this research project is to understand the practices of Child and Youth Care professionals who have encountered young people at risk of dying by suicide. The study will be guided by the following research question: What characterizes Child and Youth Care professionals' mental health literacy practices in their interactions with suicidal adolescents? The goal of this inquiry is to generate a useful and understandable theory of Child and Youth Care professionals' mental health literacy practices in their interactions with suicidal adolescents. Developing a theory, grounded in the direct experiences of participants, can be viewed as the first step to informed Child and Youth Care practice and enhanced mental health educational approaches for Child and Youth Care professionals. Informed practice can also lead to positive outcomes for young people at risk of dying by suicide.

Importance of this Research

Research of this type is important because approximately one million people in the world die by suicide every year, and amongst a third of developing and developed countries young people as a group are at the highest risk of suicide. Child and Youth Care professionals often work with young people who are vulnerable to suicide and have a role in prevention and early intervention of mental health concerns. This research may also inform Child and Youth Care mental health curriculum.

Participants Selection

You are being asked to participate in this study because you are a *supervisor* of professionals who have encountered an adolescent at risk for suicide. You oversee professionals' practice in a youth-serving agency and thus potentially influence the responses and decisions of your supervisees.

What is Involved

If you agree to voluntarily participate in this research, your participation will include one 1-2 hour interview, and one follow up 1 hour interview. The interviews will be audio taped and the researcher will make a transcription. Participants' interview data will be summarized and any

identifying information will be removed. Then the summary will be shared with a group of educators in Child and Youth Care who have an interest in discussing Child and Youth Care professionals practice with suicidal adolescents.

Inconvenience

Participation in this study may cause some inconvenience to you, including the time it may take for you to participate in the interviews and arranging childcare if you are parenting.

Risks

There are no known or anticipated risks to you by participating in this research. In the unlikely event that you experience discomfort in response to the interview, you will be offered assistance in accessing counseling supports.

Benefits

The potential benefits of your participation in this research include an opportunity to reflect upon and articulate your experiences of encountering suicidal adolescents in their practice. It may also help to expand our understanding of the relationship between education and practice and contribute to the development of mental health curriculum.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be used only if you provide explicit permission. If you do not give your permission for your data to be used, it will be destroyed.

On-going Consent

To make sure that you continue to consent to participate in this research, I will review this participant consent form at the beginning of each interview.

Anonymity

In terms of protecting your anonymity, your name and any other identifying information will be removed from any written papers. Your name will never be used in any presentations, discussions, or printed material from the study.

Confidentiality and Disposal of Data

Your confidentiality and the confidentiality of the data will be protected. All of the information will be kept in a locked filing cabinet for 5 years after the study is finished. After that time all information will be destroyed. Electronic files will be deleted and the computer hard drive will be destroyed when the computer is no longer in use. Paper files will be shredded.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: summary report to educators in schools of Child and Youth Care, summary report to youth-serving agencies who assisted in participant recruitment upon completion of the study, to write my doctoral dissertation, publish articles in professional journals, present the findings at professional meetings, and as examples in my teaching activities.

Contacts

Individuals that may be contacted regarding this study include Patti Ranahan at pranahan@uvic.ca, or Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.



Appendix K: Supervisor (Identified by Professional) Letter of Invitation to Participate

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are being invited to participate in a study entitled, Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study that is being conducted as a personal interest study and to meet the requirements of my doctoral degree in Educational Studies. **A Child and Youth Care professional participating in this study has identified you as a Supervisor** within a youth-serving agency who can provide key information for this study.

I am a doctoral student with the University of Victoria's Faculty of Education, Department of Curriculum and Instruction. I can be reached by confidential e-mail at:

Patti Ranahan
Email: pranahan@uvic.ca

The purpose of this research project is to understand Child and Youth Care professionals' mental health literacy practices when encountering a young person at risk of dying by suicide. This information will assist in:

- Understanding the process of how Child and Youth Care professionals provide direct services to suicidal adolescents,
- Advancing the field of mental health literacy through qualitative inquiry,
- The identification of barriers and opportunities for furthering Child and Youth Care professionals' responses to suicidal adolescents and access to information that supports providing care.

This research is particularly important to the enhancement of Child and Youth Care professionals' responses to young people at risk for suicide that will facilitate more awareness of their care decisions, which can result in positive outcomes in the provision of care. Your perceptions will provide the theoretical foundation for future mental health curriculum development and knowledge translation.

If you volunteer to participate in this research study, you will be asked to sign a consent form, which indicates your agreement to participate in an audio-recorded interview with Patti Ranahan for 1-2 hours. You are also asked to participate in a follow-up audio-recorded one-hour interview to clarify your interview data.

Your participation in this research study must be completely voluntary. If you decide to participate, you may withdraw at any time without consequence or explanation. If you withdraw from the study your data will not be used in the analysis. It is possible; depending on the number of volunteers responding to the recruitment request, that not all interested individuals will be able to participate in the study as participants are accepted, on a first come, first serve basis. All interested participants will be contacted.

Your personal confidentiality and the confidentiality of your data are very important components of maintaining ethical standards in this research. The Child and Youth Care professional who identified you as a potential participant will not be informed of your choice to participate in the study. All of the data will be coded and personal identifiers including participant names will be removed from the analysis and documentation of this data. Data from this study will be disposed of by the deletion of computer files, shredding of paper documents and the destruction of audiotapes.

It is anticipated that the results of this study will be shared with the University of Victoria dissertation committee, Grounded Theory Club members who are comprised of academic scholars in Grounded Theory, youth-service providers and educators within Schools of Child and Youth Care in BC. At no time will personal identifying information be shared with others. If you desire a copy of the final documentation of this study, a copy will be available to you upon request.

There are no known or anticipated risks to you by participating in this study, other than the inconvenience of attending the 1-2 hour interview and potential one-hour follow-up interview session. In the unlikely event that you experience stress in response to the interview, you will be offered assistance in accessing counseling supports.

If you have any questions or concerns about the ethical approval of this study, you may contact the Supervisor of the Dissertation Committee, Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca, or the University of Victoria Human Research Ethics Board, 250 472-4545 or e-mail ethics@uvic.ca.

Should you be interested in participating in this study, please send a confidential email to the researcher, Patti Ranahan, (pranahan@uvic.ca) with a contact phone number where you can be reached.

Thank you very much for considering your participation in this study.



Appendix L: Educators Letter of Invitation to Participate

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are being invited to participate in a study entitled, Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study that is being conducted as a personal interest study and to meet the requirements of my doctoral degree in Educational Studies. As an academic scholar and educator in Child and Youth Care, you are a key informant for the research project.

I am a doctoral student with the University of Victoria's Faculty of Education, Department of Curriculum and Instruction. I can be reached by confidential e-mail at:

Patti Ranahan
Email: pranahan@uvic.ca

The purpose of this research project is to understand Child and Youth Care professionals' mental health literacy practices when encountering a young person at risk of dying by suicide. This information will assist in:

- Understanding the process of how Child and Youth Care professionals provide direct services to suicidal adolescents,
- Advancing the field of mental health literacy through qualitative inquiry,
- The identification of barriers and opportunities for furthering Child and Youth Care professionals' responses to suicidal adolescents and access to information that supports providing care.

This research is particularly important to the enhancement of Child and Youth Care professionals' responses to young people at risk for suicide that will facilitate more awareness of their care decisions, which can result in positive outcomes in the provision of care. Your perceptions will provide the theoretical foundation for future mental health curriculum development and knowledge translation.

If you volunteer to participate in this research study, you will be asked to sign a consent form, which indicates your agreement to participate in an audio-recorded, individual interview concerning Child and Youth Care professionals' mental health literacy in situations involving adolescent suicide. Educators may choose to participate in an individual interview, or focus group interview. Focus group interviews will be arranged if there are multiple interested participants at your location. You will also be asked to review the interview transcript and participate in a follow-up email with the researcher to clarify responses if needed. It is anticipated that participation in the study will require 1-2 hours of your time.

Your participation in this research study must be completely voluntary. If you decide to participate, you may withdraw at any time without consequence or explanation. If you withdraw from the study and you have participated in an individual interview, your data will not be used in the analysis. If participating in a focus group interview, your data may be linked to others'

contributions and it will be used in the analysis in summarized form with no identifying information.

Due to the nature of the focus group interviews, your information and responses will not be anonymous and other research participants involved in the focus group interview will know your identity. Personal confidentiality and the confidentiality of your data are very important components of maintaining ethical standards in this research. As such, you will be asked to maintain the confidentiality of others' identities and their comments. All of the data will be coded and personal identifiers including participant names will be removed from the analysis and documentation of this data. Data from this study will be disposed of by the deletion of computer files, shredding of paper documents and the destruction of audiotapes.

It is anticipated that the results of this study will be shared with the University of Victoria dissertation committee, Grounded Theory Club members who are comprised of academic scholars in Grounded Theory, youth-service providers and educators within Schools of Child and Youth Care in BC. At no time will personal identifying information be shared with others. If you desire a copy of the final documentation of this study, a copy will be available to you upon request.

There are no known or anticipated risks to you by participating in this study, other than the inconvenience of the estimated 1-2 hours required to participate in the individual or focus group interview, and respond to a follow up email.

If you have any questions or concerns about the ethical approval of this study, you may contact the Supervisor of the Dissertation Committee, Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca, or the University of Victoria Human Research Ethics Board, 250 472-4545 or e-mail ethics@uvic.ca.

Should you be interested in participating in this study, please send a confidential email to the researcher, Patti Ranahan, (pranahan@uvic.ca) with a contact phone number where you can be reached.

Thank you very much for considering your participation in this study.

Appendix M: Educators Recruitment Telephone Script

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You have indicated an interest in participating in a study entitled “Child and Youth Care Professionals’ Mental Health Literacy Practices in their Encounters with Suicidal Adolescents.

The purpose of this research project is to understand the mental health literacy practices of participants who have encountered young people at risk of dying by suicide.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used in the research and be subsequently destroyed by the researcher.

The potential benefits of your participation in this research include an opportunity to reflect upon and articulate your experiences of preparing Child and Youth Care professionals for practice through pre-service education programs. It may also help to expand our understanding of the relationship between pre-service education and practice and contribute to further mental health curriculum development. Your participation will contribute to new knowledge about how mental health literacy practices are realized in Child and Youth Care professionals’ interactions with suicidal adolescents.

Your confidentiality and the confidentiality of the data will be protected outside of the interview.

There are no known potential risks to you by participating in this research. If you agree to voluntarily participate in this research, your participation will include ongoing informed consent, and participation in an individual audio-recorded interview. It is anticipated that your participation will involve 1-2 hours of your time.

If you are interested in participating in the research, we can set up an appointment to meet at your convenience to discuss the research process and answer any further questions you may have, and review the consent process.



Appendix N: Educators Participant Consent Form

Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study

You are invited to participate in a study entitled "Child and Youth Care Professionals' Mental Health Literacy Practices in their Encounters with Suicidal Adolescents: A Grounded Theory Study" that is being conducted by Patti Ranahan.

Patti Ranahan is a graduate student with the Faculty of Education in the Department of Curriculum and Instruction at the University of Victoria and you may contact her if you have further questions by e-mail at pranahan@uvic.ca.

As a graduate student, I am required to conduct research as part of the requirements for a doctoral degree in Educational Studies. It is being conducted under the supervision of Dr. Deborah Begoray. You may contact my supervisor at 250 721-7847 or email dbegoray@uvic.ca.

Purpose and Objectives

The purpose of this research project is to understand the mental health literacy practices of Child and Youth Care professionals who have encountered young people at risk of dying by suicide. This grounded theory study will be guided by the following research question: What characterizes Child and Youth Care professionals' mental health literacy practices in their interactions with suicidal adolescents? The goal of this inquiry is to generate a useful and understandable theory of Child and Youth Care professionals' mental health literacy practices in their interactions with suicidal adolescents. Developing a substantive theory, grounded in the direct experiences of participants, can be viewed as an initial step to informed Child and Youth Care practice and enhanced mental health educational approaches for Child and Youth Care professionals. Informed practice can also lead to positive outcomes for young people at risk of dying by suicide.

Importance of this Research

Research of this type is important because approximately one million people in the world die by suicide every year, and amongst a third of developing and developed countries young people as a group are at the highest risk of suicide. Child and Youth Care professionals often work with young people who are vulnerable to suicide and have a role in prevention and early intervention of mental health concerns. This research may also inform mental health curriculum in pre-service Child and Youth Care programs.

Participants Selection

You are being asked to participate in this study because you are a key informant for the study based on your role as an academic scholar and educator of future Child and Youth Care professionals.

What is Involved

If you agree to voluntarily take part in this research, your participation will involve a semi-structured interview to explore pedagogical approaches for addressing mental health and suicide and share your ideas on how mental health literacy might be developed in pre-service Child and Youth Care curriculum. The interview will be scheduled at your convenience and at a location of your choosing. The interview will be audio-recorded and transcribed by the researcher. You will

be provided with a copy of the transcript for your review and the researcher will contact you by email 2 weeks after the interview for any further comments/information you may have. It is estimated that your participation in the study will require 1-2 hours of your time.

Inconvenience

Participation in this study may cause some inconvenience to you, such as the time it may take for you to participate in the interview.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

Your participation will contribute to new knowledge about what characterizes Child and Youth Care professionals' mental health literacy practices in their interactions with suicidal adolescents. The potential benefits of your participation in this research also include an opportunity to reflect upon and articulate your experiences of preparing Child and Youth Care professionals for practice through pre-service education programs. It may also help to expand our understanding of the relationship between education and practice and contribute to further mental health curriculum development.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be used only if you provide explicit permission. If you do not give your permission for your data to be used, it will be destroyed.

On-going Consent

If you feel that the risks or inconveniences associated with your participation outweigh the benefits you can terminate your participation at any time without consequence or explanation. Your participation is completely voluntary and if you decide to participate your explicit consent is required. To ensure you continue to consent to participate in this research I will review this participant consent for at the beginning of the interview and follow up contact.

Anonymity

In terms of protecting your anonymity, your name and any other identifying information will be removed from any written papers. Your name will never be used in any presentations, discussions, or printed material from the study.

Confidentiality and Disposal of Data

Your confidentiality and the confidentiality of the data will be protected. All of the information will be kept in a locked filing cabinet for 5 years after the study is finished. After that time all information will be destroyed. Electronic files will be deleted and the computer hard drive will be destroyed when the computer is no longer in use. Paper files will be shredded.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: summary report to educators in schools of Child and Youth Care, summary report to youth-serving agencies who assisted in participant recruitment upon completion of the study, to write my doctoral dissertation, publish articles in professional journals, present the findings at professional meetings, and as examples in my teaching activities.

Contacts

Individuals that may be contacted regarding this study include Patti Ranahan at pranahan@uvic.ca, or Dr. Deborah Begoray, 250 721-7847 or e-mail dbegoray@uvic.ca. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix O: Descriptive Features of Participants and Documents

Identifier	Descriptive Features
INT-01	<ul style="list-style-type: none"> • Female, Mid-thirties • Diploma in Child and Youth Care • 4th year student in Bachelor of Arts in Child and Youth Care program • 7.5 years practice experience, residential setting for street-involved/homeless youth
INT-02	<ul style="list-style-type: none"> • Female, Mid-thirties • Graduated in 1998 with Bachelor of Arts degree in Child and Youth Care • Twelve years practice experience in group homes, children with disabilities, social worker for [services for persons with developmental disabilities]
CYC-01	<ul style="list-style-type: none"> • Female, Mid-thirties • Graduated 2009 with Bachelor of Arts degree in Child and Youth Care • Fourteen years experience in field including mental health settings, addictions outreach, outdoor-based, practice with Aboriginal children/youth, one-to-one youth worker, after-school programs, family support work, facilitating suicide prevention programs
CYC-02	<ul style="list-style-type: none"> • Female, Early fifties • Graduated in 2007 with Bachelor of Arts degree in Child and Youth Care • Practice experience includes addictions, community mental health, teaching life skills, day care setting, after school programs.
CYC-03	<ul style="list-style-type: none"> • Female, Mid-fifties • Graduated in 2007 with Bachelor of Arts degree in Child and Youth Care • Twenty-three years of practice experience as childcare worker, teacher's aid, income assistance, running parenting programs, day care, foster parent, family support work, child protection.
CYC-04	<ul style="list-style-type: none"> • Female, Mid-thirties • Graduated in 2004 with Bachelor of Arts degree in Child and Youth Care • Practice experience as early childhood development, alternate school, pregnant women, family support worker, addictions/mental health with adults, residential group care, educational assistant in schools, school-based.
CYC-05	<ul style="list-style-type: none"> • Female, Mid-thirties • Graduated in 2008 with Diploma in Child and Youth Care • Graduated in 2010 with Bachelor of Arts degree in Child and Youth Care • Eight years practice experience in field including out-of-school care, residential care, youth outreach, life skills, support services to children in care, crisis response, family support work.

CYC-06	<ul style="list-style-type: none"> • Male, Early twenties • Graduated 2011 with Bachelor of Arts degree in Child and Youth Care • Four years practice experience including youth outreach worker, camps for kids with chronic illnesses/disabilities, one-to-one support work, international work with youth
CYC-07	<ul style="list-style-type: none"> • Female, Mid forties • Graduated in 1984 with Diploma in Child and Youth Care • Graduated in 2010 with Bachelor of Arts degree in Child and Youth Care • Twenty-five years practice experience including crisis line volunteer, special needs, residential group care, family support, parent education, adolescent in/out patient treatment
CYC-08	<ul style="list-style-type: none"> • Female, Mid forties • Graduated in 2010 with Bachelor of Arts degree in Child and Youth Care • Twenty-two years practice experience including adoptions, family support, mental health-addictions/advocacy work with people involved in court system
SUP-01	<ul style="list-style-type: none"> • Female, Early thirties • Graduated in 1998 with Bachelor of Arts degree in Child and Youth Care • Graduated in 2004 with Master's of Arts, Child and Youth Care • Held supervisory role for approximately six years • Fourteen years practice experience including children's counselor, school-based, residential care, community-based, program development, youth justice, foster care
SUP-02	<ul style="list-style-type: none"> • Female, Early fifties • Graduated in 1994 with diploma in Child and Youth Care • Graduated in 2008 with Master's of Arts, Leadership • Twelve years experience in supervisory role • Eighteen years practice experience including outreach, residential child care, parks and recreation, adolescent mental health, parent education
SUP-03	<ul style="list-style-type: none"> • Female, Early forties • Graduated in 2010 with Bachelor of Social Work degree • Four years experience in supervisory role • Fifteen years practice experience including foster care, support for battered women, life skills, case management, residential settings
SUP-04	<ul style="list-style-type: none"> • Female • Mid fifties • Bachelor of Arts degree • Master's of Arts degree in counselling • Sixteen years experience in supervisory role • Practice experience includes consultation roles, therapist, suicide prevention trainer

ED-01	<ul style="list-style-type: none"> • Female • Practice experience includes residential, mental health, school-based, marriage and family therapy, advocacy, community development, family outreach • Twelve years experience as an educator in child and youth care
ED-02	<ul style="list-style-type: none"> • Female • Practice experience includes residential care, youth justice settings, school-based, family support • Seventeen years as an educator in child and youth care
ED-03	<ul style="list-style-type: none"> • Female • Practice experience includes residential care, youth justice, addictions, sexual abuse, eating disorders • Seventeen years as an educator in Child and Youth Care
ED-04	<ul style="list-style-type: none"> • Female • Practice experience includes crisis work, mental health • Ten years as an educator in child and youth care
ED-05	<ul style="list-style-type: none"> • Female • Practice experience includes day program, outreach, transition house, program evaluation • Three years as an educator in child and youth care
DOC-01	<ul style="list-style-type: none"> • Release of information and confidentiality form from youth-serving community agency • Provided by participant
DOC-02	<ul style="list-style-type: none"> • Practice guidelines document (Ashworth, 2001) • Referenced by participant
DOC-03	<ul style="list-style-type: none"> • Youth-serving community agency protocol for responding to a suicide risk of a child or youth • Provided by participant
DOC-04	<ul style="list-style-type: none"> • Assessment tool for assessing level of suicide risk for child or youth • Provided by participant
DOC-05	<ul style="list-style-type: none"> • Course outline for child and youth care course entitled “Mental Health in Childhood and Adolescence” • Provided by participant

**Appendix P: Child and Youth Care Professionals
Draft Interview Guide and Follow Up Questions⁶**

Demographic Information

1. How long have you been practicing as a Child and Youth Care professional?
2. Where/when did you receive your diploma/degree in Child and Youth Care?
3. What area(s) of practice did you experience during your diploma/degree program field placement(s)?
4. What is your current professional role in providing service to adolescents? How long have you been in this role?
5. What other roles in the field of Child and Youth Care have you held?
6. Can you describe a typical day for you when you are working?

Initial Open-ended Questions

7. Tell me about what happened in your encounter with a suicidal adolescent.
8. When did you first notice the situation concerned suicide?
9. What was it like? What were your thoughts at the time? Who, if anyone, influenced your actions? Tell me about how he/she or they influenced you.
10. Could you describe the events that led up to the encounter?
11. What contributed to the situation?
12. How would you describe how you viewed encounters involving suicidal adolescents before/after it happened? How, if at all, has your view of practice with suicidal adolescents changed?
13. How would you describe yourself as a CYC professional then? Now?

Intermediate Questions

14. What, if anything, did you know about adolescent suicide?
15. Tell me about your thoughts and feelings when you learned the situation involved suicide.
16. What happened next?
17. Who, if anyone, was involved? When was that? How were they involved?
18. Tell me about how you learned to handle/manage situations involving suicide.

⁶ Interview guide and follow up questions adapted from Charmaz (2006, pp. 30-31).

19. How, if at all, have your thoughts and feelings about adolescent suicide changed since the encounter?
20. What changes have occurred in your practice since the encounter?
21. Tell me how you go about working with suicidal adolescents. What do you do?
22. Could you describe a typical day for you when you are working? [Probe for different times.]
23. Tell me how you would describe the professional you are now. What most contributed to this change or continuity?
24. As you look back on this encounter, are there any other events that stand out for you? Could you describe each one? How did this event affect what happened? How did you respond to the event/the resulting situation?
25. Could you describe the most important lessons you learned through experiencing an adolescent at risk of suicide?
26. Where do you see yourself professionally over the next two years? Could you describe any professional development needs you see yourself having?
27. What helps you manage situations involving adolescent suicide? What problems might you encounter? Tell me the sources of these problems.
28. Who has been most helpful to you during this time? How has he/she been helpful?
29. Has any organization been helpful? What did they help you with? How has it been helpful?

Ending Questions

30. What do you think are the most important ways to work with suicidal adolescents? How did you discover [or create] them? How has your experience before this encounter affected how you handle it now?
31. Tell me about your views and actions that may have changed since this encounter.
32. How have you grown as a professional/person? Tell me about your strengths that you discovered or developed through this encounter? What do you most value about your self in practice now? What do your colleagues/supervisors/clients value most in you?
33. After having this experience, what advice would you give to someone who encounters an adolescent at risk of suicide?

34. Is there anything that you might not have thought about before that occurred to you during this interview?
35. Is there anything else you think I should know to understand your experience better?
36. Is there anything you would like to ask me?
37. Do you have any suggestions for supervisors of Child and Youth Care professionals and/or educators in Child and Youth Care that may help inform this study?

Follow Up Questions

1. After reviewing your transcript is there anything else that you think I should know to understand your experience better?
2. Is there anything that you would like to clarify or add to the information you provided?
3. Since participating in the initial interview, have you noticed any changes in your Child and Youth Care practice?
4. Is there anything you would like to ask me?

Appendix Q: Supervisors Draft Interview Guide and Follow Up Questions⁷

Demographic Information

1. How long have you been supervising Child and Youth Care professionals?
2. What is your current professional supervisory role in the agency/organization?
How long have you been in this role?
3. Could you describe a typical day for you when you are working? [Probe for different times.]
4. What other professional roles have you had in your career?
5. What pre-service program have you completed, and when did you complete this program?

Initial Open-ended Questions

6. Tell me about a time when you were supervising a Child and Youth Care professional who had encountered a suicidal adolescent.
7. What was it like? What were your thoughts at the time? Who, if anyone, influenced your actions? Tell me about how he/she or they influenced you.
8. Could you describe the events that led up to the encounter?
9. What contributed to the situation?
10. How would you describe how you viewed encounters involving suicidal adolescents before/after it happened? How, if at all, has your view of supervising Child and Youth Care professionals' practice with suicidal adolescents changed?
11. How would you describe yourself as a supervisor then? Now?

Intermediate Questions

12. What, if anything, did you know about adolescent suicide at the time?
13. Tell me about your thoughts and feelings when you learned the situation involved suicide. What comes to mind?
14. What happened next?
15. Who, if anyone, was involved? When was that? How were they involved?
16. What would you point to as evidence that the situation is resolved?
17. Tell me about how you learned to handle/manage situations involving suicide.

⁷ Interview guide and follow up questions adapted from Charmaz (2006, pp. 30-31).

18. Do you have any uncertainties about tools, guidelines, policies that are used to manage these situations?
19. How, if at all, have your thoughts and feelings about adolescent suicide changed since the encounter?
20. What changes have occurred in your supervision of Child and Youth Care professionals since the encounter?
21. Tell me how you go about supervising Child and Youth Care professionals working with suicidal adolescents. What do you do? What do you see your role as being?
22. What are you looking for professionals to be doing, and how do you evaluate their practice with suicidal adolescents?
23. Tell me how you would describe the professional you are now. What most contributed to this change or continuity?
24. As you look back on this encounter, are there any other events that stand out for you? Could you describe each one? How did this event affect what happened? How did you respond to the event/the resulting situation?
25. Could you describe the most important lessons you learned through experiencing supervising a professional interacting with an adolescent at risk of suicide?
26. What helps you manage situations involving adolescent suicide? What problems might you encounter? Tell me the sources of these problems.
27. Who has been most helpful to you during this time? How has he/she been helpful?
28. Has any organization been helpful? What did they help you with? How has it been helpful?

Ending Questions

29. What do you think are the most important ways to work with Child and Youth Care professionals who encounter suicidal adolescents? How did you discover [or create] them? How has your experience before this encounter affected how you handle it now?
30. Tell me about your views and actions that may have changed since this encounter.
31. How have you grown as a supervisor/professional/person? Tell me about your strengths that you discovered or developed through this encounter? What do you

most value about your self in practice now? What do your colleagues/supervisors/clients value most in you?

32. After having this experience, what advice would you give to someone who is supervising a Child and Youth Care professional who encounters an adolescent at risk of suicide?
33. Where do you see yourself in two years [five years, ten years as appropriate]?
34. Is there anything that you might not have thought about before that occurred to you during this interview?
35. Is there anything else you think I should know to understand your experience better?
36. Is there anything you would like to ask me?

Follow Up Questions

1. After reviewing your transcript is there anything else that you think I should know to understand your experience better?
2. Is there anything that you would like to clarify or add to the information you provided?
3. Since participating in the initial interview, have you noticed any changes in your supervision of Child and Youth Care professionals?
4. Is there anything you would like to ask me?

Appendix R: Educators Interview Guide

1. Describe your professional practice and experience as an academic/scholar in Child and Youth Care. How long have you been an educator in CYC?
2. In what ways do you currently address the topics of mental health and suicide in your teaching practice with Child and Youth Care undergraduate students?
 - prompt: any practice experiences shared?
3. In what ways does your CYC program address topics of mental health and suicide in curriculum/teaching practice?
4. How do you envision the role of CYC professionals in the care of suicidal youth?
5. Based on your understanding of mental health literacy and Child and Youth Care, what do you see as the key characteristics of Child and Youth Care professionals' mental health literacy practices?
6. What are the processes/pedagogical approaches through which mental health literacy may develop for Child and Youth Care professionals in pre-service programs? In practice?
7. How might current conceptualizations of mental health literacy be expanded upon based on Child and Youth Care perspectives/orientation to practice?
8. How might Child and Youth Care professionals' mental health literacy practices be enhanced in preparation for interactions with suicidal adolescents?
9. Is there anything you would like to ask me?

Follow Up Questions

5. After reviewing your interview transcript, is there anything that you would like to clarify or add to the information you provided in your interview?
6. Since participating in the interview, have you noticed any changes/differences in your teaching practice?
7. Is there anything you would like to ask me?