



REPRESENTATIVE FOR  
CHILDREN AND YOUTH

***Trauma, Turmoil and Tragedy:***  
Understanding the Needs of Children  
and Youth at Risk of Suicide and Self-Harm

**An Aggregate Review**

November 2012



November 15, 2012

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

Dear Mr. Speaker,

I have the honour of submitting the report *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm, An Aggregate Review* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,



Mary Ellen Turpel-Lafond  
Representative for Children and Youth

pc: Mr. Craig James, QC  
Clerk of the Legislative Assembly

Ms. Joan McIntyre  
Chair, Select Standing Committee on Children and Youth





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# Executive Summary

This is an aggregate review and analysis of the 89 suicide and self-harm incidents reported to the Representative for Children and Youth between June 1, 2007 and May 31, 2010. Included are 15 youth who died as a result of suicide and 74 youth who engaged in self-injury. Each of these youth had received services from the Ministry of Children and Family Development (MCFD).

An aggregate review is a review of a group of cases that share some common features. The intention of an aggregate review is to identify and analyze trends that will inform improvements to the child-serving system as well as broader public policy. Such reviews are part of the Representative's mandate as laid out by the *Representative for Children and Youth (RCY) Act*.

This type of review is based on data from files, as well as other administrative data, that provides an overview of the larger group, rather than specific information about individual youth. Although what we can learn from this type of review is limited by the kind of information that is consistently available in these files, it enables us to develop an understanding of the circumstances of these youths' lives and how the system of supports and services responded to them.

The report identifies a number of common circumstances in the lives of many of these children and youth, including:

- Lack of stable living arrangements – most notably, children in care being subject to multiple moves.
- Domestic violence – a significant feature in the lives of more than half the youth.
- Mental health issues – identified in nearly 70 per cent of the youth and compounded by a lack of clarity of services to address these issues.
- Substance abuse – by family members as well as the youth themselves.
- Learning disabilities and lack of attachment to school.
- Significant romantic conflict in the 24-hour period leading to these incidents.

Two other disturbing findings of the report are a significant over-representation of Aboriginal children and youth, and what is best described as varying degrees of compliance with MCFD practice standards in these cases.

The Representative acknowledges the front-line workers throughout British Columbia who daily take on the challenging role of working with vulnerable youth to try to help them cope with their circumstances and move toward a brighter future. It is difficult work, and not all suicides or serious injuries are preventable.

Although this report does not deal with each youth's individual situation, it is important to remember that each of these deaths represents a valuable loss of potential to our society, as well as a devastating event for families, friends and loved ones. The impact is very significant in Aboriginal and First Nations communities, where suicide rates among youth are five to six times higher than those of non-Aboriginal youth.

Every child has a right to succeed – some require more help than others. This report raises important questions. Did we do enough to help these youth? Can we do more? It is only through reviewing the information, through asking these questions that we can hope to improve on our outcomes.

Most of the 89 youth in the review experienced very difficult family situations characterized by major changes and instability. Of their parents, 24 had themselves been in the care of the ministry as children or youth. The majority of the youth lived in families in which the parents did not remain together, and one-quarter of the youth had a friend or family member who attempted suicide or died as a result of suicide.

At the time these incidents were reported to the Representative, the youth were either in MCFD care, living with their parents or extended family but receiving services from MCFD, or in an agreement with MCFD to receive support services while making the transition to independent living. All of the 89 youth in this review had received services from MCFD, and 58 were in the care of the ministry at the time of the suicide or self-harm incident.

Generally, the youth first came into contact with the MCFD service system at an early age – 19 per cent of them in their first year of life and more than half of them within their first five years. At one time or another, 78 per cent of the youth were taken into the care of the ministry.

These children and their families first came to the attention of the ministry in one of two ways. In 78 per cent of the files, the behaviour of the parents was assessed as a threat to the safety and well-being of their children. In the other 22 per cent of the files, the parents were overwhelmed by the behaviour of the youth or themselves raised concerns that the youth were at risk and needed help.

Some common behavioural patterns noted in the lives of the 89 youth include:

- Repeated self-injury by 72 of the youth.
- Substance abuse – self-identified or identified by social workers – by 50 of the youth.
- Running away, associating with risky people, becoming street involved and other high-risk behaviours, by 64 of the youth.
- More aggressive behavioural issues, such as breaking the law and assaulting or threatening others, by 48 of the youth.

A disturbingly high number of the youth (52, or 58 per cent) in the review were Aboriginal. The Aboriginal youth in this study were most commonly receiving ministry



services as a result of safety and well-being concerns, such as neglect, exposure to violence in the home, or physical or sexual abuse.

Of the 15 youth who died as a result of suicide, eight were Aboriginal. Of the 74 youth who sustained self-harm injuries, 44 were Aboriginal. The Representative acknowledges the tremendous challenges faced by some Aboriginal communities, and believes that much more must be done to support them as they work to improve the well-being of their children and youth.

Another concern raised by this report – and also noted in prior reports – is the frequency of moves experienced by youth in care. On average, the youth in care in this review had been in care for roughly half of their lives (49 per cent) and had experienced an average of 12 moves while in care. Five of the youth were moved more than 30 times while in care.

Although it is not possible based on information in the files to determine why each move happened, this level of instability in the lives of these vulnerable youth undoubtedly undermined their ability to form positive social attachments and the meaningful connections and relationships necessary to thrive.

Domestic violence was a significant feature in the lives of more than half the youth in this report. As with disruption and multiple moves, domestic violence can leave a child with emotional pain, deep stress and sometimes physical trauma. Children who live in fear of triggering an explosion of violence do not develop normal abilities to express themselves and seek help. The experience of having problems and being able to solve those problems, a cornerstone of developing effective coping skills, is often foreign to them.

Another factor in the lives of most of these youth was substance use in their families. Seventy-five per cent of the mothers of the youth had substance use issues. Less information about substance use was available about the fathers because they were often absent from the family or did not play a consistent role in their children's lives.

Less than half of the youth whose files were reviewed for this report were attending school on a regular basis. When vulnerable youth are struggling and acting out, the system needs more effective ways of keeping them engaged in positive activities and learning.

Approximately one-third of the youth had a romantic conflict in the 24 hours preceding their suicide or self-injury. In 10 per cent of these incidents, the use of substances (primarily alcohol) was implicated as well.

It is noteworthy that 50 per cent of the youth with no prior known history of self-injury had a significant conflict with a romantic partner within the day leading up to the incident. This included one of the three youth in care who died as a result of suicide. It was also noted that in almost all of the instances of suicide, a friend or family member had attempted suicide or died as a result of suicide.

Compliance with MCFD practice standards varied from file to file, and often within files. Specific practices were examined for all 58 youth in care at the time of the reported

incident. This examination does not constitute a formal practice audit, but it helps provide a broad picture of some aspects of ministry services. Among the practice findings:

- Comprehensive Plans of Care (CPOC) were current in only 69 per cent of the files at the time the incident was reported to the Representative.
- For the youth in care, 88 per cent had one or more CPOC on file. These varied in quality and completeness.
- 32 per cent of the youth in care had more than one Reportable Circumstance, ranging from two to seven Reportable Circumstances.
- Less than half of the Aboriginal youth in this review were in an Aboriginal placement.
- Delegated Aboriginal Agencies provided service in only 38 per cent of the files involving Aboriginal youth.
- 89 per cent of youth were meeting regularly with their social worker (e.g. at least once a month and for significant life events).

From this review it does not appear that issues such as grief, loss or recovery from domestic violence are a primary consideration when children first come into the care of the system or are receiving support services while remaining in their homes. We know that adverse and traumatic childhood experiences, such as the ones experienced by the youth in this study, can lead to significant health consequences as children grow up.

Given the high number of youth in the review with identified mental health issues, the lack of clarity of systems and services for youth in the province is also of concern. It is not always clear which youth are eligible for which services and under what conditions they will be admitted.

The Representative is conducting a broad review of Child and Youth Mental Health (CYMH) services, and will make recommendations based on the findings of that review. However, because of the clear and urgent nature of the needs of children and youth in care, the Representative recommends immediate action to address the trauma many of them experience, as evident in the current report.

Most of us cannot imagine the challenging life situations of these 89 youth. This report is a first step at increasing our awareness and understanding of the complex issues these youth faced and learning from their experiences and outcomes, with the goal of improving services for all vulnerable youth in British Columbia.

# Introduction

This report examines the life circumstances of 15 youth who died as a result of suicide and 74 youth who engaged in self-injury behaviours. All of these youth had received services from the Ministry of Children and Family Development (MCFD), and many of the youth who injured themselves are still receiving services from the ministry. This review explores how these 89 youth came into the provincial system of services and supports. While that focus helps inform us about their lives and our systems of services, we must not lose another focus – the vulnerability and pain that led these youth to take their own lives or to harm themselves, and the challenges faced by the families and caregivers concerned for their safety.

Many of these youth were disconnected from their families, and many of their families, for one reason or another, were unable to offer the stability and support that children need in order to flourish. These life circumstances do not lessen the grief or distress of families when their children are injured or die.

The desperate and final act of suicide means that at least in one moment, all hope was lost. Each of these deaths represents a loss of potential to our communities, and a devastating and life-changing event for families and loved ones.

This report also contains information about a group of youth who intentionally injured themselves. Were they expressing a cry for help? Was the self-harming symptomatic of a loss of hope? Without dependable connections to systems of services and supports, it is possible that some of the children and youth in this review may have progressed to more damaging self-injury or even suicide.

Did caregivers, community, and public services do all they could do to promote resiliency in these youth? The nature of this review does not allow us to fully answer these questions, but leads us in the direction of learning and improving service.

This report is based on aggregate data from files and other administrative records. This is high-level information that provides us with an overview of this group of youth, rather than specific information about an individual youth. This information allows us to develop a general understanding about the circumstances of these youth, and a limited understanding of the supports and services they received. It does not give us a full picture of their day-to-day lives in the way that an individual investigation report would.

The research behind this report is best characterized as exploratory. It is a first attempt to understand and assess how services were delivered to these youth using the aggregate review approach referred to in the *RCY Act*. It does not directly explore suicide or self-harm from a clinical or epidemiological perspective. Rather, it uses available information from files and other documents to attempt to paint a picture of youth who came to the attention of the Representative through critical injury and death reports received from MCFD.

This report is not about assigning blame for the outcomes observed in this group of youth. Not all suicides and serious injuries are preventable. But the more we understand about the lives of children and youth, the better we will be able to understand how we can improve outcomes. The Representative supports and encourages the child-serving system to do the best work it can to ensure the most positive outcomes possible, with the goal that resilience for youth is reinforced in all areas of their lives.

On a daily basis, front-line workers throughout our province take on the difficult role of engaging with vulnerable youth, and working to help them move away from despair and discouragement. The Representative honours the dynamic work of those who serve children and youth struggling to maintain their mental health.

The Representative also pays tribute to the strength and resilience of youth struggling against odds that most of us truly cannot fathom. The life experiences of the children and youth in this report were grim, to say the least. Some of their stories are shared to promote understanding.

What can we learn? This report is a first step in increasing our awareness and understanding of these complex issues. The Representative will continue to examine and seek to provide more clarity to these issues in future reports, based on the learning from this report, and promote more integrated and effective practice at MCFD and other social serving ministries and agencies.

### Terminology

The research literature is rife with different approaches to terminology. In this report, suicidality is used to describe self-harming behaviour with a lethal intent, and non-suicidal self-injury, shortened to simply self-injury, to describe self-inflicted injury that causes physical, bodily damage (both temporary and long term) intended to be non-lethal. The difference between suicidality and self-injury is often subtle and unclear, and some cases contain instances of both.

### RCY Aggregate Reviews

The Honourable Ted Hughes QC, in his 2006 *BC Children and Youth Review*, introduced the idea of aggregate analysis in his discussion on reviewing child injuries and deaths:

“The primary method of reviewing child injury and deaths will be to examine aggregated information, and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives” (p. 36).

Hughes used the term “aggregate” in reference to analyzing numerous examples of similar phenomena, as opposed to the practice of analyzing one case instance. He stated that an aggregate review “may be a matter of collecting and reviewing information on a number of deaths with similar characteristics (for example, youth suicides by hanging), to identify trends or patterns that will inform and educate the child welfare system and the public” (p. 37).

The *RCY Act*, sections 11 and 12, provides the mandate for the Representative to conduct aggregate reviews.

### **Rationale for Conducting this Aggregate Review**

The Representative has a sustained interest in the well-being of youth who struggle with suicidality and self-injury. In October 2010, the Representative and the Provincial Health Officer released *Growing up in B.C.*, reporting on six aspects of child well-being, including dimensions of mental health. One finding in that report was that youth who have been in care are nearly three times more likely to consider suicide – and nearly six times more likely to have attempted suicide at least once – than youth who have never been in care.

Initial review of self-injuries and suicide deaths reported to the Representative showed apparent similarities in the backgrounds and service histories of the youth. A better understanding of who these youth are – and how they interact with our system of services and supports in B.C. – is an important first step in ensuring that those systems achieve the best possible outcomes.

This aggregate review was guided by the following questions:

- What brought the youth and/or family to the attention of the ministry?
- What were their pathways into and through the service system?
- Did services meet established standards?
- Were cultural continuity and involvement of family and community addressed for Aboriginal children and youth?

# Methodology

The Representative receives regular reports from MCFD, including delegated Aboriginal Agencies (DAA), of critical injuries and deaths of children and youth who have received reviewable services within the year prior. The Select Standing Committee for Children and Youth (SSCCY) can also refer cases for review.

## Reviewable Services

Any designated services, including services and programs under the *Child, Family and Community Service Act* and *Youth Justice Act*; mental health services for children; addiction services for children; and additional services prescribed under the *Representative for Children and Youth Act*.

Reports of critical injuries or deaths are screened by the Representative to determine if they meet the criteria for further review.

The sample for this report consists of all suicide and self-inflicted injuries reported to the Representative between June 1, 2007 and May 31, 2010. Four of the suicide deaths were referred by the SSCCY and occurred between May 1, 2003 and May 31, 2007.

The Representative notes that issues with routine reporting of critical injuries have been identified. These were described in a Special Report of December 2010, *Reporting of Critical Injuries and Deaths to the Representative for Children and Youth*. While the issues identified in the Special Report have since been addressed, the period covered in the current report pre-dates improvements in reporting. Due to under-reporting prior to March 2011, the number of critical injuries profiled in this report is certainly lower than the number that actually occurred during the time period.

This selection criterion produced a sample of 89 cases – 15 deaths as a result of suicide, and 74 self-inflicted critical injuries. While 89 is a large number, these youth represent an extremely small number of the overall population of children who were receiving services. The number of youth in this review who were in care at the time of the reported incident (58) represents much less than one-half of one per cent of the overall population of youth in care.

Similar to aggregate analyses in other fields such as economics, this review relies on secondary data collected for purposes other than research. Because this was a review under the *RCY Act* rather than an investigation, family members and service providers were not interviewed individually. Instead, data was gathered from records relating to each youth and his or her family and examined by three analysts. File documentation was requested and received from MCFD (which also provided relevant records from delegated Aboriginal Agencies), the Ministry of Health, and the BC Vital Statistics Agency.

In addition, basic demographic characteristics and features of each child and family were collected across a number of psycho-social domains, similar to those used in the 2008 report on youth suicide produced by the Child Death Review Unit of the BC Coroners Service (CDRU, 2008). The CDRU review identified which types of social services the children and youth had received. However, that review did not explore each individual youth's movement through the system of supports and services, and the degree to which selected standards were met.

In summary, this aggregate method provides a range of descriptive data about the youth in this sample, their families, and the services they received. This review is limited in that it is based solely on available files and documents. Therefore, while it tracks pathways into and through the system, it cannot address effectiveness of services or the youths' experience. For example, although we can record that a Plan of Care is in the file, we can't conclude based on those file materials alone whether it was adequate or effective in meeting the needs of a child or youth.

Another limitation is that the quality and completeness of files varies. That means that what we can learn about is limited by the kind of information that can be consistently found in all of the files under review.

This report does not identify the youth and their families by name, and care has been taken to present the information in a way that does not otherwise identify them.<sup>1</sup> Embedded in this report are the life experiences of youth, many of whom are still engaged with the ministry. We seek to learn from their history while respecting their privacy.

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<sup>1</sup> Section 16(1) of the *Representative for Children and Youth Act* specifies that reports based on aggregated information not contain information in an individually identifiable form.

# Background and Descriptive Data

## Suicide Deaths

The Representative reviewed documents related to personal and service histories of the 15 youth who died by suicide and who had received MCFD services in the year prior to the incident. One of the youth was 12-years-old while the others ranged in age from 15 to 18. The suicide deaths occurred in all regions of the province. Table 1 shows a further breakdown of their gender and whether or not they were Aboriginal.

Table 1

	Non-Aboriginal	Aboriginal	Total
Female	3	6	9
Male	4	2	6
<b>Total</b>	<b>7</b>	<b>8</b>	<b>15</b>

These youth were involved in four main MCFD service streams during their lives. All but two of the 15 had a history of involvement with child protection and CYMH services at some time (one of them had a history of involvement with child protection but not CYMH services, while another one had a history of involvement with CYMH services but not with child protection). Of the 15, three of the youth were in continuing care of MCFD and the other 12 were in the legal custody of their parents but involved with ministry services.

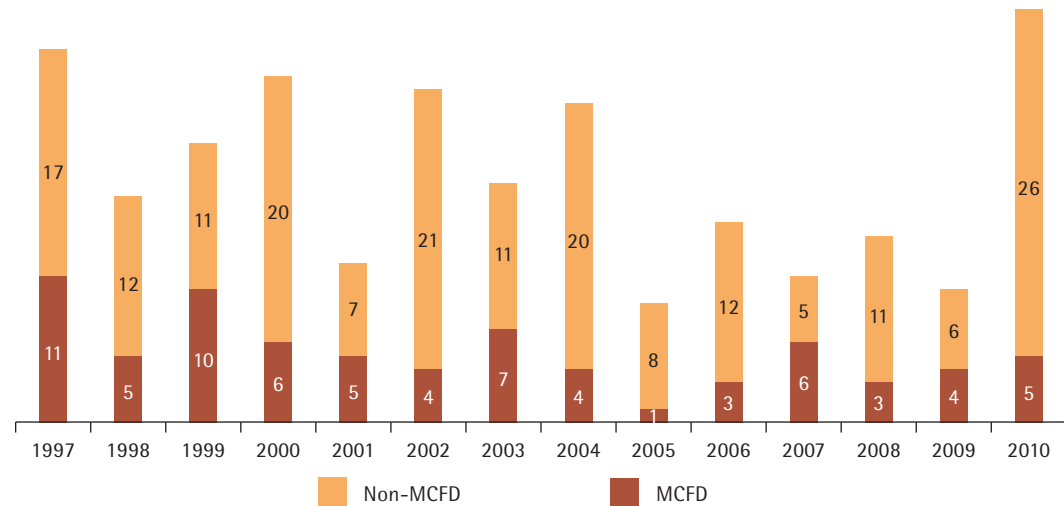
Four of the youth had previous involvement with the youth justice system, and one youth had received special needs services from MCFD.

The BC Vital Statistics Agency tracks and reports on a wide variety of data relating to significant life cycle events, including deaths. Between 1997 and 2010, the number of youth suicide deaths (12 to 18 years) in B.C. ranged from a high of 8.6 per 100,000 to a low of 2.4 per 100,000 youth, and the rate fluctuated from year to year. It is important to understand that, because absolute numbers of youth suicides are low, variations from one year to the next can seem to fluctuate more than if they are tracked over time. For example, in the 14-year period noted above, actual numbers of suicide deaths among all youth in B.C. ranged from nine to 31 per year. Over the same time period, the number of youth involved in the MCFD system of supports and services who died as a result of suicide ranged from one to 11 per year (see Table 2 following). Of all youth suicides in B.C. during those 14 years, between 38 and 42 per cent were involved with MCFD.<sup>2</sup>

<sup>2</sup> MCFD's statistics only include children and youth who received services under the *CFCS Act* in the year prior to their death.



Table 2: Youth Suicides and MCFD Service Involvement



### Self-Harm Injuries

The Representative reviewed the personal and service histories of 74 youth who had self-harm injuries that were reported as critical injuries and who had received MCFD services in the year prior. As is noted later in this report, most of them had histories of more than one self-harm incident.

Two of the youth were under the age of 12, and the rest ranged in age from 12 to 18, with most of the youth being 15 or older. The youth lived in all regions of the province. Table 3 shows a further breakdown of their gender and whether or not they are Aboriginal.

Table 3

	Non-Aboriginal	Aboriginal	Total
Female	21	34	55
Male	9	10	19
<b>Total</b>	<b>30</b>	<b>44</b>	<b>74</b>

These youth were involved in four main MCFD service streams at some time during their lives: all of the 74 youth had been involved with child protection; 43 had also received services through CYMH; 22 also had involvement with the youth justice system; and three of the youth had received special needs services.

At the time of injury, 55 of the 74 youth were in care of MCFD, 34 of them in continuing care. Ten youth had been placed in care voluntarily by their parents. The remaining 11 youth were in temporary forms of care or on Special Needs Agreements.

Unlike youth suicide in B.C., self-injuries are not tracked in the general child and youth population. Consequently, there is no comparable data that can be used to establish a baseline for these types of injuries, or provide context for this review.

### Life Circumstances of the Families

The families of origin of most of the 89 youth included in this aggregate review faced very difficult life circumstances, including many factors that were beyond their control and undermined their ability to parent. The daily challenges in their lives are foreign to most British Columbians. The repeated heartbreak they dealt with requires a compassionate response, and calls out for supportive and effective services.

These were families that lived with significant instability. Twenty-four of the parents had themselves been in the care of the ministry as children or youth. In 78 of the files reviewed, the parents separated, typically early in the youths' lives.

A significant proportion of the parents struggled with substance use. This was noted for 67 of the mothers. The fathers also had issues with substance use, but files contained less information on them because most of the fathers were absent from the family or did not play a constant role in their children's lives. A few prominent patterns were noted: fathers being present early in the child's life and then leaving the home; new partners and father figures; and domestic violence. More than half the families contended with physical abuse committed by fathers or male partners and witnessed by the children, often at an early age.

### Life Circumstances of the Youth

The youth had many challenges in their own personal lives. For example, one-quarter of the 89 youth had a friend or family member who had attempted suicide or died as a result of suicide. This was true of seven of the 15 youth who died as a result of suicide.

At the time of the reported incident, whether it was self-injury or suicide, about one-third of the youth had experienced a romantic conflict in the preceding 24 hours and, in about one-quarter of the cases, substances (primarily alcohol) were implicated in the incident. In 10 per cent of all cases, both romantic conflict and substance use were present.

Most of the youth experienced significant risks to their health, well-being and safety. High-risk behaviours such as running away from placements, getting into dangerous situations and relationships, and living on the streets were identified by social workers for 64 of the youth. These behaviours often occurred within a context of limited options, or attempts to escape from unbearable circumstances.

Other high-risk behaviours were also noted. Repeated self-injury was reported for 72 of the youth. Substance use, beyond casual use, was identified by social workers or self-identified by 50 of the youth. Mental health issues were identified in 64 of the youth. More than half of the youth (48) were involved in serious problem behaviours, such as breaking the law, physical violence, or threatening other people. Learning challenges were also common – they were identified in 45 of the youth.

**Table 4**

Characteristic	Total (Out of 89)	Per cent Aboriginal of Total
Repeated self-injury	72	55
Substance use, beyond casual use	67	63
High-risk behaviours	50	62
Mental health issues	64	53
Behavioural issues	48	58
Learning challenges	45	53

### Case Example

When she was a young girl, this youth suffered a traumatic brain injury as a result of a motor vehicle incident. This left her with nerve damage and significant cognitive and behavioural impairment.

Both of her parents had been in care themselves when they were growing up. Later, when they became parents, they had a long history with the ministry as a result of substance use, domestic violence in the home, and reports that the children were neglected.

The father left while the children were very young. The single mother then voluntarily placed her children into care when she was unable to find suitable housing and again when she later went to drug and alcohol treatment. As she continued to struggle with addiction, the children were permanently removed from her care.

At the time she was taken into care, this girl was eight-years-old. She was in the same foster home until she was 15-years-old, when she and her foster parent came into conflict. She was moved to another foster home.

The incident that brought this youth to the attention of the Representative came after she had an emotional break-up with a romantic partner and slashed her wrist. Before the break-up there was no known history of self-injury. She was admitted to hospital, where she continued slashing herself, and also attacked staff members and damaged her surroundings.

After stabilizing and receiving medical treatment, she was released into the care of her foster parent. She continued to be seen by her CYMH worker and youth outreach worker. However, after awhile, her foster parent was no longer willing or able to manage the youth's violent and threatening behaviour.

The latest available information is that she is eligible for services to address her cognitive impairments and acquired brain injury, and efforts, so far unsuccessful, are being made to find a place for her to live. She remains highly vulnerable.

## Diagnosis and Treatment in the Health Care System

As part of this review, the Representative obtained the medical and pharmaceutical billing information for each of the 89 youth. In B.C., when physicians treat a patient, they are reimbursed for their services by submitting a claim to Health Insurance BC. These claims include information about the reason for the visit, in the form of a diagnostic code. Coding information allows the claim to be verified by Health Insurance BC and is a reasonable proxy for generating statistics about causes of illness and death.<sup>3</sup>

For the youth reviewed for this report, the data showed a steady increase in the total number of medical diagnoses (and by proxy, medical visits), mental disorder diagnoses, and drug prescriptions as these youth moved into adolescence.

Just seven of the 89 youth accounted for 32 per cent of the medical visits and 57 per cent of the drug prescriptions. All seven of these youth had a history of serious mental health issues and received multiple mental health diagnoses for which medication was prescribed. In addition, two of them had serious physical ailments, which also necessitated frequent doctor's visits and medication.

During the teen years of the youth in this report, diagnosis of mental disorders accounted for roughly one-quarter of the total number of medical diagnoses.

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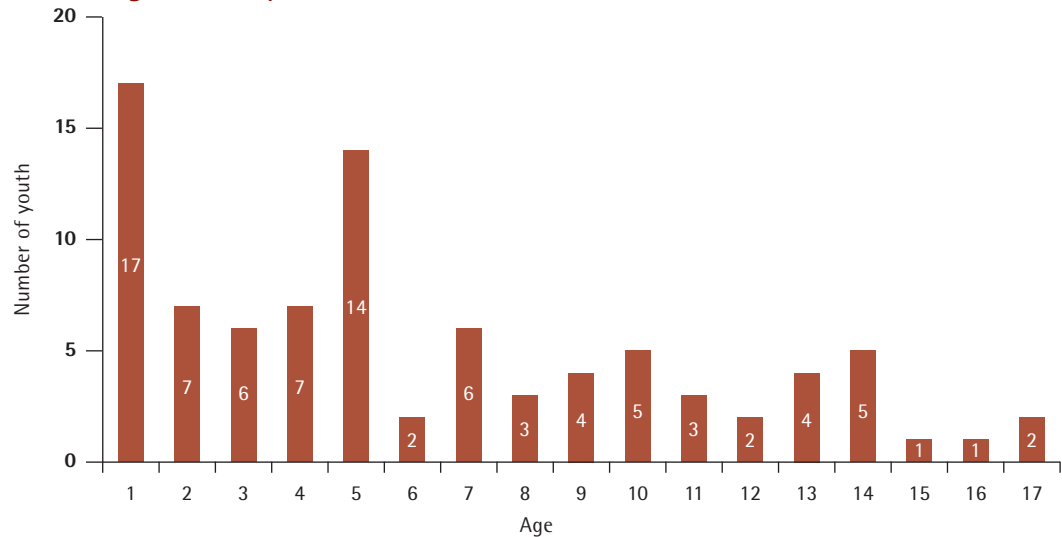
<sup>3</sup> The diagnostic codes used are based on the ninth revision of the *International Classification of Diseases* developed by the World Health Organization, commonly referred to as ICD9. Within the ICD9 coding framework, associated diseases are grouped together (for example, diseases affecting the nervous system, or diseases affecting the respiratory system).



# Entry into the Service System

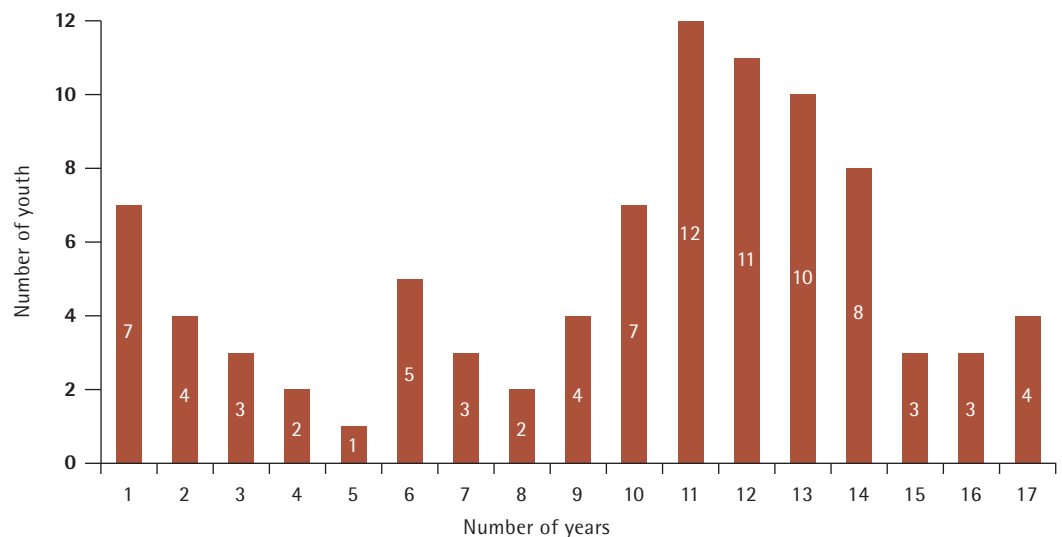
Many of the youth in this review first came into contact with the MCFD service system at an early age – 19 per cent of them in their first year of life and more than half of them within the first five years of life.

**Table 5: Age at first system involvement**



In most cases, they were receiving services or were known to MCFD long before the incident that resulted in a report to the Representative. For example, 58 of the youth had been involved with the ministry for 10 or more years. Only seven were involved with the ministry for one year or less prior to the incident reported to the Representative.

**Table 6: Years between first involvement with MCFD and incident**



## Pathways through the Service System

There were two entry points by which these children and their families came to the attention of the ministry, regardless of whether they were youth who injured themselves or youth who died as a result of suicide.

In 78 per cent of the cases, the initial contact resulted in the ministry identifying concerns that the behaviour of the parents was a threat to the safety and well-being of their children.

In the remaining cases, the parents were overwhelmed by the behaviour of the youth, or the parents raised concerns that their child was at risk and needed help. These youth received support services or CYMH interventions.

At one time or another, 78 per cent of the youth were taken into care of the ministry. As would be expected, this outcome was more than three times as likely when the initial concerns were about safety and well-being than when the initial concerns were about behaviour.

One way of getting a fuller understanding of these youths' histories is to trace what happened once they became involved with the ministry. These pathways differ depending on the legal status of the children and youth at the time of the incident that was reported to the Representative. The types of services provided depended on the primary issues identified during early contact with the ministry, and whether the youth were in care of the ministry or remained with their parents or in another non-care arrangement.

## Youth in Care

The average age of first contact with MCFD for the 58 youth who were in care at the time of the reported incident was 5.7 years. The youth who came into the system as a result of behavioural concerns such as aggressive behaviour and substance use that could not be managed by their parents – rather than safety and well-being concerns – were slightly older at first contact.

Initial interventions by MCFD were usually focused on supporting the child in his or her home. This did not generally succeed. Most often, the children were subsequently brought into care. Whether the problems in the family were so serious that safety could not be established, or whether the interventions themselves were not particularly effective or responsive is beyond what this review captures, but warrants a closer analysis by MCFD.

In each case, there were one or more instances in which the parents and/or the youth were not fully engaged with the services that were offered. A common notation in the records was that there was incomplete follow-through with services (for example, a parent’s inability to finish drug and alcohol treatment or complete anger management programs, or a youth being assessed by a CYMH clinician and subsequently not attending the recommended counseling program).

The time span from first MCFD contact, to coming into care was typically short. More than 50 per cent came into care within a year, as shown in Table 7.

**Table 7: Years from first MCFD contact to entry into care**

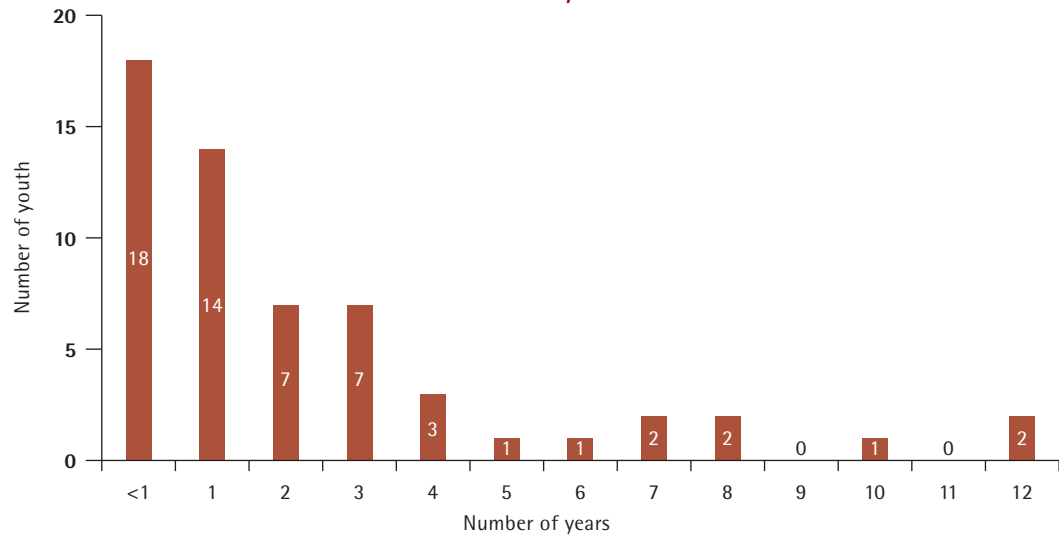


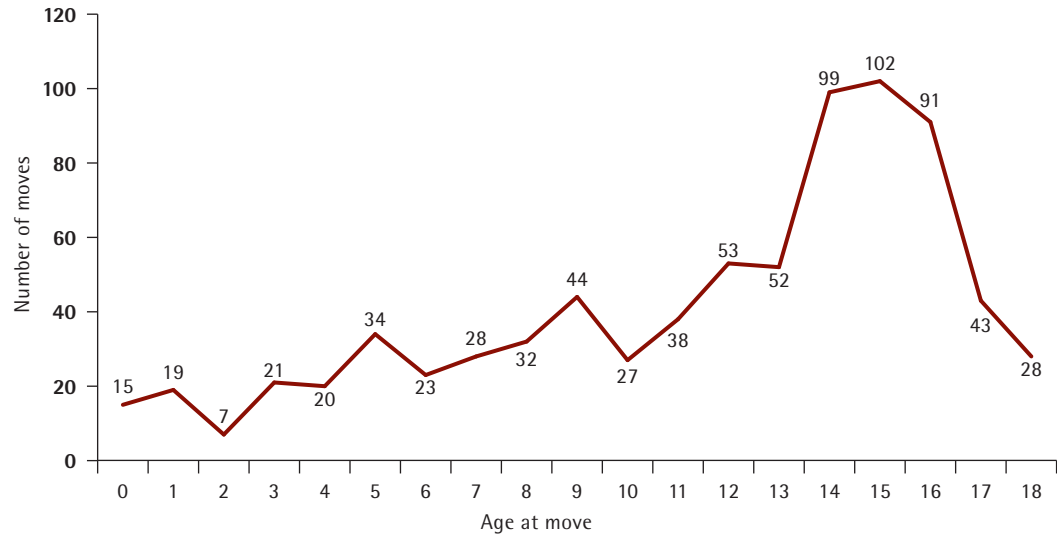
Table 8 displays the number of moves experienced by youth who were in care at the time of the reported incident. Each youth is grouped by the total number of home moves they experienced while in care.<sup>4</sup> This measure gives primacy to stability rather than continuity. It is not uncommon for youth to move frequently between a few placements. For example, if a youth moved from placement A to placement B, back to A and then back to B that would be three moves as opposed to two placements.

<sup>4</sup> The number of moves in care is different from the total number of placements (for example, some of the youth moved many times between a small number of placements).



Table 8 illustrates that the 58 youth in care experienced a combined total of 776 moves while in care.

**Table 8: Number of moves in care**



Just over half the youth experienced between 10 and 20 moves while in care. There were five youth who each moved more than 30 times while in care. They accounted for 227 of the 776 moves. Put another way, these five youth represent nine per cent of the youth in this sample who were in care, but account for 29 per cent of the total number of moves.<sup>5</sup> This degree of instability and disruption in relationships no doubt led to significant challenges in the lives of these youth, already challenged by so many life circumstances.

At the time of the critical injury or death being reported to the Representative, 65 per cent of the youth were in ministry care, and more than half of these youth (53 per cent) had remained in care on a continuing basis since they were first placed in the care of the ministry. In three of the cases, the youths had been placed into care on five or more occasions. Child in Care Service Standard 12 recognizes that a change in placement can be disruptive and detrimental to the development of a young person.

<sup>5</sup> It was not possible to determine on the basis of a file review the exact reason why each move happened. The most common reasons included youth-initiated moves, foster parent-initiated moves, incarcerations in custody centres, and placements in residential treatment centres.

### Case Example

This girl was born to First Nations parents who struggled with drug and alcohol addiction and undiagnosed mental illness. As a result, her parents could not meet her needs. They lived in poverty and did not have the skills to provide a safe home. There were reports to the ministry that the child was being neglected.

Her circumstances didn't improve when she was taken into the care of the ministry at age two, because she and her siblings were moved frequently between foster homes and their parents for several years. Eventually, she and her siblings were taken into permanent care. Moves to different foster homes continued.

As she matured, the girl's behaviour became more challenging for her foster families to manage. Diagnosed with Attention Deficit and Hyperactivity Disorder, Fetal Alcohol Syndrome and Post Traumatic Stress Disorder, she was abusing alcohol and drugs in an effort to ward off what one clinician described as "the continuous pain she feels."

She lived in 34 different placements after her initial involvement with the ministry as an infant, not including the time she spent in hospital or drug and alcohol treatment. She was drinking to the point of blacking out and stealing psychiatric medications from her siblings. Given her history, it is little wonder that she didn't form trusting, long-term relationships, or trust that caregivers would really help her.

In the incident reviewed for this study, the girl had gone missing from the staffed specialized resource where she was living, and had made her way back to her reserve. She then phoned the staffed resource and told a worker there she was despondent because of a recent argument with other family members and that she had taken "a bunch of medication." She would not tell the worker where she was.

Police finally found her, and an ambulance took her to hospital. She was certified for involuntary admission to hospital because she was found to be a risk to her own safety. She was treated, released from the hospital, returned to her residence, and made a full recovery. Workers from CYMH, a local family resource centre, and the hospital were involved in planning for her care after the incident.

Of the 31 youth in this review who had been in care continuously, 14 had spent at least 50 per cent of their entire lives in care.

The ministry has the ongoing responsibility of assessing and planning for the needs of children and youth in care. Having taken on these responsibilities, the ministry is expected to play the role of a kind and prudent parent. This is important, because one-third of these youth were in care continuously for 10 or more years prior to the incident that was reported to the Representative. Only 42 per cent were in care for three years or less.

Of the group of 58 youth who were in care, 84 per cent (including the three who died as a result of suicide) had a history of self-injury, 64 per cent<sup>6</sup> had previously received mental health services through CYMH, and 79 per cent were involved in a service of some kind at the time of the incident.

Half of the youth attended school only sporadically or had stopped attending school or extra-curricular activities altogether.

File information alone does not enable conclusions to be drawn about precipitating events. It is noteworthy that 50 per cent of the youth with no known prior history of self-injury had a significant conflict with a romantic partner within the 24 hours prior to the incident. This included one of the three youth in care who died as a result of suicide. Among those youth in care with an established history of self-injury, 27 per cent had experienced a romantic conflict in the preceding 24 hours. Substance use was present in a little over one-third of these incidents.

Among this group of youth who were in care, based on these observed patterns, a composite, representative profile would include:

- Early contact with MCFD at age five or younger.
- Coming into care around age eight.
- Developing various behavioural and mental health issues.
- Becoming increasingly difficult to manage
- Developing a history of repeated self-injury.
- Coming to the attention of the Representative around age 16 as the result of a reported critical injury or suicide death.

The pattern for Aboriginal youth was generally similar, except that they were more likely to have entered the system in the child welfare stream as a result of a variety of safety and well-being concerns including neglect, exposure to violence in the home, physical abuse, or sexual abuse. All three of the youth in care who died by suicide were Aboriginal. They were removed from their parents as the result of substantiated concerns about their safety and well-being, and all had histories of repeated self-injury.

One of the significant issues giving rise to concerns about safety and well-being of children and youth is neglect. In First Nations families, the prominence of neglect is highlighted by a recent analysis of child protection investigations published by the Assembly of First Nations (2011) and based on the 2008 Canadian Incidence Study. Although the analysis deals specifically with First Nations children rather than all Aboriginal children, the findings highlight that neglect is the dominant factor in substantiated concerns related to safety and well-being for children.

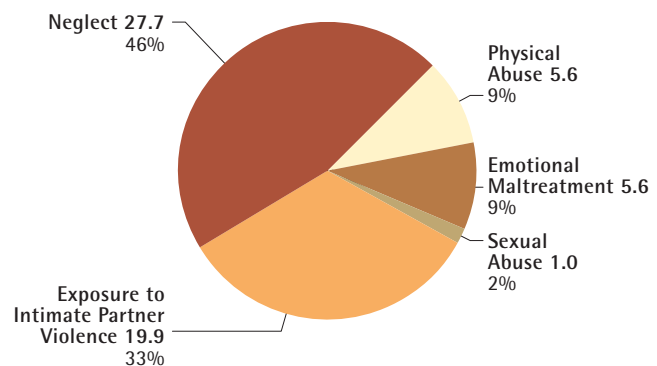
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<sup>6</sup> The percentage of youth referred to CYMH is much higher than those who received treatment. A number of youth were referred to CYMH but declined the service.

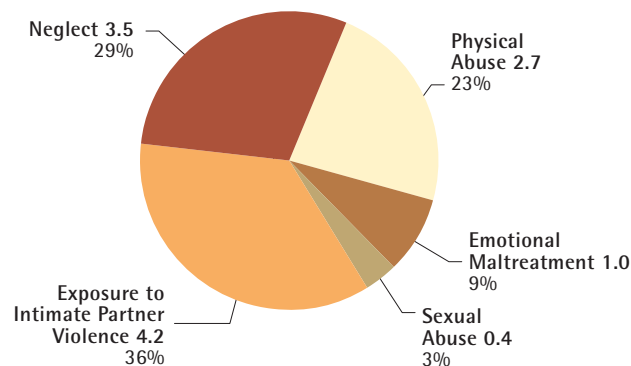
Table 9 illustrates that neglect accounts for 46 per cent of substantiated maltreatment investigations involving First Nations children. The primary form of neglect found in the study was parent or caregiver failure to supervise, which led to the child suffering or being likely to suffer physical harm as a result.

**Table 9: Primary categories of maltreatment in substantiated maltreatment investigations, involving First Nations and non-Aboriginal children, conducted in sampled agencies in 2008**

(rate per 1,000 First Nations or non-Aboriginal children in areas served by sampled agencies and per cent)<sup>7</sup>



**First Nations**  
59.8 Substantiated Maltreatment Investigations per 1,000 Children in Areas Served by Sampled Agencies



**Non-Aboriginal**  
11.8 Substantiated Maltreatment Investigations per 1,000 Children in Areas Served by Sampled Agencies

<sup>7</sup> Sinha, V., Trocme, N., Fallon, B., et al. (2011), pg. xix.

### Case Example

This First Nations boy died as a result of suicide by hanging. Ministry child protection services had been involved with the family throughout his life – there were more than 19 child protection reports. These reports involved severe substance abuse by the parents, domestic violence, and possible sexual abuse of the children by a relative.

The file documented a family history of intergenerational abuse and neglect in the parents' families of origin. It appears that a number of the reports involved concerns that the children were unsafe when the mother was drinking, when they would be left unsupervised and there were incidents of domestic violence. It appears that the children were assessed as being safe if the mother had arranged for the children to stay with relatives or friends when she was drinking.

The children were removed six times, the first removal when this youth was four-years-old. These removals were, for the most part, short term and placements were with relatives. The second removal, when the boy was seven-years-old, resulted in an order for supervision. The children were removed for the third time during this supervision period.

A second supervision order was granted and was subsequently extended. At the end of the supervision order, the file was closed. It was re-opened a month later following another child protection call. A third supervision order, this time without removal of the children, was granted. Three months later, the children were removed for the fifth time and a fourth supervision order was granted. During the term of this supervision order, a further child protection report was received and the children were removed for the sixth time. An interim care order, and later a temporary care order, were granted.

The children remained in care for more than a year. As little had changed in the family circumstances, MCFD planned to apply for a Continuing Custody Order, but did not make the application within the time frame required by the *CFCS Act*. Instead, the children were returned to the parents under a fifth supervision order. Another child protection report was received within two months and the children were again removed. The children were returned to the mother under the same supervision order. At the expiry of this order, the file was closed.

Subsequent to the file closure and four months before the youth's death, four more child protection reports were received. The children were assessed to be safe and no court orders were requested. The family was referred for support services. Later, the youth was suspended from school.

One evening, he was observed alone in the community after midnight, and was returned home by the police. His mother was reported to be still drinking heavily.

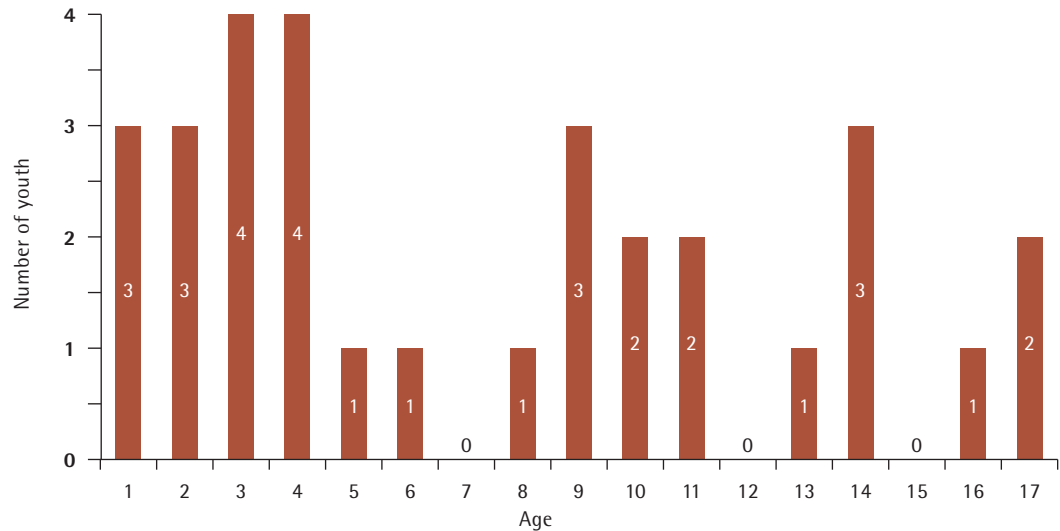
About a month later, the youth died as a result of suicide. MCFD conducted a review of its involvement with his family. The review concluded that intervention was not effective in achieving any positive change. It was noted that the ongoing chaos in the home was not responded to by MCFD workers. The emotional impact of this environment on the children was not recognized or addressed.

### Pathways of Youth Not in Care

The other group of youth in this review was not in care at the time of the reported incident, but they were receiving services from MCFD. Approximately one-third of these 31 youth had previously been in care on more than one occasion. In addition, it is notable that almost all of these youth had a history of self-injury.

The age at first contact ranged from one-year-old to 17-years-old.

**Table 10: Age at first MCFD contact**



In this group of youth, 35 per cent were involved with the ministry as a result of their behaviour rather than having been found to be in need of protection. In fact, three-quarters of them remained living at home with parents. There was also a significant incidence of violence toward family members. In contrast to the youth in care, who tended to be victims of abuse or neglect, file records did not depict these youth as victims of mistreatment.

This group of youth also showed the pattern observed in the youth in care group – an incident occurring within 24 hours of having a significant conflict with a romantic partner.

Substance use was also present in 38 per cent of the incidents.

# Ministry Services

MCFD has established practice standards, based on ministry policy and legislative requirements, to guide staff in delivering services. Delegated Aboriginal Agencies follow practice standards called Aboriginal Operational Practice Standard Indicators (AOPSI). For the purposes of this review, focus was placed on key aspects of service delivery, particularly those that could be reasonably assessed on the basis of file information. The practice standards that were assessed were consistent between the ministry and AOPSI.

The youth in this review were involved in five streams within MCFD. These include children in care, child and family services, youth agreements, youth justice, and Child and Youth Mental Health.

This limited review of adherence to practice standards revealed varied results. The complete set of findings is in Appendix D.

It is important to note that the following information is not the result of a formal audit. It does not survey all aspects of practice, and is not a deep or rigorous assessment of compliance with standards. However, it helps us paint a broad picture of some aspects of ministry services to these particular children and youth.

The Representative is in the process of completing a formal audit of Comprehensive Plans of Care (CPOC), which she will report on in the coming months.

## Children in Care

When a child is brought into temporary or permanent care, the ministry assumes guardianship and becomes responsible for his or her growth and development.

Specific guardianship practices were examined for all 58 youth in care at the time of the reported incident. The focus was on safety, planning, placement stability and specific responsibilities with respect to Aboriginal children and youth:

- 32 per cent of the youth in care were the subject of more than one Reportable Circumstance,<sup>8</sup> ranging from two to seven reports.
- The CPOC mentioned services intended to support the identity and cultural needs for 73 per cent of the Aboriginal youth in care. The adequacy of the identified services could not be assessed based on file information.

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<sup>8</sup> The ministry's Child and Family Service Standard 25 requires the reporting of serious incidents of children in care or receiving services. Serious incidents can include: injuries; deaths; allegations of mistreatment; allegations of criminal involvement; missing children or high-risk situations; or life threatening medical difficulties. Reports are generated in the MCFD service regions and distributed to analysts and managers in MCFD as well as the RCY. The Representative released a Special Report in December 2010 covering MCFD's Reportable Circumstance mechanism and its relation to the *Representative for Children and Youth Act*. The report can be found at <http://www.rcybc.ca/content/Publications/Reports/2010.asp>

- 41 per cent of Aboriginal youth in care were in an Aboriginal placement.
- On average, Aboriginal youth spent 37 per cent of their time in care in Aboriginal placements.
- 38 per cent of Aboriginal youth were served at least some of the time by a delegated Aboriginal Agency.
- 89 per cent of the youth were meeting regularly with their worker (e.g. at least once a month and for significant life events).
- For the youth in care, 88 per cent had one or more CPOC on file. These varied in quality and completeness.
- In 69 per cent of the cases, the CPOC appeared to be current at the time of the incident that was reported to the Representative.
- On average, the youth in care had been in care for half their lives and experienced 12 moves while in care.

### Child and Family Services

Child and family services are provided to support parents in raising their children. They are sometimes put in place to assess the level and severity of risks to the children, and to develop a plan to reduce and mitigate risks that will allow children to remain in their parents' care.

For the 13 youth who were not in ministry care or in a Youth Agreement (YAG), but were receiving child and family services:

- In 91 per cent of cases where the youth was found to be in need of protection, there was a completed Comprehensive Risk Assessment (CRA).
- In 70 per cent of the cases requiring a CRA, there was a current Risk Reduction Service Plan on file.
- For the Aboriginal youth receiving services at the time of the incident reported to the Representative, all of them had their community and family members involved with case planning.
- In all of the cases where the child or family were receiving services, these youth and/or their families had been offered services by the ministry at the time of the incident, including such services as parent-teen conflict mediation, drug and alcohol counseling/treatment or respite care.



### Case Example

This Aboriginal child was born to a mother who struggled with alcohol and drug use during the pregnancy. When the baby was still very young, her mother was left alone to care for her. Over a seven-year period, the ministry undertook 13 investigations into the child's safety in response to reports of drinking, domestic violence and neglect in the home. The child was moved repeatedly from her mother's care to foster care.

As the girl moved into adolescence, she began drinking heavily. Her foster parent reported that she was drinking four or five nights a week, and was routinely brought home by police who would find her in an advanced state of intoxication.

The girl was referred twice to an Aboriginal drug and alcohol treatment program, but left both times before completing treatment. A peer family program didn't work out, as the girl continued to engage in high-risk behaviours during the program. The girl attended a six-month healing lodge program that, although not focused specifically on drug and alcohol treatment, did include counseling in that area.

However, during weekend visits home, she and her mother would drink. She formed a relationship with another program participant, who was himself struggling with substance use. All of this added up to a continued struggle with drinking.

Although testing showed her to have average to high-average intelligence, the girl was not successfully engaged with the school system. She attended many different schools because she was frequently expelled or suspended for behavioural issues. Being disconnected from school contributed to her vulnerability.

High-risk use of alcohol also left her vulnerable to sexual victimization. Although there were concerns that she had been sexually assaulted on at least one occasion, she refused to co-operate with police. She also became aggressive when intoxicated, and she was convicted of robbery after two incidents in which she attacked other women and tried to take their purses.

The incident that is included in this report occurred when the girl, upset after an argument, returned to her foster home and overdosed on anti-depressants. As she was passing out, she called 9-1-1 and was taken to hospital. After being treated for potential organ damage and monitored in hospital overnight, she was released the following day into the care of her foster parent, with whom she had a strong relationship. She made a full recovery from the overdose and subsequently completed a residential drug and alcohol treatment program.

### Youth Agreements

A Youth Agreement (YAG) is an alternative to bringing a youth into care and is put into place with the goal of assisting the youth in achieving independence or providing a measure of support and ensuring safety and well-being while efforts are underway to return the youth to the family home. YAGs are an option for youth ages 16 to 19. Seven youth were in a YAG with the ministry at the time of the incident that was reported to the Representative.

Specific practices were examined, focusing on short- and long-term assessments, service planning, and monitoring the well-being of youth on agreements:

- All of the youth under a YAG at the time of incident had received both an immediate assessment and, later, a longer term assessment.
- All of the youth under a YAG at the time of incident had been referred to service and support providers, and there was evidence on the file to indicate they were attending.
- In all of the files, workers were physically checking on the youth at least once a week.

### Youth Justice

Specific practices were examined for 54 youth who were in different streams of the youth justice program, focusing primarily on assessment and planning:

- In 87 per cent of the youth who had community sentences, probation officers had completed multiple Youth Community Risk/Needs Assessments, and Supervision Plans.
- 87 per cent of youth who were detained in custody centres had multiple Youth Needs Assessment case plans on file.
- All but one<sup>9</sup> of the youth ordered to undergo a forensic assessment were assessed or received an assessment.

### Child and Youth Mental Health

CYMH services are offered throughout B.C. to help treat a wide range of mental health issues using a variety of treatment methods. They are offered to children, youth and their families and participation is voluntary. Prior to the incident that was reported to the Representative, 62 of the youth had involvement with CYMH.

Specific practices were examined, focusing primarily on assessment and participation with services:

- 90 per cent of the youth who were referred were formally assessed.
- 91 per cent of the youth who were assessed attended some of their scheduled sessions.

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<sup>9</sup> The examination could not be complete due to the youth's sporadic attendance.

### Case Example

This young girl came to the attention of the ministry as a five-year-old, when her mother was arrested for public intoxication. She was placed in temporary care when her mother was jailed. Her father was no longer involved with the family.

Over the next few years, the ministry conducted numerous child protection investigations. These were often the result of the mother abandoning the child, sometimes because she had been drinking.

The child was placed in foster homes and was twice returned to the mother under a supervision order. The mother had attended numerous alcohol treatment programs, with varying degrees of success, but ultimately was unable to manage her addiction. Because of this, the mother was unable to adequately care for the child, who lived with relatives for several years, and then went into foster care.

By about age 16, the youth was drinking heavily and using drugs, and she began to get into fights with her foster parents. She succeeded in getting some control over her substance use issues and began to stabilize. She then lived in a supported independent living arrangement while still in care of the ministry. Although things seemed to be going well, she engaged in self-injury by cutting.

### Case Example

This youth achieved high grades in school and was actively engaged in sports and recreational activities. Around age 12, she developed symptoms of anxiety and depression after having been sexually assaulted. Although this was reported to a family physician, it was not reported to police, and she later said it hadn't happened.

As a teenager, she got into high-risk behaviours, including frequent alcohol and marijuana use, street drug use and self-inflicted cutting. There were also significant parent-teen conflicts in the home.

About six months after the reported sexual assault, the youth took approximately 200 non-prescription pills. Drug use escalated to include hallucinogens, heroin, cocaine and crystal methamphetamine. After living on the streets and in shelters for several months, she was admitted to detox facilities three different times.

She was admitted to an inpatient psychiatric facility four times over an approximately one-year period after suicide attempts and other high-risk behaviours.

She also became involved with Youth Justice Services after a shoplifting charge. She did not offend again, but was in trouble for having breached a court order repeatedly. Over the next year, there were several referrals to community service agencies. She made several more suicide attempts.

Eventually, the youth was placed in a foster home, and she went into a drug and alcohol program. While she was in that program, she took her own life.

# Analysis and Recommendations

## Overall Finding

*Generally, these youth had a lengthy history of concerning behaviour and a lack of safety and stability in their lives. This means that, for most of them, there were many opportunities to reduce their vulnerabilities and improve outcomes. There were no consistent approaches to addressing deep factors such as the persistence of trauma and its impact on parenting and mental health.*

The vast majority of these youth came from remarkably similar family backgrounds, characterized by poverty, domestic violence, parental substance abuse, or various combinations of these factors. Generally, several types of maltreatment occurred together. For example, domestic violence, substance addiction and neglect frequently occurred together rather than singly.

Among the small group that came from families where there were no major problems noted, or there was no history of maltreatment, there was typically a traumatic event in the youth's life that occurred outside the family. In general, the youth were engaged in multiple behaviours that posed risks to their health and well-being, including clear incidents of self-injury.

Most of the youth became involved in the service system early in their lives. Although outcomes were not generally positive, these youth had extensive involvement with the service system, including MCFD and the medical system.

## Pathways Through the Service System

**Finding:** *The patterns observed in this aggregate review reinforce what we know from the literature about self-injury and suicide: youth with extremely difficult backgrounds have an increased susceptibility to self-injury and suicide death. It was common for youth in this review to self-injure with lethal and non-lethal intent at different times. There were similar patterns in life circumstances between those youth who came to the attention of the Representative as a result of self-injury and those youth who died by suicide. They experienced similar problems, and they received similar services.*

Examination of the life experiences and history of services of these youth paints a vivid picture of the circumstances in their lives, and their parents' lives, that created serious risks to their health and safety. Most of the youth in this review came from families that faced a number of difficulties. All of the youth faced significant challenges in their lives.

Among the youth in care, a large majority had been victims of abuse and neglect, and had experienced violence in their homes, including domestic violence. These youth experienced a remarkable lack of stability in their lives and numerous moves. Most of them were involved with many different service providers at many different points in their lives.

More than 75 per cent of these 89 youth were in ministry care at one time or another in their lives, and 65 per cent of them were in ministry care at the time of the incident that was reported to the Representative. The majority of the youth who died as a result of suicide (12 out of 15) were not in care of the ministry at the time of their deaths, although seven had been in care at some point in their lives.

As they were growing up, these youth had lives rife with unpredictability and they regularly had to cope with adversity. For most of them, their personal histories were lost in the chaos of constant change, including a parade of caregivers and service providers coming through their lives. What could they see as a future for themselves? For some of the youth, there was not enough hope to keep them going.

The life experience and challenges faced by these youth are outside the frame of reference of most British Columbians. Children and youth in the child welfare system have a significant chance of engaging in behaviours that threaten their health – for example substance use, depression and suicidality, and aggressive behaviour (Leslie, K.L., James, S., Monn, A., et al., 2010). Swannell, Martin, Page, et al. (2012) have reported a strong association between child maltreatment and subsequent non-suicidal self-injury.

Moreover, 34 per cent of the youth in this review had used substances, mostly alcohol, at the time of their injury or death. This observation has been frequently identified in research about self-injury and suicide attempts among adolescents (Schilling, E.A., Aseltine Jr., R.H., Glanovsky, J.L., et al., 2009). These researchers note that consuming alcohol can play an important role in suicides and suicide attempts because it can increase impulsivity and aggression, and decrease the ability to think clearly. For youth who have a tendency towards aggression and impulsivity, similar to some of the youth in this sample, alcohol may have increased their risk of suicidality.

Perhaps the most troubling finding was the high number of moves faced by these youth in their lives. Stability of placement is a complex issue, requiring a robust inventory of placement resources, as well as difficult judgment calls about returns to family.

For some of the youth in this sample, the number of placement changes was extreme. It is noteworthy that, as the young people in this review moved into adolescence, the number of placement changes increased drastically. Frequent moves can have serious consequences for young people as noted by O’Neil, Risely-Curtis, Ayon, and Williams (2012), such as further traumatizing already vulnerable children, higher levels of anxiety, feelings of loss and depression, and negative impacts on their social and emotional development.

The placement changes observed in this review occurred for a variety of reasons (for example, repeated entries into care, foster parents requesting a move, youth requesting a move, allegations of mistreatment in a placement, stays in treatment centres, or residing in youth custody centres).

There is some evidence that youth with the emotional and behavioural challenges described in this review have an increased risk for frequent changes (Barth, R.P., Lloyd, C., Green, R.L., et al., 2007) to such an extent that it can form a mutually reinforcing cycle. In other words, youth who develop emotional and behavioural challenges are more likely to act out, youth who act out experience a change in placement, and a placement change increases the likelihood of future placement changes (Rosenthal, J.A. & Villegas, S., 2010).

It should not be surprising that youth who have had turbulent backgrounds act out, or present challenges to traditional services and institutions. Can we imagine what it feels like to lose our family, move homes and live with different people and parent figures time after time, while remembering violent incidents and chaotic circumstances in our past? At the very least, for most of these youth, an overwhelming burden of loss and sadness has been part of their daily lives.

In an earlier report, *Kids, Crime and Care – Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes*, the Representative recommended that whenever a child or youth in care or in the Child In the Home of a Relative program has more than three changes in placement outside of the parental home within one 12-month period, a report should be made to the Regional Director of Integrated Practice. To date, this recommendation has not been implemented, however MCFD indicates it is working on a reliable tracking process so that such cases can be readily identified. The youth in the current review would have no doubt benefited from closer attention to the number of placement moves.

Another very troubling observation is that less than half of the youth whose cases were reviewed for this report were attending school on a regular basis. Lack of attachment to school is not surprising given the few stable personal supports available to these youth, and the often negative reactions they receive from others. Lack of school attachment has major consequences beyond academic outcomes. In addition to compromising educational achievement, it means that the youth were missing out on chances to have caring adults support them and to have positive social extracurricular activities. When youth such as those described in this report are acting out and the school suspends them, the system is divesting itself of a major responsibility to provide support and guidance to this highly vulnerable group.

## MCFD Services

**Finding:** *Overall, adherence to practice standards was mixed. Better attention was paid to care planning, offering mental health services, youth justice services and monitoring youth on Youth Agreements. There was less success in meeting standards for placing Aboriginal children in Aboriginal homes. Following standards, while important, is not enough, because services were not geared to addressing the trauma in the lives of these youth or their parents, and inter-generational trauma was prominent in their lives.*

Measures related to service standards for children in care showed that having Aboriginal children placed with Aboriginal caregivers remains a challenge. Among the Aboriginal youth in this review, fewer than half were in an Aboriginal placement and, on average, less than half of their total time in care was in an Aboriginal placement. Delegated Aboriginal Agencies provided service in 33 per cent of cases. The Representative encourages ongoing work to better support cultural continuity for Aboriginal children and youth, and preservation of their Aboriginal identity.

Placement of Aboriginal children with Aboriginal caregivers is important in order to foster identity and cultural continuity. Recruitment and retention of Aboriginal caregivers to enable such placements is a goal that remains unmet. Addressing this issue will require supporting Aboriginal families and communities in reconciling past trauma and developing specialized skills.

It is important to note that for all of the Aboriginal youth who were involved with the system but were not in care, community and family members were involved in case planning. This is an important and necessary component of maintaining cultural continuity and family ties for Aboriginal youth. The current review did not assess whether the family and community participation in planning was meaningful. That would require extensive consultation with family and community members, which was not within the scope of this aggregate review.

With respect to CPOCs, a current plan was on file in only 69 per cent of cases reviewed for this report. This is a situation that must improve. In future months, the Representative will report on an audit of plans of care that will provide an in-depth picture of compliance with standards.

The Representative is encouraged that youth were meeting with their workers on a regular basis – at least once per month in addition to times of significant life events. However, given the profound challenges faced by this group of youth, the Representative believes that more frequent contact may be prudent and, in at least one way, improve stability in the lives of these youth.

Seven of the youth in this review were on Youth Agreements. Two aspects of relevant standards were reviewed – referrals to services and ongoing monitoring of the youth. In all of the cases, workers provided youth with referrals to services and engaged in ongoing monitoring of the youth. These two practices can be important to support youth to make better judgments and encourage healthy and positive decision making.



There were also high levels of adherence to practice standards for planning and assessment of youth in community youth justice as well as youth custody and youth forensic services.

In terms of CYMH services, 90 per cent of the youth were formally assessed and, of that group, 91 per cent were attending at least some of their appointments with service providers. The nature of this review does not allow for evaluation of those services.

Even when youth were successfully engaged in services, attendance tended to be spotty. Does this mean that the services were not well-matched to the individual youth? Or does it simply demonstrate that adolescents require more personal support to engage and attend when they are in despair?

Although that cannot be determined on the basis of the data in this review, the friendliness of – and ease of access to – support is a question of great interest to the Representative. Fuller engagement in services can only lead to improved outcomes. An evaluation of services to youth such as those in this review will be an important foundation for service design in the future.

### Supporting High-Risk Vulnerable Youth

**Finding:** *It is not possible to conclude whether these deaths and critical injuries were preventable. Even with the highest quality interventions, not all outcomes will be positive. These youth had multiple challenges in their lives, and most of them were extremely vulnerable from birth. Many of them also experienced a significant adverse event in adolescence, compounding their vulnerability. The opportunity is there to promote better practice to address trauma, as outlined below.*

The Representative has heard through her advocacy work that youth who are, or who have been, in care are profoundly hurt and traumatized. They do not have the benefit of the personal and institutional supports they need to plan ahead for their transition into adulthood and improve their mental health. Observations from this review suggest that innovative ways need to be found to shift from episodic, crisis-based approaches to approaches that provide stability and continuity, meaningful, nurturing relationships, and a sense of commitment to the youth that spans years.

These youth had highly disrupted lives, characterized by early losses and wrenching instability. Services did not address the tremendous trauma they had experienced and opportunities to promote recovery from trauma, when these youth first came to the attention of the system, were missed. As a result, they did not have the benefits most children enjoy – the stability and the role models that support positive development. Nor did they have the skills or opportunities to advocate for what they needed.

We know from research that adverse, traumatic childhood experiences, similar to the abuse and neglect experienced by the youth in this study, can lead to significant health consequences as children become adults. An emerging movement aimed at reducing the effects of trauma is the ‘trauma-informed systems’ perspective – one that has gained



traction at the federal level in the U.S. Administration on Children, Youth and Families. This is a relatively new field of study, but it shifts the treatment focus of practitioners from the problematic behaviour of the child, to the traumatic events they experienced and the ensuing implications for intervention. Conradi and Wilson (2010) describe a trauma-informed system as:

...a wider system impacting children and families, with multiple components designed to meet the varying needs of traumatized individuals who are receiving services. These include collaboration across service agencies...partnership with youth and families receiving services, knowledge and understanding of trauma and its symptoms, and supporting the workforce in trauma work (p. 622).

Conradi and Wilson suggest 12 key components of a trauma-informed system:

1. Individual and organizational knowledge that trauma is pervasive and includes numerous short-term and long-term effects.
2. Trauma-specific screening and assessment.
3. Integrating the use of evidence-based and evidence-supported trauma-focused treatment and ‘core components’ of trauma treatment.
4. Safe, nurturing and predictable social environment, including psychological safety.
5. Helping children build attachment and relationships.
6. Partnership with youth and families receiving services.
7. Training and self-care for practitioners/front-line workers to prevent secondary trauma and burnout.
8. Treating the entire person.
9. Interventions tailored to meet the individual needs of the child and family.
10. Strengths-based.
11. Cross-system collaboration.
12. Acknowledgement and incorporation of trauma-specific knowledge and thinking into local, provincial and federal policy.

Based on the information in the files of these youth, trauma was not a primary focus of service delivery. The components listed above are not evident in the ministry’s approach to children and youth, and it is clear that better outcomes will require a trauma-informed approach.

CYMH services are among ministry services that are sometimes called “voluntary” services. In other words, they are not statutory programs like child protection or youth justice. In British Columbia, we have a reasonably well-developed child and youth mental health system. However, the system of services can be difficult to navigate for youth and their caregivers, including ministry staff acting as guardians.

There is little systematic information available about CYMH services across the province. Have family-focused mental health strategies been developed for Aboriginal children and youth? Is the system sufficiently geared toward early identification and prevention? Are there barriers to access? Do these youth have strong caregiver advocates to help them get what they need? Do the services work to actively engage youth? Is there consistency of services from one community to the next, and across regions?

It is not always clear which youth are eligible for which services, and under what conditions they will be admitted. Is access to a service based completely on the willingness of the client? Will the service tolerate challenging behaviour? The answers to these questions are unclear.

It is also not clear what the outcomes are, overall, for youth with mental health challenges. The October 2010 joint report by the Provincial Health Officer and the Representative for Children and Youth, *Growing Up in B.C.*, noted that there is a lack of data both on the positive aspects of child mental health and on mental illness. In absence of this information, as well as a lack of solid information about effectiveness of services, it is impossible to draw conclusions about access to services, adequacy of services and outcomes.

In May 2012, MCFD released a three-year *Operational and Strategic Directional Plan*. It identifies CYMH services as one of its core service lines and identifies a key action of reviewing and undertaking a two-year action plan to strengthen CYMH. This provides an excellent opportunity for the ministry to develop a system of effective evidence-based services.

A significant re-focusing will be required, along with a commitment to invest the resources needed to meaningfully address the needs of highly vulnerable children and youth across the province. Targeted strategies will also be required to meet the special circumstances of Aboriginal children and youth and their families. The Representative looks forward to significant improvements in CYMH and will be monitoring and reporting on the implementation of the two-year action plan.

The information in this aggregate review provides important food for thought. It identifies a need to address trauma early on in the lives of children and to find approaches to services that will engage and benefit children and youth such as those described in this report. The Representative is in the process of conducting a review of CYMH, including input from youth, families and service providers, which will also provide important insights into required changes to services.

The Representative will issue a report on her review of CYMH services in the coming months, and at that time will make recommendations for required improvements. The results of the current review will help to inform that report.

Because the experiences of the youth described in this report call out for an urgent response, the Representative makes the following recommendation at this time.

## Recommendation 1

That MCFD address the need for trauma-informed services for children in care in its 2012–2013 action planning on strengthening child and youth mental health services.

### Detail:

The plan should include the following components:

- A thorough assessment of children when they are taken into care to identify patterns of trauma they may have experienced.
- Planning for services that will help them recover from that trauma.
- Triggering trauma-specific screening and assessment when significant life events occur, and a review of the plan of care in each such instance.
- Review of need for specialized therapy each time a plan of care is developed.
- Funding for enhanced services to meet these needs, including family-based interventions and therapies, accessible for children throughout the province.
- Clear strategies to reduce the number of moves and disruptions experienced by children in care.

The plan should be complete by March 31, 2013, with implementation beginning in fiscal 2013–2014.

## Domestic Violence

**Finding:** *Exposure to parental domestic violence was a prominent feature in the backgrounds of more than half of these youth. There is ample evidence of serious negative developmental consequences when children live in homes where domestic violence occurs.*

Domestic violence creates an atmosphere of anxiety and fear and it perverts power relationships within a family. For most children, the more they are exposed, the more they are affected by violence among their parents. Often abuse is not limited to the adults in the home. Children are often caught in the cross-fire during violent events between parents (Jaffe & Juodis, 2006). Direct injury to children may occur because children are trying to intervene in the violent event such as calling for help, or children are sometimes used by their father as a means of harming or threatening the mother (Edleson et al., 2003).

Domestic violence, like disruption and moves, leaves a child with emotional pain, deep stress, and sometimes physical trauma. In addition, domestic violence and child abuse often co-occur and this has consequences for children's development and outcomes (Moffitt & Caspi, 2003; Gewirtz & Edleson, 2007). The consequences of child abuse and exposure to domestic violence include:

- Emotional consequences such as isolation, shame, guilt, low self-esteem and fear.
- Psychological consequences such as post-traumatic stress disorder, anxiety and depression.
- Behavioural consequences such as eating disorders, teen pregnancy, school dropout, suicide attempts, delinquency, violence and substance use.
- Relational consequences such as insecure attachment, and poor conflict resolution skills (Herrenkohl et al., 2008).

Domestic violence also affects development of effective coping skills in young people. Most children who live in constant fear of triggering an explosion of violence learn that their own needs are not important, and they learn not to expect a calm and rational response if they do seek help. Jaffe and Juodis (2006) report that children who have lost a parent in a domestic homicide often blame themselves for perceived failure to protect their parent and this can show up in the form of suicidal thoughts and attempts.

Children exposed to domestic violence tend to develop insecure attachment, making it difficult for them to relate to people. These children also tend to have many placement changes, difficulties maintaining meaningful relationships, and difficulties expressing themselves (Kaplan, Black, Hyman & Knox, 2001). While these effects are common, some youth show resilience (Jaffe, 2003).

### Case Example

This Aboriginal youth died as a result of suicide. Her family had been involved with ministry child welfare services for approximately 10 years. Their first contact with the ministry was a result of domestic violence in the home and suicide attempts by the mother. The children were first removed from the mother's care when the girl was eight-years-old. The youth came into permanent care two years later. The children were returned to the mother a few years later, and the file was closed.

Approximately one year after the children were returned, several calls were received by the ministry over a six-month period regarding the children, including this youth having suicidal thoughts. She disclosed having been sexually assaulted by another youth. She received services from CYMH and community agencies and later was taken into care. After coming into care, she received services, including CYMH, other community-based services, and a one-to-one worker. She was hospitalized several times as a result of suicidal thoughts. The youth wanted to return home, but it was not safe for her because of domestic violence at home.

The youth engaged in self-harm behaviours such as cutting and burns to the body. She began using marijuana, crystal meth and alcohol. A mental health clinician also had concerns about the youth's escalating and intense thoughts of suicide. The youth was hospitalized for a drug overdose. Her use of street drugs increased and, according to file information, the psychiatrist declined to continue treatment. Later, the youth was referred for community support/transition services, detoxification, and a semi-independent living program, which included a counseling component. Several assessments were completed. The CYMH file was closed.

Shortly thereafter, the youth was hospitalized for a drug overdose. A few months later, the CYMH file was re-opened with a new counselor. The youth attended a residential treatment program, but shortly after died as a result of suicide.

MCFD conducted a comprehensive review. The review found that there were a number of committed individuals involved with the youth and that many appropriate and supportive services had been offered. The review also found that there were weaknesses in the assessment process in all areas, that there was a lack of collaboration between professionals and that critical information was not shared between program areas. The review found significant documentation gaps on the youth's guardianship file, indicating the social worker may not have been aware of some significant information. The review also identified a number of significant events in the youth's life that occurred just prior to the death.

The impact of domestic violence on parenting can be immense and there is support for the claim that the mother's ability to care for her children is often compromised when she is in a violent relationship (Appel & Holden, 1998, Kelleher, 2008, Levendosky & Graham-Bermann, 2000). The mother spends a great deal of emotional resources when resisting the violence; therefore, the provision of effective resources and supports at the right time can go a long way in helping a mother to adequately care for her children.

From file documentation, it does not appear that issues such as grief, loss or recovery from domestic violence are a primary focus of attention when children first come into the system, whether they are brought into care, or receiving support services while remaining in their homes. However, we know that the best chance of recovery and resilience comes with early identification, harm-reduction measures and interventions aimed at stopping cycles of abuse and violence.

For Aboriginal children and youth, additional trauma comes in the form of broken cultural and community ties.

### Fetal Alcohol Spectrum Disorder

As noted elsewhere, this review found significant documented evidence of substance use problems in mothers of youth requiring mental health services, and of youth with significant mental health and behavioural challenges. This review does not include data related to Fetal Alcohol Spectrum Disorders (FASD) because it was not typically referred to in the documents reviewed and there were no records of formal diagnosis. However, it is reasonable to assume that some, if not many, of the children and youth in this review were dealing with FASD since many of the challenging behaviours and cognitive limitations noted were consistent with the characteristics and symptoms of the disorder.

FASD includes a wide range of impairments to a youth's physical, mental, behavioural and learning capacity caused by the mother's consumption of alcohol during pregnancy. There is no single defining characteristic of FASD because the degree of prenatal exposure affects each child in unique ways. This has created challenges in assessment and has led to misdiagnoses and under-diagnoses because of the similarities to other mental health disorders, lack of trained professionals and limited resources, especially in remote areas.

Life is challenging for youth with FASD and it can be especially daunting for youth in care, who are often dealing with the traumatic early life experiences of being removed from their families, physical and sexual abuse and the resulting painful memories. These youth are of great concern to the Representative and she intends to focus her work on learning more about the system of supports and services for these children and youth in future reviews.

# Conclusion

This aggregate review is a first step to a better understanding of the circumstances of a specific group of highly vulnerable children and youth and the system of services and supports that works to keep them safe and help them cope. Although its scope is limited by the aggregate method and the nature of the information that is available in the youth's files, as the first such study of its kind in British Columbia, it makes an important contribution. It furthers our understanding and it raises compelling questions. Most importantly, it points out the critical need to collect the kind of outcome data that will give us the tools to assess whether meaningful improvements are being made.

Although this review is not a formal evaluation, it enables the Representative to make observations about the system of supports and services. It is abundantly clear that ongoing and persistent attempts were made by ministry staff to intervene and provide supports. Most of these youth were formally assessed and were in contact with social workers.

It is also abundantly clear that the system falls short of meaningfully addressing the depth of vulnerability and trauma in lives of children and youth such as these, or the intergenerational issues that permeate the lives of their families. When families face compounded challenges such as domestic violence, substance abuse, mental illness and poverty, they lack the means to take control over their environment. They lack the means to provide the stability and guidance their children need for optimal development.

When children wake up in countless different homes, always starting over with strangers, they lack the chance to form meaningful attachments. When we consider that this is often layered on top of a life experience of abuse or neglect, and countless social workers and service providers, the sense of despair that permeates this report is understandable.

In the coming months, the Representative will release a major review of CYMH services in British Columbia, and a formal audit of plans of care for children in care. In these reports, specific recommendations will address issues raised by this review. However, more urgent action is recommended in addressing pervasive trauma in the lives of children in care.





# Glossary

“**Aboriginal**” is a broad term which, according to the *Constitution Act* of 1982, includes the Indian, Inuit and Métis people of Canada. However, the term “Aboriginal” is generally more broadly interpreted as including people who are registered status Indians, non-registered Indians, Inuit and Métis. Non-registered Indians are generally people who self-identify as having Aboriginal heritage, but who are not eligible to be registered under the *Indian Act*.

**Child in care:** any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act*.

**Child protection report:** a report received about a child’s need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include: taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth, or conducting a child protection investigation.

**Child protection investigation:** a process of inquiring into or tracing through inquiry, collection of information, and interviews with parents, teachers, daycare providers, public health nurses, physicians, and extended family members to evaluate whether a child is in need of protection.

**Comprehensive Plan of Care:** an action-based planning tool for children in care, used to identify specific developmental objectives based on continuous assessments of the child’s evolving needs and the outcomes of previous decisions and actions. Care plans are completed by the child’s worker with the involvement of the child, the family, the extended family and Aboriginal community if the child is Aboriginal, the caregiver, service providers and significant people in the child’s life.

**Comprehensive Risk Assessment:** a process and document that describe the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. A Comprehensive Risk Assessment is completed whenever a child is found in need of protection.

**Delegated Aboriginal Agency:** through delegation agreements, the First Nations Director (the Director) gives authority to delegated Aboriginal Agencies, and their employees, to undertake administration of all or parts of the *Child, Family and Community Service Act (CFCSA)*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency and the level of delegation provided by the Director.

**First Nation(s)** is a term that became more common during the 1970s to replace the term “Indian.” While there is no legal definition for term “First Nation(s),” it is meant to describe those persons who are registered as “Indians” under the federal *Indian Act*.

**Hughes Review** (*The BC Children and Youth Review*): the 2006 independent review of British Columbia’s child protection system by the Hon. Ted Hughes, QC. It was a review that recommended the appointment of an independent Representative for Children and Youth.

**Initial Reportable Circumstance:** Initial written report of death, critical injury or serious incident provided by ministry front-line staff to the provincial director.

**Intake:** The process by which child protection reports and requests for service are introduced into an office. These reports and requests for service are assessed and assigned to social workers for follow-up.

**Reportable Circumstance:** The ministry’s Child and Family Service Standard 25 requires the reporting of serious incidents of children in care or receiving services. Serious incidents can include: injuries; deaths; allegations of mistreatment; allegations of criminal involvement; missing children or high-risk situations; or life threatening medical difficulties.

**Reviewable service:** any of the following designated services:

- (a) Services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*;
- (b) Mental health services for children;
- (c) Addiction services for children;
- (d) Additional designated services that are prescribed under section 29(2)(b) (e.g. health care).

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# Appendix A: Representative for Children and Youth Act

## Part 4 – Reviews and Investigations of Critical Injuries and Deaths

### Section 11 – Reviews of critical injuries and deaths

- (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for review under subsection (3).
- (2) For the purposes of subsection (1), the public body may and provide that information to the representative in time intervals agreed to between the public body and the representative.
- (3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to inform improvements to reviewable services or broader public policy initiatives.

# Appendix B: Documents Reviewed

## **Ministry of Children and Family Development**

- Family service files including electronic records
- Child service files including electronic records
- Resource files including electronic records
- File reviews and Comprehensive reviews
- Provincial office and Regional Director office records
- Reportable Circumstance reports
- Youth Justice files including electronic records
- Child and Youth Mental Health files

## **Healthcare**

- Hospital records
- MSP records
- Pharmanet records

## **Coroners Service**

- Kimble reports
- Pathology and toxicology reports
- Coroners reports

## **Education**

- School attendance records

**MCFD Legislation, Policy and Standards Documents**

- Aboriginal Operational and Practice Standards and Indicators (AOPSI)
- Child, Family and Community Service Act and Regulations (1996)
- Child and Family Development Service Standards: Child and Family Service Standards, November 2003
- Child and Family Development Service Standards: Child in Care Standards, November 2003
- Quality Assurance Standards
- Child and Youth Mental Health Service Standards (2006)
- Child and Youth Mental Health Suicide Risk Intervention Policy (2005)
- Community Youth Justice Programs Manual of Operations
- Violent Offender Treatment Standards and Guidelines
- Standards for Youth Support Services and Agreements
- Youth Custody Operations Manual
- MCFD Operational & Strategic Directional Plan 2012/13-2014/15

**Other Material References:**

Hughes, E. N. *BC Children and Youth Review: An independent review of BC's child protection system*. April 2006. Victoria, B.C.

## Appendix C: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry for Children and Family Development (MCFD) within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a Regulation outlines the terms of appointment of members of the Team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, child protection
- Policing
- Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and development disabilities
- Public health



### Multidisciplinary Team Members at the Time of This Review

**Dr. Evan Adams** – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation, and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

**Lucy Barney** – Lillooet Nation, RN, completed her Masters of Science in Nursing from the University of British Columbia, and is currently employed as a perinatal nurse consultant with the BC Perinatal Health Program. She is the vice president of the Native and Inuit Nurses' Association of BC, and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal health and she developed the braid theory which looks at the mind, body and spirit, and demonstrates a holistic view on health.

**Beverley Clifton Percival** – Ms. Percival is from the Gitksan Nation, and is a negotiator with the Gitksan Hereditary Chief's Office in Hazelton. She holds a degree in anthropology and sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator, and instructor at the college and university level.

**Jim Gresham** – Supt. Gresham is the superintendent and officer in charge of the RCMP E Division Major Crime Section. He has been a plainclothes investigator involved since 1991 in the investigation of crimes against persons, including homicides and historical unsolved homicides. He is a member of the E Division Major Case Management Committee, and an accredited Team Commander for the investigation of major crimes.

**Dr. Jean Hlady** – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

**Doug Hughes** – Mr. Hughes is currently the Provincial Director of Child Welfare for the Province of British Columbia. He has 26 years experience in child welfare as a child protection social worker, community development worker, community services manager, regional executive director and finally as an Assistant Deputy Minister. He graduated from the University of Calgary with Master of Social Work in 1992.

**Norm Leibel** – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service, who has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

**Sharron Lyons** – With 32 years in the field of paediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children’s Hospital, is past-president and current treasurer of the Emergency Nurses’ Association of BC, and is an instructor in the provincial Paediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

**Dr. Ian Pike** – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Paediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

**Dr. Dan Straathof** – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children’s Hospital, and assists the BC Coroners Service on an ongoing basis.

# Appendix D: MCFD Practice Standards

## Ministry Practice: Children in Care

When a child is brought into temporary or permanent care, the ministry assumes the primary responsibility for his or her growth and development. This is referred to as the ministry's guardianship responsibilities. Of the 89 youth in this review, 58 were in ministry care at the time of the incident that was reported to the Representative.

Specific practices and outcomes relating to seven practice standards for children in care were assessed. These focus on safety, planning, placement stability, and specific responsibilities with respect to Aboriginal children and youth.

### CIC Standard #5: Ensuring child's safety and well-being while in care

According to this standard, one of the ministry's primary responsibilities for youth in care is to keep them safe. When a youth is involved in a situation that threatens his or her safety or well-being, it is recorded as a Reportable Circumstance and tracked. This is an important aspect of guardianship because it calls attention to potential case management issues, or a requirement for additional supports or interventions.

In relation to this standard, the following relevant outcomes were observed at the time of incident:

- 32 per cent of the youth in care had more than one Reportable Circumstance, ranging from two to seven Reportable Circumstances.

### CIC Standard #1: Preserving the identity of an Aboriginal child in care

#### CIC Standard #2: Preserving service that respect a child's culture and identity

According to these two standards, ministry services provided to Aboriginal youth should nurture their Aboriginal identity and relationships with their people, support their current cultural practices and facilitate further exploration of their culture.

In relation to these standards, the following information was gleaned from the files:

- The Comprehensive Plan of Care (CPOC) identified services required to support the identity and cultural needs for 73 per cent of the Aboriginal youth in care.
- 41 per cent of Aboriginal youth in care were in an Aboriginal placement.
- On average, Aboriginal youth spent 37 per cent of their time in care in Aboriginal placements.
- 38 per cent of Aboriginal youth were served by an Aboriginal agency.

### **CIC Standard #9: Developing and maintaining a meaningful relationship with a CIC**

When children are in continuing care of the ministry, the ministry is their legal parent and guardian. Foster parents provide the day-to-day supervision and support of children and youth in care, but it is important for children and youth to have regular contact with their guardianship worker. The worker can assess the changing needs of the young person and plan accordingly, and hear updates on the status of their placement.

In relation to this standard, the following information from the files was noted.:

- 89 per cent of the youth were meeting regularly with their guardianship worker, e.g. at least once a month and for significant life events.

### **CIC Standard #11: Assessing and Planning**

Like all children and youth, children and youth placed into care have specific and unique needs across a wide array of dimensions, including physical health, education, and social development. Attending to these needs through the provision of appropriate services requires thorough assessment and planning. A Comprehensive Plan of Care (CPOC) is the mechanism the ministry uses to specify the types of services a youth requires to meet his or her developmental needs, and to track his or her progress. CPOCs should be updated every six months, or more often if needed.

In relation to this standard, the following information was found in the files:

- For the youth in care, 88 per cent had one or more CPOC on file.
- In 69 per cent of cases, the CPOC was current at the time of the incident that was reported to the Representative.

Based on the file information alone, an accurate assessment of compliance with the plan of care was not possible for the purposes of this review. However, the Representative is conducting a formal audit of plans of care using a larger sample, and will report the results of this audit in the future.

### **CIC Standard #12: Supporting and Assisting a Child With a Change in Placement**

The standard recognizes that a change in placement can be disruptive and detrimental to the development of a young person.

In relation to this standard, the file information yielded the following information:

- On average, the youth in care had been in care for half their lives and experienced, on average, 12 moves while in care.

### Ministry Practice: Child and Family Services

Child and family services are provided to families to support parents in raising their children, to assess the level and severity of risks to the children and develop a plan to reduce and mitigate risks that will allow children to remain in their parents' care, or to improve overall functioning.

For the 13 youth who were not in ministry care or entered into a Youth Agreement, but were receiving child and family services, four practice standards were assessed. These related to assessment, risk reduction planning, and assimilating the views of Aboriginal communities and families through various assessment and planning stages.

#### CFS Standard #18: Developing and implementing a plan to keep a child safe

When concerns regarding the safety and well-being of a youth are brought to the attention of MCFD and the youth is found to be in need of protection, workers need to assess the risks and strengths of a family and develop a plan to keep the youth safe. This can be accomplished through the use of a Comprehensive Risk Assessment (CRA) and a Risk Reduction Service Plan (RRSP).

In relation to this standard, the following information resulted from the file review:

- In 91 per cent of the files where the youth was found to be in need of protection, there was a completed CRA
- In 70 per cent of the same files, there was a current RRSP on file.

#### CFS Standard #2: Children and families from Aboriginal communities

This standard is designed to incorporate the views and opinions of the family and community of Aboriginal youth with respect to planning and support services in order to promote better outcomes for children and youth.

In relation to this standard, the following information was recorded in the files:

- For Aboriginal youth and their families receiving services at the time of the incident reported to the Representative, all of them had their community and family members involved with case planning.

#### CFS Standard #7: Support services to strengthen capacity

When the needs of parents and youth are brought to the attention of the ministry this standard suggests that workers offer services appropriate to the family's unique needs.

In relation to this standard, the following was recorded in the files:

- In all cases, these youth and/or their families had been offered services by the ministry at the time of the incident, including such services as parent-teen conflict mediation, drug and alcohol counseling/treatment or respite care.

### **Ministry Practice: Youth Agreements**

Youth Agreements are an option for youth ages 16 to 19. A Youth Agreement (YAG) is an alternative to bringing youth into care with the goal to assist youth in achieving independence, or to provide a means of support and ensure safety and well-being while efforts are underway to return a youth to the family home. Seven youth were on Youth Agreements when the report was made to the Representative.

#### **YAG Standard #5: Assessing for and Providing Short-Term Supports**

##### **YAG Standard #6: Assessing for Longer-Term Service**

Short term safety plans are intended to meet a youth's immediate basic needs while further assessment, service planning and the potential for family reintegration is explored. Longer-term service planning begins once a youth service worker has attended to a youth's immediate needs and safety concerns.

In relation to these standards, the following information was noted in the files:

- All the youth under a YAG at the time of incident had received both an immediate assessment and, later, a longer-term assessment.

##### **YAG Standard #8: Longer-Term Service Determinations and Planning**

Based on the outcomes of the planning and assessment stages, youth service workers are to make referrals and organize supports that will meet the youth's identified needs.

In relation to this standard, the following information was noted in the files:

- All the youth under a YAG at the time of incident had been referred to service and support providers, and there was evidence on the file to indicate they were attending.

##### **YAG Standard #14: Monitoring a YAG**

Because YAGs are used with high-risk youth, they typically require frequent face-to-face meetings to monitor how well a youth is doing.

In relation to this standard, the following information was noted in the files:

- In all cases, workers were physically checking on the youth at least once a week.

### Ministry Practice: Youth Justice

Community Youth Justice provides a range of community-based services to meet the needs of youth who are alleged to have committed a crime, but who have not been sentenced to custodial care. These services are designed to promote an increase in law abiding behaviour and help contribute to public safety. Twenty-three youth in this report had Community Youth Justice involvement prior to the incident that was reported to the Representative.

#### Policy: Section D – 2.12 Assessment and planning

To provide the appropriate community-based services for youth, probation officers complete a Youth Community Risk and Needs Assessment and develop a Supervision Plan in conjunction with the youth. The assessment and planning describe the services youth are required to attend as part of their supervision in the community.

In relation to this standard, the following information was recorded in the files:

- In 87 per cent of cases, probation officers had completed multiple Youth Community Risk and Needs Assessments and Supervision Plans.

Youth Custody Services are specialized facilities that house and service youth offenders who have been court ordered to serve time in custody, or for youth who are required to remain in custody while they await their court appearance. Fifteen youth in this report had previously been involved with Youth Custody Services.

#### Policy: Section I – 5.02 Assessment and planning

To provide the appropriate services for youth who are in custody, case managers complete a Community Risk and Needs Assessment and develop a Supervision Plan in conjunction with the youth. The plan describes the services youth are required to attend as part of their rehabilitation and reintegration in the community.

In relation to this standard, the following information was recorded in the files:

- In 87 per cent of cases of youth who were detained in custody centres, there were multiple Youth Community Risk and Needs Assessment case plans on the file.

Youth Forensic Psychiatric Services provides inpatient and outpatient assessment and select treatment services for youth involved with the youth justice system. When a youth is charged with a criminal offence, a judge can order a medical, psychiatric or psychological report. The collection of these reports forms a forensic assessment, a comprehensive evaluation of a youth and his or her family and social background. The results of the assessment are submitted to court and can be shared with other professionals working with a youth for which it may serve an important part in formulating ongoing treatment plans. Sixteen youth in this review were ordered to receive a forensic assessment.

There are only a few general standards governing the administration of a forensic assessment. The Representative's interest here is in determining whether or not a court-ordered forensic evaluation was carried out.

In relation to this, the following information was recorded in the files:

- All but one<sup>10</sup> of the youth ordered to undergo a forensic assessment were assessed.

### **Ministry Practice: Child and Youth Mental Health**

Child and Youth Mental Health (CYMH) services are offered throughout B.C. to help treat a wide range of mental health issues using a variety of treatment methods.

They are offered to children, youth and their families, and participation is voluntary. Prior to the incident that was reported to the Representative, 62 of the youth had involvement with CYMH.

#### **CYMH Standard #5 - Policy B-4: Mental Health Assessments**

#### **CYMH Standard #6 - Policy B-8: Treatment**

CYMH follows a basic referral-assessment-treatment model with workers using evidence-based treatment methods. Youth and their families can voluntarily seek service. They can also be referred to services by community health professionals or social workers. Upon initiating contact with CYMH, cases are prioritized in terms of urgency of need for service in relation to the other youth seeking service and they are either seen immediately or placed on a wait list.

In relation to these standards, the following information was noted in the files:

- 90 per cent of youth who were referred were formally assessed.
- 91 per cent of youth who were assessed attended some of their allotted sessions.

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<sup>10</sup> The examination could not be completed due to the youth's sporadic attendance.



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