MANDATORY REVIEWS INTO CHILD DEATHS

APRIL 1, 2018—SEPTEMBER 30, 2018

ocya
OFFICE OF
THE CHILD AND
YOUTH ADVOCATE
ALBERTA

MARCH 2019

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THE CHILD AND
YOUTH ADVOCATE
ALBERTA

Under my authority and duty as identified in the *Child and Youth Advocate Act* (*CYAA*), I am providing one report encompassing the mandatory investigative reviews regarding nine young people who passed away between April 1 and September 30, 2018.

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

In accordance with the *CYAA*, Investigative Reviews must be non-identifying. Therefore, the names used in this report are pseudonyms (false names). Finding an appropriate pseudonym can be difficult, however it is a requirement that my office takes seriously and respectfully. Whenever possible, family members were consulted to determine pseudonyms.

In reviewing the circumstances of nine young people who passed away over this six-month period, I am struck by the grief that those closest to them feel. Their circumstances vary and to their loved ones, my deepest and heartfelt condolences.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

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INTRODUCTION

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act* (*CYAA*).

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

Mandatory Reviews of Death

On March 30, 2018, the *Child Protection and Accountability Act* (also known as Bill 18) was proclaimed and embedded into the *Child and Youth Advocate Act* under Section 9.1 - Mandatory review of death. It expanded the mandate of the Child and Youth Advocate (the "Advocate") to publically report on the death of a young person involved with Child Intervention Services, who was identified as a child in need of intervention at the time of their death, or within two years of their death.

The Advocate is required to release a public report within one year of notification of a young person's passing. The purpose of the report is to relay the young person's experiences with government systems, identify whether services and supports were appropriate, provide public assurance, and identify systemic issues that might have been present. The Advocate comments on findings, observations and/or makes recommendations that may help prevent similar incidents from occurring in the future. The Advocate has decided that these Mandatory Reviews will be released twice a year (March and September).

The investigation process includes reviewing child intervention, health, and education records, and informing and involving family members, caregivers, and professionals, consultation with experts, and for First Nation and Métis young people, with Elders.

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

- specific enough that progress made on recommendations can be evaluated; yet,
- not so prescriptive to direct the practice of Alberta government ministries.

It is expected that ministries will take careful consideration of the recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children involved with the child intervention system.

EXECUTIVE SUMMARY

Between April 1, 2018 and September 30, 2018, the Advocate received notification of the deaths of eleven young people who passed away. They were identified as children in need of intervention and were receiving child intervention services at the time of their death or within two years of their death, meeting the criteria for a mandatory review by the Advocate. A police agency or the Crown Prosecution Service requested stays (put on hold) on two of the eleven notifications.

This report contains nine separate and distinct Investigative Reviews. Each includes a history of the young person's involvement with government systems, individual findings, observations and/or recommendations.

The Terms of Reference for the Reviews were established and are provided in Appendix 3. The list of experts and Elders who were consulted is provide in Appendix 2 and the Glossary of Terms for definitions used throughout the Reviews is provided in Appendix 1.

1. 3-Month-Old Sophia

Sophia was three months old when she passed away. She was receiving Child Intervention Services through a Custody Agreement and placed in a foster home when she died. She was found unresponsive in her crib. The Office of the Chief Medical Examiner continues to complete their report (as of February 21, 2019).

The Advocate found that Sophia had additional needs because she was affected by her mother's substance use during her pregnancy. Infants, like Sophia, require additional supports to have their needs met.

The Advocate is making **one recommendation:**

Recommendation

Child Intervention Services should review and revise their policies so that the additional needs of substance-affected infants are identified and appropriate resources are provided.

2. 6-Month-Old Russell

Russell was six months old when he passed away in his parents' care. He was receiving Child Intervention Services through an Enhancement Agreement when he died. The Office of the Chief Medical Examiner determined that Russell passed away from sepsis.

The Advocate found that Child Intervention Services' focus was on keeping Russell in his parents' care while not fully addressing safety concerns. There are no new recommendations and an observation was made that Children's Services is strengthening their approach to safety decisions regarding vulnerable children under five years old. Further, the Advocate referenced previous relevant recommendations and expects their full implementation.

3. 4-Year-Old Steven

Steven was four years old when he passed away from medical complications from a pre-existing medical condition. He was receiving Child Intervention Services through a Permanent Guardianship Order.

The Advocate found that services and supports provided to Steven and his family met their needs. Caseworkers worked collaboratively with family and professionals so that Steven received the best care possible. No gaps in services and supports were identified.

4. 12-Year-Old Nova

Nova was 12 years old when she died by suicide. She had received Child Intervention Services through an Enhancement Agreement within two years of her death.

The Advocate found that Nova had complex mental health needs that were not addressed. Her mother did everything she could to keep Nova safe, however, supports and services were not adequate to meet her needs. It is difficult for families to navigate mental health services. Crisis interventions are mainly provided through emergency rooms at hospitals and are often not effective. Child Intervention Services provided support through an Enhancement Agreement which was helpful, but when Nova went to stay with relatives on a temporary basis, her child intervention file was closed.

The Advocate is not making any new recommendations. The following observations were made:

- It is important that children and families receive seamless services when they move between child intervention jurisdictions. Child Intervention Services' policy supports this.

- A review by Alberta Health Services and/or a public fatality inquiry would be beneficial because many questions remain unanswered – such as why Nova's child intervention file was closed; and, why the number of her visits to the emergency room were not flagged.

5. 15-Year-Old Andy

Andy was 15 years old when he died from fentanyl poisoning. At the time of his death, he was receiving Child Intervention Services through an Enhancement Agreement.

Andy was adopted by his foster parents when he was seven years old. For a number of years, they continued to foster and provide respite care. This resulted in a chaotic home environment. The high number of children in his home compromised the stable, reliable care that Andy needed and may have resulted in his exposure to chronic stress.

The Advocate is making **two recommendations:**

Recommendation

Child Intervention Services should include young people, who are living in a foster home, in the annual foster home assessment process.

Recommendation

Child Intervention Services should coordinate with Family Support for Children with Disabilities (FSCD) to implement a system that monitors the numbers of children placed in respite at any given time in a foster home so that young people receive the care they need. Numbers of children should not exceed a caregiver's capacity.

The Advocate also made a finding related to supporting young people. Services are improved when young people are involved in decision-making that affects them. Andy's caseworkers sought his perspective about his circumstances throughout their involvement. This was not extended to FSCD service provision nor the Supports for Permanency (SFP) program. The Stronger Safer Tomorrow Action Plan looks to improve disability and SFP services for young people. The inclusion of a young person's views in the supports they receive through these programs should be part of the implementation of the Action Plan.

6. 16-Year-Old Christine

Christine was 16 years old when she was struck by a car while crossing the street. She died from her injuries. Christine was receiving Child Intervention Services through an Enhancement Agreement when she passed away. She had complex mental health needs.

The Advocate found that supporting young people with complex mental health needs, mental health crisis services, accessing and navigating mental health services, and family and community-based mental health care could be improved. While no new recommendations were made, prior relevant recommendations were referenced. The Advocate noted that there are many government initiatives related to mental health services and is hopeful that they will result in meaningful improvements for young people.

In addition, it was noted that caseworkers and professionals collaborated; a specialist was later involved with Christine and her family, assisting with systems navigation and bringing family and professionals together. This resulted in Christine's circumstances improving.

7. 16-Year-Old Darian

Darian was 16 years old when he passed away from injuries sustained in a motor vehicle accident. He was receiving Child Intervention Services through a Permanent Guardianship Order.

The Advocate found that Darian's circumstances would have been better if healthy connections were fostered when he was young. There was an observation that Children's Services is enhancing practice and amending policies and procedures to reflect the importance of family, connection, and belonging through a number of initiatives. This is promising and the Advocate will monitor their implementation and progress.

An additional finding and observation was related to the youth justice system. Darian was incarcerated a number of times and his negative behaviours often resulted in him being separated from his peers or his programming being suspended. These consequences should be short-term and address safety concerns. Meaningful, long-term interventions should be used that result in positive change for the young person and address the underlying cause of the negative behaviours.

8. 17-Year-Old Jaxon

Jaxon was 17 years old when he died by suicide. At the time of his death, Jaxon was receiving Child Intervention Services through a Permanent Guardianship Order.

The Advocate found that the importance of stable relationships and supportive environments are critical to a young person's well-being. An observation was made related to the complex decisions that caseworkers have to make and the support that they should have to make those decisions.

The Advocate is making **one recommendation:**

Recommendation

Child Intervention Services should provide financial and organizational supports for front-line staff to have immediate access to a variety of subject matter experts, as needed.

9. 18-Year-Old Faith

Faith was 18 years old when she died from a suspected drug overdose. She had received Child Intervention Services through an Enhancement Agreement with Guardian that ended within two years of her death. The Office of the Chief Medical Examiner continues to complete their report (as of February 21, 2019).

Faith's mother had cognitive delays and had difficulty taking care of her children. She received some supports from Persons with Developmental Disabilities (PDD) that did not help her with her parenting challenges. Her children missed a lot of school, resulting in Attendance Board intervention and court orders directing her to send her children to school.

The Advocate found that supporting parents with cognitive disabilities, enhancing school engagement, and providing services to youth could be improved.

The Advocate is making **one recommendation:**

Recommendation

Child Intervention Services should amend their policy so that an Enhancement Agreement with Youth can be used, in exceptional circumstances, to support young people who live with their guardians.

Information about recommendations, responses to recommendations and progress on implementation can be found at the following:

Previously released OCYA Investigative Reviews are posted at:
http://www.ocya.alberta.ca/adult/publications/investigative-review/

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

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

THE YOUNG PEOPLE

3-MONTH-OLD SOPHIA

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Prior to birth	Limited prenatal care Prenatal exposure to drugs and alcohol
Birth – 1 month old	Sophia and her mother lived in a parented group home Sophia taken into care Sophia's needs assessed within the normal range (Level 1) Sophia hard to settle
2 months old	Sophia's calories increased, prescribed medication Sophia's needs assessed at a moderate level, Support Plan required (Level 2) Sophia's mother had regular visits with Sophia
3 months old	Sophia passed away

ABOUT SOPHIA AND HER FAMILY

Sophia[1] was described as a beautiful baby who had chubby cheeks, brown eyes and lots of thick curly hair.

Her mother, Nicole, was a young mother of First Nation heritage.[2] She had a difficult childhood and was the subject of a Permanent Guardianship Order when she was 11 years old. Nicole struggled with addictions, was affiliated with a gang and had involvement with the justice system. She was living in an Indigenous group home for pregnant and parenting teens when Sophia was born. When Sophia was three weeks old, she was taken into care and placed in a foster home.

Sophia was three months old when her foster mother found her unresponsive in her crib. Emergency Medical Services (EMS) determined that she was deceased. At the time of her death, Sophia was receiving Child Intervention Services through a Custody Agreement.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Sophia from Birth to 1 Month Old

Child Intervention Services became involved with Sophia shortly after her birth. Nicole had limited prenatal care and used alcohol and drugs during most of her pregnancy. Sophia showed signs of drug withdrawal. She had tremors, frequently vomited and was hard to settle. Nicole struggled to focus on Sophia's needs and admitted that she had drugs delivered to the hospital.

Nicole returned to her group home with Sophia after they were discharged from the hospital. They had 24-hour supports. Nicole was very attached to her daughter and tried her best to meet Sophia's needs. She was open to advice and support from group home staff. She received additional supports that included an outreach worker and a family wellness worker.

Nicole continued to have contact with gang members. She said it was hard for her to stay away from her "street family" because they had raised her. Nicole talked about going to detox and treatment, but had urges to use drugs.

When Sophia was 26 days old, Nicole entered into a Custody Agreement and Sophia was placed in a foster home. Sophia's needs were assessed and she scored

1 All names in this report are pseudonyms.

2 Her father is unknown.

at a Level 1 on the Foster Care Placement Needs Scoring Chart, which meant that her needs were within a normal range and a Support Plan was not needed.

Sophia from 1 to 2 Months Old

Regular visits were scheduled for Nicole and her daughter, but Nicole's addictions affected her ability to see Sophia. However, when Nicole visited, she was attentive to her daughter. She spoke in soothing tones and told Sophia how much she loved her.

Sophia's foster mother said that taking care of Sophia was challenging. Her withdrawal symptoms included excessive, high-pitched crying, tremors, hyper-sensitivity to sound and light, she did not feed easily and did not sleep well. Tightly swaddling Sophia seemed to comfort her and she was more content when she was held. Sophia was not gaining weight and acid reflux caused her to vomit. Her pediatrician recommended increasing her calories and prescribed medication. Sophia's needs were re-assessed and she was classified at a Level 2 on the Foster Care Placement Needs Scoring Chart, which meant that her needs were considered to be moderate and a Support Plan was required.

Circumstances Surrounding Sophia's Death

Approximately three weeks after Sophia's appointment with her pediatrician, her foster mother found three-month-old Sophia unresponsive in her crib. Emergency Medical Services were unable to revive her. The Office of the Chief Medical Examiner continues to complete their report (as of February 21, 2019).

Sophia's mother and her foster parents continue to grieve her loss.

ABOUT THIS REVIEW

Sophia's death met the criteria for a mandatory review by the Advocate because she was identified as a child in need of intervention at the time of her death. Sophia was in government care through a Custody Agreement.

The purpose of the Advocate's mandatory review was to examine Sophia's experiences with government systems throughout her life, specifically looking at the services and supports she received.

Through the investigation process, we spoke with Sophia's family, caregivers and staff from Children's Services and Alberta Health Services.

Findings

Sophia was prenatally exposed to substances and had complex needs that required supports. Nicole was a young mother who was involved with child intervention from early childhood and used substances, which impacted her ability to take care of an infant. Nicole left the hospital with Sophia and returned to the group home. Group home staff were not involved in discharge planning and were unaware of Sophia's needs. Their role was to support Nicole and give updates to caseworkers on how mother and baby were doing. They were not responsible for Sophia's care and were concerned about how much day-to-day care they were providing. Discharge planning from the hospital for babies, like Sophia, is critical. It must involve all service providers and caregivers, so that each is aware of their roles and limitations, the child's needs, parental capacity and resources required.[3] This type of planning requires time and collaboration.

Public health nurses visited Sophia at the group home, however, information was not shared between group home staff and the nurses. It is unclear if public health was aware of Nicole's ability to parent a newborn or that she was using substances.

Nicole entered into a Custody Agreement and Sophia was placed in foster care because Nicole recognized that she was unable to take care of her daughter. Opportunities were missed to share information between staff at Nicole's group home and Sophia's foster parents about the severity of Sophia's withdrawal symptoms. This may have led to earlier identification and provision of additional supports to meet Sophia's needs.

3 Alberta Health Services (2018)

The Advocate made a recommendation in 2014[4] regarding information-sharing and collaboration for a timely response to meeting the needs of children exposed to drugs in-utero. Since March 2018, there has been no progress identified. More needs to be done to ensure that this recommendation is met.

In Alberta, it is estimated that that the number of babies affected by opioid withdrawal went up 75% between 2013 and 2017.[5] Caregivers report challenges caring for infants with prenatal substance exposure that include irritability, inconsolability, and difficulty with feeding, settling, being soothed, and sensory sensitivity.[6]

When Sophia was taken into care, her foster parents talked to her caseworker about excessive, high-pitched crying, tremors, hyper-sensitivity to sound and light, and that Sophia was not feeding or sleeping well. They swaddled her, had skin-to-skin contact and kept her in an environment that was quiet and stimulant-free, which seemed to comfort her.

Alberta Health Services uses a Neonatal Withdrawal Observation Sheet that tracks a baby's progress and outlines symptoms to be aware of, such as poor feeding, excessive sucking and projectile vomiting. Tools that identify concerning behaviours or symptoms can clarify a child's needs and result in the provision of appropriate supports. A Foster Care Placement Needs Scoring Chart determined Sophia's needs and the necessary supports. The form has one reference to substance use/exposure and does not adequately address the needs of substance-affected babies, and the demands placed on their caregivers.

Recommendation

Child Intervention Services should review and revise their policies so that the additional needs of substance-affected infants are identified and appropriate resources are provided.

4 Office of the Child and Youth Advocate (April 2014)

5 Kaufmann (2018)

6 Marcellus, MacKinnon, Gordon & Shaw (2017)

Additional Comments

Caregivers require additional supports to meet the needs of substance-affected infants. These babies are usually more difficult to care for than those who are not affected by prenatal substance use. Supports for their care should be reflective of their specific needs. The Foster Care Placement Scoring Chart is used to assess the needs of children placed in foster care. Expansion of this tool to include withdrawal symptoms will help to identify the unique needs and required supports for infants impacted by in-utero substance exposure.

Expected Outcomes

- The needs of substance-affected infants are appropriately assessed.
- Substance-affected infants receive timely and adequate supports tailored to their individual needs.
- Substance-affected infants will have fewer placement breakdowns.

6-MONTH-OLD RUSSELL

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 2 months old	Intake; Assessment; family violence
3 months old	Russell discharged from hospital to his mother's care Russell missed pediatrician appointment Russell seen by pediatrician, concerns raised about weight loss and follow-up requested Concerns reported that his mother used substances while caring for Russell Concerns that Russell missed two consecutive appointments with Public Health Nurse to be weighed
4 months old	Russell admitted to hospital in respiratory distress X-rays showed multiple bone fractures Russell discharged to his father's care with Safety Plan not to be alone with his mother Enhancement Agreement
5 months old	Police investigation unable to determine who injured Russell Russell back in hospital for respiratory concerns Multiple contacts with parents stressing importance of working with medical team
6 months old	Russell discharged to his father's care Russell missed two pediatrician appointments Parents reconciled and stayed with maternal grandparents Concerns received about missed appointments with pediatrician and Public Health Russell missed pediatrician appointment Russell passed away

ABOUT RUSSELL AND HIS FAMILY

Russell[7] had chubby cheeks, dark hair and dark eyes. His birth was premature and he had a number of medical concerns. He was Bridgette and Robert's only child. Russell had two older brothers (two-year-old Randy and four-year-old Adam). The family lived on-reserve and did not have their own home. They stayed with various relatives.

Russell was six months old when he passed away while in his parents' care. At the time of his death, Russell was receiving Child Intervention Services through an Enhancement Agreement.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Government Systems Involvement Prior to Russell's Birth

Prior to Russell's birth, Children's Services received two reports from another province regarding family violence between Bridgette and Joseph (Randy and Adam's father). Bridgette's grandparents brought her and her children to their home on-reserve and child intervention involvement ended. Bridgette and her children were not able to stay with her mother (Sally) because of Sally's substance use issues.

Russell from Birth to 3 Months Old

Russell was born with complex needs and he remained in hospital for three months. His immune system was weak, and he required morphine to help him withdraw from pre-natal drug exposure. While in hospital, his parents had minimal contact with him.

When Russell was approximately one month old, Child Intervention Services received a report regarding his parents' drug use, their lack of contact with Russell in hospital, and the safety of his brothers (who were toddlers). Bridgette said her grandparents took care of Adam and Sally took care of Randy. Bridgette was referred to an addictions program, but she did not go and later said that she and Robert were not interested in additional information about addictions programming.

Russell's medical team asked that Bridgette and Robert be at the hospital six to eight hours a day to learn how to care for Russell. They received funding for accommodations and meals. They did not visit daily and when they visited, it was often at night for short periods of time.

7 All names in this report are pseudonyms.

When Russell was approximately two months old (and still in hospital), police were called to his parents' hotel room. Robert was high on drugs; he had repeatedly punched Bridgette and trashed their room. Randy was present during the assault and Adam's whereabouts were not known. Bridgette refused medical attention. She and two-year-old Randy were moved to another room for the night and an arrest warrant was issued for Robert.

Approximately two weeks later, there was a family meeting to plan for Russell's discharge from hospital. His family was unable to make a plan for his care. Although Bridgette's grandparents were supportive, they were not able to care for Russell full-time. A second meeting was scheduled, but did not happen because of an illness in the family, and then Bridgette missed a subsequent meeting with caseworkers.

Russell's medical team wanted Bridgette to spend time with him to learn his feeding and medication routine. The day before he was to go home, caseworkers found Bridgette and took her to the hospital. Three-month old Russell was discharged to his parents' care and the family went to stay with Sally. Shortly afterward, Robert moved to his father's because there were a number of adults who drank, used drugs and smoked at Sally's. Bridgette, Russell and Randy remained there. Adam stayed with his great-grandparents.

Over the next week, caseworkers met with Bridgette and Russell twice. Bridgette said that her mother helped take care of Randy, but was not comfortable taking care of a baby. Caseworkers confirmed that Bridgette had transportation to take Russell to his pediatrician appointment, but she did not take him. The appointment was rescheduled. When the pediatrician saw him, there were concerns about his low weight, so follow up appointments with public health were recommended. Child Intervention Services received concerns about the condition of Sally's home that included problems with the plumbing and an infestation of bed bugs and cockroaches.

Shortly afterward, a report was received that Bridgette used drugs while Russell was in her care. He had missed two consecutive appointments with public health. Additional concerns were received about Bridgette's drug use. File information did not indicate whether a referral was made for treatment.

Russell from 4 to 6 Months Old

The following week during a visit, Robert took Russell to the hospital because he was worried about him. Russell was admitted in respiratory distress and x-rays showed that he had multiple bone fractures. The police investigated, but were unable to determine the cause of his injuries.

Caseworkers received a report that Robert used substances and there was a warrant for his arrest.[8] The following day, four-month-old Russell was discharged to his father's care with a Safety Plan that Russell was not to be left alone with his mother. Bridgette and Robert continued to live apart and each entered into an Enhancement Agreement with a plan that they would work individually with a family support worker.

Two weeks later, five-month-old Russell was re-admitted to hospital with respiratory problems and weight loss. Caseworkers spoke with family members about the importance of working with medical professionals to ensure that his needs were met.

Russell was discharged to his father's care. Caseworkers were notified that Robert missed two pediatrician appointments and that public health workers had difficulty checking on Russell. Bridgette and Robert reconciled and stayed with Bridgette's grandparents. A third appointment was booked, but was also missed.

Circumstances Surrounding Russell's Death

Approximately one week after the third missed appointment, Russell's great-grandfather noticed that he was having difficulty breathing and Emergency Medical Services were called. Russell stopped breathing before the ambulance arrived and a relative began Cardiopulmonary Resuscitation. Russell passed away at home. Bridgette and Robert were with him.

Russell's brothers are in the permanent care of their great-grandparents who are their guardians. His family grieves his loss and his parents continue to struggle with addictions.

8 Related to previous assault on Bridgette.

ABOUT THIS REVIEW

Russell's death met the criteria for a mandatory review by the Advocate because he was identified as a child in need of intervention at the time of his death. His family was receiving services through an Enhancement Agreement with Guardian and he was in their care.

The purpose of the Advocate's mandatory review was to examine Russell's experiences with government systems throughout his life, specifically looking at the services and supports he received.

Through the investigation process, we spoke with Russell's relatives, and staff from Children's Services and Alberta Health Services.

Findings

Russell was a medically fragile infant whose health and physical condition required safe and consistent care. His parents struggled with addictions, violence, and homelessness. Research indicates that there is a strong association between parental substance use and a higher rate of child maltreatment,[9] especially for those children who require special care (i.e., extended stays in hospital because of medical conditions or born with Neonatal Abstinence Syndrome).[10]

Child Intervention Services received a report about Russell when he was approximately one month old and still in hospital. An opportunity was missed to engage immediately with his parents and relatives to address the domestic violence, addictions and housing issues prior to his discharge. Approximately two weeks before Russell left the hospital, caseworkers brought the family together to plan for his discharge. The issues of addictions, violence and homelessness remained unaddressed. An assessment of his relatives' ability to care for him and their means to do so was needed, but not completed.

The Advocate has made a previous recommendation in relation to training to strengthen critical thinking, risk-assessment and case-planning.[11] Although this recommendation has been met through various initiatives to enhance the analysis and assessment skills of frontline child intervention staff, this was an area of concern identified in Russell's circumstance.

9 Dawe, Harnett & Frye (2008)

10 Sidebotham et al. (2016)

11 Office of the Child and Youth Advocate (November 2014)

After his initial discharge to his parents, Russell's health and physical condition deteriorated and he had unexplained broken bones. He was then re-admitted to hospital and discharged twice to his father's care with a Safety Plan that they would live with Russell's grandfather and he would not be left alone with Bridgette. The cause of his injuries remained unclear.

Russell's parents did not follow through with medical appointments and family support workers were unable to connect or work with either Bridgette or Robert. The expectation remained that Russell's relatives would ensure his safety and well-being. A critical analysis and review of the Safety Plan, given the increasing risk factors including his parents' failure to work collaboratively with professionals, could have increased Russell's safety.

The Ministry of Children's Services implemented Signs of Safety in May 2014. This practice model creates safety networks by identifying a family's strengths and resources along with factors that may place a child at risk. When making safety decisions, caseworkers need support so that they are not making critical decisions in isolation. In Russell's circumstance, there was an overemphasis on his safety network ensuring his well-being without an adequate assessment of their ability to mitigate the risks.

For a Safety Plan to be effective, the family and all service providers must collaborate, have clear and ongoing communication, share information, and know their roles and responsibilities. The circle of safety for Russell included his parents, relatives, pediatrician, health nurse and family support workers. Although each was counted on individually as a protective factor, the group was not brought together. This type of collaborative work would have improved the services and supports Russell received.

The Advocate has made a previous recommendation that collaborative strategies should be in place for every young person receiving intervention services and must include regular case conferences.[12] Along with this, the Advocate has recommended that the changing circumstances of children and families be continually reassessed and reflected in planning.[13] Although these recommendation have been met, Russell's circumstance highlights the need for more work to be done.

Observation

Since Russell's death, Child Intervention Services released a practice directive aimed at supporting frontline staff and strengthening child intervention's approach to

12 Office of the Child and Youth Advocate (November 2014)

13 Office of the Child and Youth Advocate (June 2015)

safety decisions regarding vulnerable children under five years old.[14] The plan is to implement this directive into policy in 2019.

The Advocate is not making any new recommendations and expects that Children's Services fully implements previous recommendations.

14 Office of the Statutory Director, Children's Services, Directive - June 21, 2018

4-YEAR-OLD STEVEN

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 8 months old	Custody Agreement First heart surgery followed by cardiac arrest and medical interventions Multiple health setbacks followed by second heart surgery Discharged to a medical foster home In-home supports provided, including medical training
9 months – 2 years old	Additional health complications required hospitalizations Physiotherapy Home visits with his mother and grandmother Steven's grandmother became a kinship care provider Permanent Guardianship Order with Shared Caregiver Agreement Shared Caregiver Agreement Support plans for both family and foster parents
2 – 4 years old	Additional medical complications Hospitalized, third heart surgery delayed Physical, occupational, speech and language therapy Shared time between caregivers and regular supported visits with Steven's father Early intervention; Individual Program Plan developed Behavioural Consultant supported caregivers Speech and mobility improved Third heart surgery, complications followed by various medical procedures Steven passed away

ABOUT STEVEN AND HIS FAMILY

Steven[15] was described as a happy and energetic young boy. He loved music, singing, clapping and the colour pink. When sitting in the car, he liked to recite the names of everyone he loved. Steven had complex medical needs and was hospitalized for long periods of time.

Steven's parents (Carolynn and Kirk) were Métis and had two children together. His family was Catholic and their faith was important to them.

Stephen was four years old when he passed away because of medical complications related to a heart condition. At the time of his death, Steven was receiving Child Intervention Services through a Permanent Guardianship Order.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Government Systems Involvement Prior to Steven's Birth

Steven's mother (Carolynn) received the Assured Income for the Severely Handicapped (AISH) benefits because she was diagnosed with Cerebral Palsy and was developmentally delayed. Carolynn's mother, Mary, had adult guardianship of her.

Steven's father (Kirk) had criminal and child intervention involvement in Alberta and in another province because of domestic violence and alcohol use. He said that alcohol was a problem for him.

Steven from Birth to 8 Months Old

When Steven was born, Child Intervention Services received a report because of his significant medical needs. The matter was assigned to the Alberta Vulnerable Infant Response Team (AVIRT). His grandmother was unable to care for him because of his extensive medical issues and the financial implications. She was already caring for Carolynn, another child, and two grandchildren. Relatives were not able to help and Steven was taken into care through a voluntary agreement.

Steven had his first heart surgery within days of his birth. The following week, he went into cardiac arrest and required medical intervention.

A neuropsychological assessment found that Carolynn could not care for Steven without 24-hour support. She bonded with him and remained by his bedside during

15 All names in this report are pseudonyms.

his hospital stay. Carolynn found it hard to understand his medical needs or why she could not take care of him. Kirk had visits, but was asked to leave the hospital because of his alcohol use and aggressive behaviours.

Family Supports for Children with Disabilities (FSCD) was explored, but was not available because Steven was in the care of Children's Services.

Steven had medical setbacks that caused him to remain in the hospital longer than anticipated. Family members received medical training to meet his needs. When Steven was seven months old, he had his second heart surgery. Approximately two weeks later, he was discharged. Steven's family agreed to him being temporarily placed in a medical foster home. In-home supports were provided. A worker was medically trained to facilitate visits with relatives.

Steven from 9 Months Old to 2 Years Old

Following his second surgery, Steven had seizures, moderate right heart failure and illnesses that required hospitalizations. Doctors said Steven would likely be delayed because he had a lack of oxygen. He was fed through a feedline and had poor circulation.

Mary wanted to take care of Steven through kinship care so she could receive supports from Child Intervention Services. She and Carolynn wanted Steven home, but medical staff recommended that he stay in his foster home until he was two years old or had his third surgery.

When Steven was 15 months old, his health improved and he had his first visit at Mary's. Visits were supervised to support Steven's medical needs. He continued to improve and two months later, he was transported for visits with Mary without the need for medically trained drivers.

Steven's family consented to a Permanent Guardianship Order, which was granted when he was 17 months old. The Order provided reasonable access to his parents and Mary. A Shared Caregiver Agreement was made with Mary and with Steven's foster parents. Eventually, Mary was to have Steven in her care half-time.

Steven from 2 to 4 Years Old

When Steven was two years old, his health worsened. He needed the third corrective heart surgery, suffered a stroke, and his bones were weak. He was not a good candidate for surgery because of his low weight. He received physical therapy, speech and language therapy, and occupational therapy. Steven began having regular supervised visits with his father.

Mary had Steven in her care half-time while Carolynn also lived in the home. He went to an early intervention program where his educational needs were assessed and an Individual Program Plan was created. He began to speak and his mobility

increased. He also started to have some aggressive behaviours, so behavioural specialist supports were provided.

Steven tired easily because of his heart condition. He was hospitalized for two days before his third birthday because of a respiratory virus that delayed a scheduled heart procedure. When active, his shortness of breath became more noticeable.

By the time Steven was three years old, his ability to walk and talk improved. Approximately six months later, his heart surgery was delayed because of challenges that included an infection, low oxygen levels and a fever. Mary said she could not care for Steven full-time because of his medical condition.

Two months prior to his fourth birthday, Steven had his third heart surgery.

Circumstances Surrounding Steven's Death

After his surgery, Steven had ongoing complications that required significant medical intervention. He was routinely surrounded by family and caring professionals. Steven frequently pulled out essential medical lines, feeding tubes and scratched at his stitches.

As his condition worsened, medical staff considered a possible heart transplant or treatment in the United States. Caseworkers applied for Steven's passport and the Goals of Care form was completed. Approximately three months after being hospitalized for surgery, Steven passed away with his family and foster parents by his side.

Steven's death met the criteria for a mandatory review by the Advocate because he was identified as a child in need of intervention at the time of his death. He was receiving services through a Permanent Guardianship Order.

The purpose of the Advocate's mandatory review was to examine Steven's experiences with government systems throughout his life, specifically looking at the services and supports he received.

Through the investigation process, we spoke with Steven's relatives, caregivers and staff from Children's Services and Alberta Health Services.

Findings

Steven was a young boy who spent a significant part of his childhood in the hospital because of a rare heart condition. At birth, he was assessed and transferred to a specialized medical facility where he underwent life-saving heart surgery. Child intervention became involved because Steven's family was unable to meet his complex medical needs.

Steven and his family received exceptional care because services were specialized, collaborative, and focused on family connection. The Alberta Vulnerable Infant Response Team's involvement helped reduce confusion and streamlined communication between Child Intervention Services, Alberta Health Services and Steven's family. Research indicates that stakeholders who communicate and share information are able to provide caregivers with consistent messages. As a result, caregivers feel less overwhelmed and are not faced with competing demands from multiple professionals.[16]

Strong collaboration between service team members enabled timely and effective changes in Steven's planning. Family and professionals quickly identified and addressed new issues because they had ongoing and open communication. Medical training was given to service providers before Steven was discharged from the hospital.

When Mary was unable to care for Steven full-time, other relatives were explored. Mary spoke with professionals so she could make an informed decision between private guardianship and being a kinship care provider. When Steven was discharged from the hospital, he was placed with foster parents who specialized

16 Green, Rockhill & Burrus (2008)

in working with medically fragile children. The foster care support worker also had enhanced medical knowledge and experience. Steven's family later received services from a caseworker who specialized in supporting medically fragile children and their families.

The Permanent Guardianship Order was accompanied by an Access Order that maintained family connection. Staff who had specialized medical training transported Steven and supervised visits with relatives. Mary had a kinship care worker who made sure that she had the required supports to keep Steven safe.

Child intervention practices have become increasingly responsive to a child's need for stability, love, and strong bonds with family, community and friends. Abuse and neglect are traumatic, but separation from one's parents and family, along with changes in school, neighbourhood, and even culture, is now recognized as causing emotional scars. Reducing these secondary destabilizing losses while keeping children safe, is the goal of family engagement work.[17]

As his health improved, Steven spent more time with his family. His biological and foster family developed a strong relationship centered on Steven's well-being and happiness. Regular meetings often included both caregivers to ensure that they had the required information and support, and that Steven felt the least amount of disruption. Steven's caregivers knew he felt safe and loved because he told them when he was ready to return to the other's home. It is a testament to the bond that was created that when four-year-old Steven passed away, both families were by his side. His biological family chose to bury him in the same cemetery as his foster parents' relatives, despite it being hours away.

Observation

The Advocate recognizes the good casework practice evident in Steven's circumstance. This was the result of collaboration and information sharing between staff from Child Intervention Services, Alberta Health Services, the family and other professionals. Steven's biological and foster families received prompt support from specialized service providers and were involved in decision-making. They built a relationship that helped Steven feel loved and supported. His needs were the focus of service delivery and helped ensure that he had the highest quality of life possible.

17 Friesema, Barshaw, St. Pierre, Jann-Jordan & Tochiki (2013)

12-YEAR-OLD NOVA

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 9 years old	4 intakes No child intervention involvement for 7 years
10 – 11 years old	Intake; Closed with community referral Intake; Assessment; Enhancement Agreement Intensive therapy program (ITP) referral Nova taken to the hospital and discharged after a severe behavioural outburst that involved self-harm Enhancement Agreement Temporarily moved to her relatives Enhancement Agreement ended
12 years old	Nova died by suicide shortly after her 12th birthday

ABOUT NOVA AND HER FAMILY

Nova[18] was described as energetic, outspoken and artistic. She enjoyed the outdoors and sports; and, she loved animals and children. Nova was the younger of two siblings. Her parents (Fred and Monique) were of First Nation heritage and their children had Treaty Status. They separated when Nova was an infant. The children were raised by their mother and had visits with their father. They lived in a small city that had limited local resources.

Nova was 12 years old when she died by suicide. She had recently celebrated her birthday. Nova and her family had involvement with Child Intervention Services within two years of her death through an Enhancement Agreement.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Nova from Birth to 9 Years Old

When Nova was seven months old, Child Intervention Services received a report because Nova and her sibling were exposed to domestic violence and Fred's drinking. He was later arrested for impaired driving while one of his children was in the car. Child intervention involvement ended because Monique was the children's primary caregiver.

There was no child intervention involvement for the following seven years. During that time, Nova had anxiety and was fearful about being separated from her mother. Nova received mental health supports through Alberta Health Services.

When Nova was seven years old, she was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and anxiety. She was prescribed medication. Shortly before her eighth birthday, Child Intervention Services received a report that Nova was abused by a family member. The police were informed, the alleged perpetrator was charged, and his contact with Nova was terminated. Child intervention involvement ended.

Two years later, a report was received that Nova and her sibling were physically disciplined by Monique's boyfriend. The concerns were not substantiated and child intervention involvement ended.

18 All names in this report are pseudonyms.

Nova from 10 to 11 Years Old

Nova was in Grade 4 when Child Intervention Services received two reports about her self-harming behaviours—one incident at school was so serious she was taken to hospital by ambulance. Nova also had difficulty with peer relationships and said that she was bullied at school.

Nova was referred to an intensive therapy program (ITP)[19] that was about two hours away from her home. She was unable to use community mental health services until she had completed that program. Early Intervention Services provided supports for Nova prior to and during child intervention involvement, but support workers were inconsistent. Nova and her mother found it difficult to retell their story. Monique went to parenting courses to help her manage Nova's behaviours and she was advised to take Nova to the hospital if she was suicidal.

An older student asked 10-year-old Nova to send him inappropriate pictures of herself through social media. Her mother reported the incident to the police and a No Contact Order was put in place. Nova said that she continued to be bullied by him and other students. Caseworkers made a referral to a psychiatrist and the school psychologist. However, they were unable to provide services because they were providing therapy to the student who asked Nova to send the pictures. The school provided one-on-one supports to ensure her safety.

Approximately one month before Nova's 11th birthday, professionals suggested that Monique take Nova to an urban hospital for a psychological assessment. She was described as traumatized and impulsive; and, she threatened to harm herself and others. She was seen in the Emergency Department and sent home. Medical staff recommended that her medications be reviewed and that she change schools for a fresh start. A nurse practitioner in their home community managed Nova's medications and referred her to a new psychiatrist, also located some distance away. She was seen in-person for the first session and then by Telehealth for subsequent sessions. Her mother gave updates to the psychiatrist's office following any further incidents.

Nova from 11 to 12 Years Old

Nova finished Grade 5 in her new school. Although she saw a school psychologist, she continued to run away from school when she was upset. She did well over the summer holidays and went to two summer camps. She enjoyed being outside and spending time with her family. Nova saw a privately arranged psychologist while she waited for the ITP, but she did not share much. Her caseworker discussed Family Supports for Children with Disabilities (FSCD) services with Monique; however, the application was not completed.

19 The program provided play, individual, group and family therapy to children ages 3 to 17 who are dealing with trauma.

Shortly after Nova's 11th birthday, Monique entered into an Enhancement Agreement to help cover the cost of ITP and to reduce wait times.[20] A new caseworker was assigned. Monique was worried about having involvement with Child Intervention Services because it could impact her employment. She said that her family had experienced intergenerational trauma that impacted her ability to trust government services. Further, she felt judged because of Nova's mental health problems and sometimes felt socially isolated.

Nova returned to her previous school for Grade 6 because she felt more comfortable there. Support staff monitored her because she ran away when she was angry or upset, but this was not sustainable because of the cost. Her mother was asked to come to the school following any incident or to keep Nova at home afterwards.

Monique constantly worried about Nova (that she would run away or harm herself), which made it hard for her to sleep. Her employment was at risk because of her time away from work. She sometimes missed taking Nova to appointments because of the distance, her work schedule or Nova's reluctance to go. Child Intervention Services remained involved, providing in-home supports while Nova waited for the ITP to start. A referral was made for youth programs.

Monique told caseworkers that she felt overwhelmed and wanted to explore out-of-home placements. The situation was getting worse and she was unable to cope. Occasionally, Nova ran away, and at times, resisted her mother's efforts to bring her back. Nova's medications were adjusted and caseworkers suggested Monique look into the possibility of having Nova stay with a relative.

Approximately two months later, Monique told caseworkers that Nova was temporarily going to live with relatives (the Smith's) on a neighbouring First Nation. Shortly afterward, Monique received a letter informing her that child intervention involvement was ending three months early because Nova was not living in their jurisdiction. Nova was no longer prioritized for the ITP because her child intervention file was closed. It was suggested that Monique could access the following services:

- Child Intervention Services where Nova was temporarily residing;
- Family Support for Children with Disabilities (continue with the application);
- Community groups; and
- Early Intervention Services.

20 Children Intervention Services' had a contract with the service provider for spaces within their program, where the waitlist was shorter.

Monique contacted the child intervention office (as directed) and was told that her home community, where they had been receiving supports, needed to re-open their file.

Nova went to a new school where she was also bullied. After her move, communication was challenging because the Smith's did not have internet or a telephone. In addition, their family had experienced losses due to suicide. Nova saw the school psychologist twice. She returned home for visits and to access psychiatric services.

Within one month of moving, the police went to the Smith's home because Nova had intentionally scratched her arms at school and made them bleed. Monique arranged for Nova to go to the hospital and she met her there. After Nova saw the doctor, she was sent home with her mother. A referral to the Indigenous Health Liaison Worker was discussed, but not completed. Nova remained with her mother for two weeks over the school break and then returned to the Smith's.

Shortly afterward, Nova said that the bullying was getting worse and some incidents had become physical. She refused to name the students involved and said she thought about killing herself. Her mother took her to the hospital. While they were waiting to be seen, Nova asked why they kept going to the hospital because she "never got help."

A week later, school staff met with Monique to discuss a Safety Plan. A code word was identified that Nova could use when she was being bullied that allowed her to leave class and go to the principal's office.

Over a 14-month period, Nova went to the emergency room eight times. In addition, Monique went to over 80 meetings with various service providers regarding Nova's needs.

In the month before Nova's 12th birthday, she talked more frequently about killing herself and Monique asked the Smith's to keep a close eye on her. Nova lost weight, isolated herself, stopped talking about her worries and showed no interest in her hobbies.

Circumstances Surrounding Nova's Death

Shortly after her 12th birthday, Nova ran away from the Smith's. She told a younger relative that she wanted to die. A few hours later, she was found deceased. Nova died by suicide.

Monique did everything she could to get Nova the help she needed. Her family is heartbroken and those who knew Nova continue to mourn her loss.

ABOUT THIS REVIEW

Nova's death met the criteria for a mandatory review by the Advocate because she was identified as a child in need of intervention within two years of her death. She and her family had received intervention services through an Enhancement Agreement.

The purpose of the Advocate's mandatory review was to examine Nova's experiences with government systems throughout her life, specifically looking at the services and supports she received.

Through the investigation process, we spoke with Nova's relatives, caregivers and staff from the ministries of Children's Services, Education, Justice and Solicitor General, as well as Alberta Health Services.

Finding

Systems Collaboration and Navigation

Nova's exposure to early childhood trauma impacted how she viewed, trusted and reacted to her world. She struggled with peer relationships and said she was bullied, which turned physical (pushing). The response to the incidents at school often meant that Nova was isolated from other students and restricted to certain areas of the school. When Nova was upset, she ran away or hurt herself. Her mother had to pick her up from school when there was an incident and keep her home until there was a meeting.

Nova changed schools four times over ten months. There was open communication between the schools to ensure she had continuity in services. School staff collaborated with mental health professionals and some offered onsite mental health support. Despite open communication and collaboration with service delivery providers, the education system did not have the resources to meet Nova's needs.

When child intervention was involved, caseworkers played a key role in helping Monique navigate systems when she had difficulty accessing services for Nova. Child intervention involvement gave Nova priority on the waitlist for a contracted space in an intensive therapy program (ITP), and while she waited, she saw a psychologist who was funded through Indigenous Services Canada (ISC).

When child intervention involvement ended, Nova's services were significantly impacted and the services she had been receiving were terminated, including her priority on the waitlist for the ITP. Monique had to coordinate services on her own. This can be overwhelming for caregivers and significantly impacts work hours,

family relationships and caregiver well-being.[21] The challenges that brought Nova's family to seek help from Child Intervention Services remained unresolved when involvement ended. Continued child intervention involvement would have provided supports until Nova was connected to the appropriate resources.

Observation

Child Intervention Services has policy regarding children and families who move between jurisdictions. The policy states that families who move will continue to receive timely, seamless and culturally-appropriate services. The policy reinforces that every effort will be made to maintain continuity of supports and services.[22] Child Intervention Services should have remained involved to ensure continuity of services when Nova temporarily moved to her relatives.

Finding

Mental Health Services

Nova began having mental health challenges when she was seven years old. By the time she was ten years old, she hurt herself and talked about suicide. There were a number of service providers involved with her family, but they were fragmented and inconsistent. The resource that may have addressed her underlying trauma was unavailable because of lengthy wait times. A thorough psychological assessment in a specialized in-patient program would have provided a plan to meet her needs.

Nova was referred to a psychiatrist, and over a ten-month period, she was seen in-person once and then through Telehealth for subsequent appointments. When she went to live with relatives, it became more difficult because she had to travel to the health centre to access Telehealth. Tele-psychiatry has been approved for consultation, education, and training, but research is limited about the efficacy of tele-psychiatry for children and adolescents.[23]

Families can experience challenges when navigating systems, communicating with various professionals and accessing follow-up care. In times of crisis, it may be difficult for parents and caregivers to understand and retain information.[24] During Nova's last visit to an emergency room, Monique was offered the services of an Indigenous Liaison Worker, but this did not occur. This referral was promising because caseworkers were no longer involved with Nova and her family, and they felt comfortable receiving help from an Indigenous professional. Research

21 Suen, Fraser, Allen, Bercov & Scott (2018)

22 Alberta Children's Services (2018)

23 Roberts, Hu, Axas & Repetti (2017)

24 Suen et al. (2018)

indicates that culturally-appropriate supports embedded within the health care system improves access to care and outcomes for Indigenous people.[25] Nova and her family may have benefitted from the involvement of an Indigenous health care professional.

Emergency rooms across the province respond differently to young people with mental health concerns. Consideration should have been given to the number of times doctors saw Nova in the emergency room. In the 14 months before her death, she was taken to an emergency room eight times for self-harm and suicidal ideations. Her medication was changed and it was suggested that she either switch schools or keep the same routine for stability. Nova was not referred to services that may have helped, and she said that going to the emergency room was not helpful.

Observations

Outcomes for children and adolescents can improve if they receive timely mental health services. The prevalence of psychiatric disorders amongst young people in Canada ranges from 15% to 25%; one in five receive mental health services.[26] Access to services for people living in remote communities is more difficult because of the shortage of psychiatric expertise and mental health professionals. Gaps in service include lack of timeliness, geographical distance, and a continued shortage of child and adolescent psychiatrists for the number of young people in need.[27]

Alberta Health Services has initiatives to address lengthy wait times for mental health services.[28] A virtual outreach program that provides smaller regional hospitals access to pediatric specialists is being launched that will provide smaller regional hospitals access to pediatric specialists. One goal is to increase inpatient beds and specialist care.[29] A second initiative, in the planning stages, is a new mental health center for children and youth that will provide services to Edmonton and northern Alberta. Resources will include inpatient beds, specialized outpatient clinics and a mobile response team.

Jordan's Principle is another avenue used to address the gaps in publically funded health, social and educational programs for First Nation young people. Interim funding under Jordan's Principle would pay for a variety of services such as mental health, social work, personal support work, psycho-educational assessments

25 Dicker (2012); Foreman & Steward (2011) (as cited by Allan & Smylie, 2015)

26 Roberts et al. (2017)

27 Roberts et al. (2017)

28 Suen et al. (2018)

29 Alberta Health Services (October 1, 2018)

and respite care.[30] Nova would not have been involved with Child Intervention Services had these types of resources been available at the time. The Advocate looks forward to the full implementation of Alberta Health Services' initiatives and Jordan's Principle, so that children and families receive seamless and timely services.

Nova had mental health concerns from early childhood and began to talk about killing herself when she was 10 years old. Two years later, just after her 12th birthday, Nova died by suicide. Her mother worked tirelessly to get Nova the help she needed. Since 2014, the Advocate has made 15 recommendations regarding youth suicide. Although some progress has been made, more work needs to be done. When children, especially those as young as Nova, and their families reach out for help, child-serving systems must stop, listen and take action.

Nova's mental health issues were complex; services and supports did not meet her needs. A review of Nova's experiences by Alberta Health Services and/or through a public fatality inquiry would be beneficial because, in spite of the Advocate's investigation, many questions remain unanswered, such as:

- Why was her intervention file closed when she went to stay with relatives on a temporary basis?
- Why were the extensive number of emergency room visits not flagged nor followed up?
- Why were mental health services not provided through the school when Nova was 10 years old? She clearly required support and intervention because of incidents related to inappropriate pictures and bullying.

30 Assembly of First Nations (2018)

15-YEAR-OLD ANDY

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 8 years old	2 Intakes; 1 Assessment; 1 Apprehension 1 Foster home placement Permanent Guardianship Order Placed in Wilson Foster Home Adopted by Wilson Family
9 – 12 years old	1 Intake – closed 2 Intakes; 2 Assessments 3 Enhancement Agreements
13 – 15 years old	1 Intake; 1 Assessment; 2 Supervision Orders Andy passed away

ABOUT ANDY AND HIS FAMILY

Andy[31] was a young Métis man who was artistic, personable and athletic. He liked the outdoors and enjoyed family outings. Andy was part of a youth group and was close to his pastor.

Andy and his two siblings (Mary and Mathew) were adopted when he was eight years old. They had no further contact with their birth family after the adoption. Their adoptive family had two other children, whom Andy and his siblings grew close to. Andy's adoptive parents (Pat and Terry) separated during his teenage years.

Andy was 15 years old when he passed away from fentanyl poisoning. At the time of his death, Andy was receiving Child Intervention Services through a Supervision Order.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Andy from Birth to 8 Years Old

Child Intervention Services had no involvement with Andy in his first year. When his parents were unable to take care of him, he and his siblings stayed with their grandparents. Just before his second birthday, Child Intervention Services received a report regarding his parents' substance use. Andy remained with his grandparents and child intervention involvement ended. His parents separated and Andy later returned to his mother. His father lived and worked in another community, but continued to visit his children.

When Andy was three years old, Child Intervention Services received a report that his mother used drugs, the children were not fed, their medical needs not met, and their father had criminal charges. Their grandparents were unable to care for them, so they were taken into care and placed in a foster home. When Andy was three years old, he became the subject of a Permanent Guardianship Order (PGO).

Andy and his siblings moved to Pat and Terry Wilson's foster home when he was four years old. Andy was a happy child and laughed often. In school, he had difficulty following through on tasks, making friends and managing his emotions. At seven years old, he was assessed and diagnosed with Neurobehavioural Disorder (ND) Unknown Exposure to Alcohol.

31 All names in this report are pseudonyms.

Pat and Terry were active foster parents and members of a caregiver support group. Terry, whose first language was not English, learned to read along with Andy and the other children. Terry was a stay-at-home parent and Pat worked outside the home.

When Andy was eight years old, Pat and Terry adopted him and his siblings. Andy was happy about his adoption, but worried about his birth parents. Family Support for Children with Disabilities (FSCD) and Supports for Permanency (SFP) programs provided funding for child care and community aid workers.

The Wilsons continued to be active foster parents, and provided respite care for children with disabilities. Their home was described as chaotic because of the number of children needing intensive supports. At times, there were up to 12 children in the home. Pat eventually joined Terry as a stay-at-home parent to meet the needs of the children. Andy and his siblings were affected by the aggressive behaviours of the foster children and asked their parents to stop fostering.

Andy from 9 to 12 Years Old

Shortly before Andy's 10th birthday, Child Intervention Services received a report that he was severely disciplined by Pat for eating too much. Child intervention involvement ended because the incident had occurred a year earlier. There was no further involvement with the Wilson family for the following two years.

When Andy was 12 years old, a report was received that Pat was emotionally abusive - frequently yelling, calling the children names, and joking about their disabilities. A specialized placement assessment team determined that Pat and Terry could no longer care for foster children. They went to counselling and Pat worked with a family doctor to manage bouts of anger related to a medical condition. Andy said there was less yelling and chaos at home with fewer children living there. Child intervention involvement ended.

Andy from 13 to 15 Years Old

When Andy was 13 years old, Pat and Terry separated. Pat stayed in the home with the children. Pat's new partner (Blair) and daughter (Olivia) moved in. Terry had weekly visits. Andy became angry and confrontational because he did not like having Blair in the house.

Two months after Terry moved out, Child Intervention Services received a report that Pat was restricting food and hygiene products. The children were made to stay in their rooms for extended periods—sometimes up to 12 hours. It was reported that Pat yelled and called the children names and there were escalating arguments with Blair. Andy wanted to live with Terry, who struggled to find housing. Andy was connected to an Indigenous Support Worker at school. Pat and Terry entered into an Enhancement Agreement.

Two months into the Agreement, Andy was taken to the hospital after being physically aggressive during an argument with Blair. He said that he was blamed for things at home and he started stealing money to buy marijuana. He also had flashbacks and nightmares about abuse from his childhood which made sleep difficult, so he used marijuana to cope. Andy was admitted to the hospital and medical staff recommended follow-up by Child Intervention Services. He was subsequently transferred to a stabilization program.

While Andy was in the hospital, caseworkers suggested that he and the other children be voluntarily placed with alternative caregivers. After his discharge, Andy and three of his siblings went to live with Terry. There were concerns that Terry could not provide the supervision and structure the children needed.

Terry and Pat entered into another Enhancement Agreement together. Terry subsequently signed a third Agreement alone because Pat felt the supports were not helpful. Andy went to counselling, met with support workers and visited between his parents' homes. It was reported that Andy was tired because of the number of appointments and time spent travelling between residences.

By the time Andy was 14 years old, his drug use increased. He went to school, but was suspended after Pat reported that he had marijuana in his locker. Andy lost a close friend to suicide. He went to an addictions treatment program where he had sessions with a family therapist and met with a psychiatrist. His parents also met with professionals. While Andy lived with Terry, Pat often took the initiative to set up appointments and coordinate services. The family appeared to be doing well and child intervention involvement ended.

When Andy was 15 years old, he went to a residential addictions treatment program for two months. He liked the program, but was asked to leave early after hiding and selling his medication. Andy was told that he had to wait one year before he could return.

Two weeks after leaving treatment, Andy was taken to the hospital because he said that he intentionally harmed himself. He said he wanted to feel better, was confused, and did not know how to cope after breaking up with his girlfriend. Although he told medical staff that he took high doses of several medications, tests did not confirm any drugs in his system. Andy was admitted to an in-patient mental health unit. Three weeks later, he was transferred to a voluntary youth addictions program where he stayed for two weeks.

While Andy was in the hospital, Child Intervention Services received a report that neither of his parents could have him return to their homes because of his escalating behaviours. There were concerns about ongoing emotional abuse by Pat. Terry was diagnosed with Depression and Anxiety, which made parenting difficult.

Andy's parents felt he needed an out-of-home placement that could provide more supervision and support. His mental health team did not have any placement options and asked Children's Services to provide one. Caseworkers did not agree that Andy needed to be in a group home. A Supervision Order was obtained that stipulated the children were to live with Terry and that Pat would have supervised visits.

When Andy was discharged from hospital, he returned to Terry's. He went back to his addictions program and later to a specialized trauma counsellor whom he saw four times. His caseworker offered to take him to more appointments, but Andy did not want to go. He became more aggressive at home and did not go to school. Despite worries that his drug use was increasing, tests were negative for anything other than marijuana. His parents believed the test results were inaccurate. Around this time, Andy began to talk about wanting to reconnect with his birth family.

Five months into the Supervision Order, Andy was confined through the *Protection of Children Abusing Drugs Act* (*PChAD*) for 10 days. He did not want to go to a voluntary treatment program when he was discharged. Terry missed the deadline to have the Order extended and worried about Andy's return home. He needed more supervision than his parents could provide. Caseworkers suggested that Andy could go to a youth shelter or work with a support worker to settle him when he was discharged. Terry did not agree with either option and Andy returned home without supports.

Circumstances Surrounding Andy's Death

Two weeks after leaving the *PChAD* facility, 15-year-old Andy was found at home, unresponsive. Emergency Medical Services (EMS) and police were called; he was pronounced deceased. Andy died from fentanyl poisoning. A celebration of Andy's life was held and many friends, family, church members and professionals who worked with him were there. They continue to grieve his loss.

ABOUT THIS REVIEW

Andy's death met the criteria for a mandatory review by the Advocate because he was identified as a child in need of intervention at the time of his death. He and his family were receiving intervention services through a Supervision Order. Andy was in his parents' care when he passed away.

The purpose of the Advocate's mandatory review was to examine Andy's experiences with government systems throughout his life, specifically looking at the services and supports he received.

Through the investigation process, we spoke with Andy's relatives, caregivers and staff from Children's Services, Family Support for Children with Disabilities, and Alberta Health Services.

Finding

Assessing and Supporting Caregivers

Chronic stress and poor child-parent relationships have a negative impact on the physical health, future cognitive abilities, and behaviour of children.[32] To ensure that young people receive safe and nurturing care, it is important that caregivers have the supports necessary to address risk factors associated with their own stress. Identifying when caregivers need additional support is critical.

At times, the Wilsons failed to report incidents of physical and verbal aggression, and refused in-home supports. Lack of self-reporting and refusal to access supports can be warning signs of increased stress and compassion fatigue.[33] Professionals working with young people and caregivers need to be able to recognize the signs associated with chronic stress and the coping behaviours exhibited by caregivers.

To manage the stress associated with fostering children, foster parents are expected to use their personal health benefits plan to pay for counselling. Some may not have benefits that provide this type of coverage. Given the nature of compassion fatigue and chronic stress, it would be beneficial if these types of resources were funded by Children's Services, when needed, to preserve positive parent-child relationships.

Andy's parents fostered many children during his childhood. Foster homes are assessed annually. Currently, the tools used to assess the functioning and well-being

32 Kalil (2015)

33 Zalewski, Thompson & Lengua (2017)

of foster parents rely on caregiver self-reporting and information from foster care support workers and caseworkers. It is not a requirement to involve young people, who are living in a foster home, in the annual assessment process. Child Intervention Services is currently reviewing the Foster Care Annual Assessment Forms.

At times, there were up to 12 children in the Wilson's foster home. This included Andy, his birth and adoptive siblings, foster children and children in the home for short-term respite care both through child intervention and Family Support for Children with Disabilities (FSCD). The demand on their parenting abilities was significant.

The high number of children in the Wilson home compromised the stable, reliable care that Andy needed and may have resulted in his exposure to chronic stress. Andy wanted his parents to stop fostering because his home environment felt chaotic. Foster parents who adopt, sometimes continue to foster. Caseworkers need to consider the increased number of children in their assessment of a foster parent's capacity when deciding to place more children in the home.

Currently, the licensing process for foster homes does not take into consideration the number of biological children, adoptive children and children receiving respite from other programs in its count of children placed in a home. In addition, Child Intervention Services and FSCD do not track the number of children in respite care in one home at any given time. These factors can result in foster parents being challenged to meet the needs of each child in their care.

Recommendation

Child Intervention Services should include young people, who are living in a foster home, in the annual foster home assessment process.

Recommendation

Child Intervention Services should coordinate with Family Support for Children with Disabilities (FSCD) to implement a system that monitors the numbers of children placed in respite at any given time in a foster home so that young people receive the care they need. Numbers of children should not exceed a caregiver's capacity.

Additional Comments

The involvement of young people in the annual assessment process may vary depending upon their age and/or ability. The 2019 amendments to the *Enhancement Act* addresses the need to include the viewpoints of children and youth in matters that impact them.

Respite care is important to support both caregivers and young people to maintain positive parent-child relationships. There is benefit to knowing how many children are in one home at any given time so that young people continue to receive quality care while caregivers provide respite services. This should include the overall number of children living in the home.

Expected Outcomes

- Young people will have a say in the care they receive.
- Young people will receive high quality care when respite is provided in their home.
- There will be a thorough assessment of caregiver capacity when caseworkers, foster parents and guardians are deciding where a young person will be placed for respite.
- Each child will receive the individualized care that they need.
- There will be less stress in the home, for both children and caregivers.

Finding

Supporting Young People

As concerns came up about the Wilson's parenting strategies, Andy's situation worsened and he was unable to cope in positive ways. He worried about himself and his family. He talked about some of his worries to the important adults in his life, and to professionals, who tried to offer support.

Andy underwent assessments, met with counsellors, addictions and FASD workers, child intervention caseworkers and community supports; these services and supports focused primarily on his deficits. His schooling, evenings and weekends were interrupted for him to go to his appointments. He became tired and said the services were not helping. A more balanced approach that addressed his issues and helped him find positive outlets[34] was needed.

34 Hammond & Zimmerman (2012)

Andy loved the outdoors, was artistic, and curious about his identity. Increased support to explore his culture and answer questions about his birth family may have helped. These supports could have included access to a Métis Elder to help him establish a connection to cultural teachings and traditional ways of healing.

Observation

Services for young people improve when they are involved in the decision-making that affects them. Child Intervention Services is enhancing a young person's inclusion in their services through upcoming legislative changes. Andy's caseworkers sought his perspective about his circumstances throughout their involvement. However, he appeared to have little involvement in his services from FSCD and Supports for Permanency (SFP).

The Stronger, Safer Tomorrow Action Plan looks to improve disability and SFP services for young people. The inclusion of a young person's views in the supports they receive through these programs should be a part of the implementation of the Action Plan.

16-YEAR-OLD CHRISTINE

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 10 years old	Christine had sensory issues when she was an infant and her tantrums became progressively worse Difficulty with routines and socialization at school Therapy in the community Out-patient psychiatry
11 – 14 years old	Emergency department visits Hospitalized on a child psychiatry unit Went to hospital-based day program Diagnosed with Obsessive-Compulsive Disorder, Bipolar Disorder, and Anxiety Specialized community school program Intensive community-based program
15 years old	Child Intervention Services involvement Confined under *Protection of Children Abusing Drugs Act (PChAD)* order *Protection of Sexually Exploited Children Act (PSECA)* voluntary involvement (6 months) Custody Agreement Group care placement Continued involvement with community-based program
16 years old	FSCD assumed financial responsibility for Christine's placement Support continued under an Enhancement Agreement Waitlist for Supported Independent Living Christine passed away

ABOUT CHRISTINE AND HER FAMILY

Christine[35] enjoyed music, drama and writing. She was interested in a career as a cosmetologist. Her parents (Heather and Mark) separated when Christine was three years old. She lived with Heather until she was 15 years old and then went to stay with Mark.

Christine was 16 years old when she was struck by a car while crossing the street. She passed away from her injuries. At the time of her death, Christine was receiving Child Intervention Services through an Enhancement Agreement.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Christine from Birth to 10 Years Old

From infancy, Christine had long tantrums during which she was inconsolable. She was not a good sleeper and had chronic stomach problems. When she started school, Christine was anxious and had difficulty adjusting to changes in routines. She insisted on wearing the same clothes for long periods, washed her hands until they bled, and injured herself when she was stressed. She started seeing a psychologist when she was seven years old. Heather found parenting on her own difficult and it was hard to find consistent childcare.

Christine was nine years old when she started seeing a psychiatrist. Heather took her to appointments while she worked two jobs and went to school. She declined in-patient treatment for Christine because she was concerned that it would be too difficult for her daughter to be away from home. Christine's behaviours gradually worsened.

Christine from 11 to 14 Years Old

When Christine was 11 years old, she threatened to hurt herself and her mother. She was admitted to a psychiatric unit and diagnosed with Obsessive-Compulsive Disorder. She subsequently went to a hospital-based day program for approximately four months, where further diagnoses of Bipolar Disorder and Anxiety Disorder were added. A psychological assessment indicated Christine had the most difficulty at home with Heather, but she also needed ongoing, intensive support at school.

Christine continued to see a psychiatrist and psychologist through an out-patient clinic. She went to a specialized mental health school program for Grades 7, 8 and 9. Heather was given advice about how to manage her daughter's behaviours, but she

35 All names in this report are pseudonyms.

wanted help implementing these strategies. Heather contacted the police a number of times for help when Christine was in crisis. Respite and community supports from Family Support for Children with Disabilities (FSCD) were approved. However, Heather did not use these services because she had to find and hire people on her own.[36]

Approximately two years later, 14-year-old Christine went to an intensive community-based program that offered individual, group and family therapy. Heather said that the intake process to get into the program was overwhelming and she felt exhausted. Despite these barriers, Christine completed the program.

Christine at 15 Years Old

When Christine was 15 years old, she moved in with Mark because Heather asked for his help. He had a wife and two young children. Christine verbally and physically acted out with Mark, used drugs, and was involved in online relationships. Her parents often discussed how they could help her.

Child Intervention Services became involved with Christine and Mark after the police took her to the hospital. She had been physically aggressive with Mark and tried to hurt herself. She was confined under the *Mental Health Act* for an assessment and was diagnosed with Emerging Borderline Personality Disorder. Christine was discharged to Mark's care after approximately one week and she returned to the intensive community-based program. The program operated a group home where she could stay if needed, and child intervention involvement ended. However, the group home stopped operations shortly afterward, leaving no options if Mark and Christine had difficulty and she needed somewhere else to stay.

Approximately one month later, Christine was confined under the *Protection of Children Abusing Drugs Act* (*PChAD*). Her parents and her psychiatrist were concerned about her marijuana use. Mark entered into a Custody Agreement when Christine was ready to be discharged because he could not provide the supervision she required. She was placed in a group home for adolescents where the supervisor had expertise in adolescent mental health. Staff from the community-based program and the group home worked with Christine and her parents to rebuild their relationship. They provided coaching for school staff as needed.

Christine's parents learned that she was looking at websites that put her at risk of sexual exploitation. She received voluntary services under the *Protection of Sexually Exploited Children Act* (*PSECA*) that ended after five months because the concerns about sexual exploitation were resolved.

36 Typically, FSCD provides parents with lists of agencies.

Caseworkers communicated regularly with Christine, her parents, group home staff, and the community-based program. Christine did not want to return to either of her parents' homes, but she had visits and participated in therapy with them.

Christine at 16 Years Old

Child intervention staff were concerned that 16-year-old Christine did not fall within their mandate because she was not a child in need of intervention. She had been in care for approximately six months and a Permanent Guardianship Order would be necessary if she needed to stay at the group home long-term. A specialized worker explored programs that were involved with Christine to help coordinate services. Mark obtained FSCD funding, which then paid for Christine's placement. Child Intervention Services continued to provide additional supports for Christine through an Enhancement Agreement with Mark. After approximately one year, Christine's self-harm, drug use and risky online activity decreased. She was doing better at school and working part-time. She was eager to move into Supported Independent Living (SIL).

Circumstances Surrounding Christine's Death

Approximately two months before her 17th birthday, Christine was returning to her group home when she was struck by a car while crossing the street. Emergency Medical Services transported her to the hospital where she passed away. The driver was charged.

Following Christine's death, her parents spent time at the group home to be with the staff and young people there, and to support one another. They planned and went to Christine's funeral service together. Mark and Heather have stayed in contact with many of the people who worked with their family.

ABOUT THIS REVIEW

Christine's death met the criteria for a mandatory review by the Advocate because she was identified as a child in need of intervention at the time of her death. She and her family were receiving intervention services through an Enhancement Agreement. Christine was living in a group home when she passed away.

The purpose of the Advocate's mandatory review was to examine Christine's experiences with government systems throughout her life, specifically looking at the services and supports she received.

Through the investigation process, we spoke with Christine's relatives, caregivers, and staff from community agencies, Family Support for Children with Disabilities, the Ministries of Children Services, and Education, as well as Alberta Health Services.

Findings

Supporting Young People with Complex Mental Health Needs

Although Christine and her family used mental health services from the time Christine was seven years old, her behavioural issues continued to escalate and became more difficult for her parents to manage. Families can become exhausted and are at increased risk of breaking down when they are stressed. Child Intervention Services often receives calls regarding young people with complex mental health needs who are not considered to be children in need of intervention as required by the *Enhancement Act*. They are frequently redirected to the health system, which may not be able to provide timely, intensive services. This results in a gap for young people and families who need help.

The Advocate has previously recommended that Child Intervention Services improve how it responds when parents request help to keep their child safe. The Advocate recommended that Alberta Health Services and Child Intervention Services enter into a formal agreement to identify how they will work collaboratively to serve young people with complex mental health needs when their safety is in jeopardy.[37] Both systems have taken steps to address these recommendations,[38] [39] but more must be done.

37 Office of the Child and Youth Advocate (September 2015)

38 Alberta Human Services (January 2016)

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

Over the 18 months before Christine passed away, she received services that improved her circumstances because there was effective collaboration between Christine, her parents, and professionals from a number of programs.

Mental Health Crisis Services

Most of the programs Christine was involved with operated during the daytime from Monday to Friday. When she was home, she harmed herself or directed her anxiety and anger towards her parents. These behaviours became more frequent and severe as she grew older. Her parents took her to the hospital, sometimes with help from the police. They often waited in emergency rooms (ER) for hours to have Christine assessed, only to have her sent home.

In 2016, Alberta Health Services began research on the increased number of young people visiting ERs with mental health and addictions issues. A survey of youth, parents, and caregivers found that:

- People were not aware of where to go for help. Especially during evenings and weekends, when many programs were closed;
- ER staff needed support and training specific to serving people with mental health and addictions issues;
- Parents and caregivers were in crisis themselves and needed support coping with their children's behaviours while trying to get help for them;
- Young people and parents were unaware of what to expect while waiting to be seen in the ER; and
- People did not receive consistent standards of mental health and addictions care across ER sites.[40] [41]

The second phase of this research is underway, seeking to identify existing and potential models of service delivery to address these concerns.

This year, Alberta Health Services is planning a dedicated addictions and mental health clinic in Edmonton, set to operate 24 hours a day, seven days a week. It is intended to provide assessment, crisis counselling and stabilization, referrals and telephone support.[42] While the clinic is not dedicated to serving children, young people close to their 18th birthday can receive supports there.

40 Suen et al. (2018)

41 Office of the Child and Youth Advocate (September 2015)

42 Gomez (2018)

Large cities in the province have mobile mental health teams that respond to children and youth in the community. These teams do risk assessments, try to stabilize the young person and, when needed, refer them to emergent care. This service is available until late evening, but does not operate 24/7.

Accessing and Navigating Mental Health Services

Alberta has a number of mental health services for children and adolescents, particularly in major urban centres. However, it can be challenging for families to access and navigate them. Most programs are available through a centralized mental health intake, while others require a psychiatric referral. The number of young people who need addictions and mental health services has increased over the last three years. Alberta Health Services has identified a goal that children and youth receive non-urgent mental health care within 30 days of their initial assessment. Depending on where one lives in the province, this standard is met between 49% to 90% of the time.[43]

Christine had difficulty adjusting from one service to the next. Her parents were tired of completing intakes for each program and retelling their story. In 2015, the Government of Alberta appointed a committee to review mental health services in the province. The committee noted the need for improved linkages across programs, especially between hospital emergency services and treatment services. They recommended navigators (workers dedicated to help link people to appropriate programs).[44] Implementation of these roles is in progress.

Research indicates that housing a variety of services together makes it easier for young people to get help and move between programs, especially as they transition into adulthood.[45] In Edmonton and Calgary, plans are underway to locate multiple mental health programs in singular sites, either adjacent to hospitals or located in the community.[46] [47] In other parts of the province, addictions and mental health services are strengthening local partnerships with government and non-government programs by co-locating in service "hubs."

Professionals also have difficulty navigating service delivery systems. In some urban centres, Child Intervention Services has specialists who help caseworkers navigate mental health services. A specialist was critical in bringing Christine's caseworker and her parents together with professionals who could potentially help. All children in Alberta could benefit from this service.

43 Alberta Health Services (November 15, 2018)

44 Alberta Mental Health Review Committee (2015)

45 Salt, Parker, Ramage & Scott (2017)

46 University of Alberta (2018)

47 Alberta Health Services (November 29, 2018)

Family and Community-Based Mental Health Care

Family participation in child and adolescent mental health treatment is more effective than interventions that focus exclusively on the young person.[48] Understanding a family's circumstances, especially during their child's early years, is critical to providing appropriate services. Parents and caregivers need intensive support and coaching to help their child. Outcomes are better if young people and families feel like they are working in partnership with service providers.[49]

Alberta Health Services provides intensive family-based care for young people in the community. The demands on parents and caregivers to coordinate services and participate in them can be overwhelming and may not always be taken into consideration. Where needed, meaningful help to meet these expectations will make a difference in the outcomes for young people.

Christine received intensive family-based treatment later in her adolescence and it made a positive difference for her. After she was taken into care, skilled staff from her group home and the community-based program worked together to provide individual and family therapy. Instead of pressuring Christine and her parents to reunite, treatment focused on strengthening their relationships. Even when young people are not living with their parents or caregivers, the health of these relationships is essential to their well-being.[50]

Observation

The Advocate has no new recommendations related to Christine's circumstances. Recent initiatives by Alberta Health Services are promising and will hopefully address the difficulties that young people encounter in getting the right kind of help at the right time. Most of the changes are happening in Edmonton and Calgary. More support is needed to improve emergent mental health care for children, and increase availability of programs across the province. Intensive, community-based programs that involve families in treatment complement traditional hospital-based services and improve outcomes for children and youth.

48 National Scientific Council on the Developing Child (December 2008)

49 Parents for Children's Mental Health & Ontario Centre of Excellence for Child and Youth Mental Health (2017)

50 The Care Inquiry (2013)

16-YEAR-OLD DARIAN

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 2 years old	Supervision Order 9 Intakes; 4 Assessments; 3 Enhancement Agreements
3 years old	Apprehended and placed in foster care Temporary Guardianship Order; moved to kinship care
4 years old	Permanent Guardianship Order
12 – 13 years old	Left kinship home; placed with his father 2 group care placements Placed with his father
14 – 16 years old	12 group care placements 6 incarcerations in a youth justice facility Darian passed away

ABOUT DARIAN AND HIS FAMILY

Darian[51] was an artistic, charismatic First Nation youth. He had a great sense of humour and was loyal to the people he cared for. Darian and his six siblings were exposed to domestic violence and their parents' substance use. They lived with relatives or were taken into care when they were young children. Darian was close to two of his siblings.

Darian was 16 years old when he was in a car accident. He passed away at the scene. At the time of his death, Darian was receiving Child Intervention Services through a Permanent Guardianship Order.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Darian from Birth to 2 Years Old

When Darian was born, there was an existing Supervision Order related to his older siblings. His mother (Mary) said that she used drugs and alcohol throughout her pregnancy. Darian was added to the Order.

Over the next two years, Child Intervention Services received a number of reports about neglect and parental substance use. At times, in-home supports were provided through an Enhancement Agreement.

Darian from 3 to 11 Years Old

When Darian was three years old, he and his siblings (who were still in their parents' care) were apprehended after their father (Brian) assaulted Darian's older brother. The children were temporarily placed in foster homes before they were moved into a kinship placement. Darian was diagnosed with a moderate to severe language delay; he knew approximately 15 words and was very hard to understand. A Permanent Guardianship Order was granted when he was four years old.

When Darian was seven years old, it was noted that he had trouble paying attention, and was, at times, aggressive. His doctor suspected he had Attention-Deficit/Hyperactivity Disorder and Fetal Alcohol Spectrum Disorder (FASD). Darian was moved to a special needs class and referred to an FASD clinic for an assessment. When he was nine years old, an educational assessment found that his reading, math and writing skills were at a kindergarten level.

51 All names in this report are pseudonyms.

Over the next two years, Darian's older siblings left the kinship home and used substances. Just before his 11th birthday, Darian went to counselling with his caregiver to work through his feelings about his siblings leaving and his desire to be connected to his biological family. The therapist noted that Darian and his caregiver got along well and had a shared sense of humor.

Darian from 12 to 16 Years Old

When Darian was 12 years old, he began to distance himself from his caregiver, pushed limits and did not follow rules at home. He was diagnosed with FASD. Some of the highlights from the assessment included that:

- He was in Grade 7 and displayed behaviours consistent with a child five to seven years old;
- Academically, he was at a Grade 2 level;
- He could not always understand what people said to him and had significant trouble expressing himself;
- He was unable to predict consequences;
- He required a predictable, stable living environment and his caregivers needed extra support to meet his needs;
- He was at risk for being victimized and victimizing others;
- He needed developmentally appropriate support regarding relationships, sexuality and substance use; and
- Without supports, Darian would be involved with the youth justice system.

Darian asked to be placed with his father. His caseworker arranged for Brian to receive basic financial supports to care for him. Darian's 18-year-old brother (who used substances and was involved in criminal activity) also lived in the home.

Shortly afterward, Darian moved to his father's home, he used substances and had trouble following rules. Approximately nine months later, Darian was moved and placed in residential care because Brian was unable to provide the structure, supervision and support that he needed. Over the next four years, Darian moved 14 times between short-term group homes, residential placements and his father's home. At times, Darian was homeless.

When he was 13 years old, Darian stopped going to school. At 14 years old, he was incarcerated for the first time. The following year, he became involved with a gang. He said he felt torn because he did not want to use substances and be in jail, but he did not know any other way to meet his needs.

Darian was incarcerated three more times. After his release from custody, Child Intervention Services provided a group home placement and he was assigned a new

caseworker. Within days of his 16th birthday, Darian was incarcerated a fifth time. Group home staff and his caseworker maintained contact with him while he was in jail and he returned there when released. He had a good relationship with staff and adapted well to the placement expectations. Within two months, Darian was arrested and incarcerated again.

Throughout his time in custody, Darian broke rules and youth custody staff used emergency response options.[52] He had to appear before several disciplinary committees that determined that he would be separated from his peers and programming would be suspended as a consequence for his behaviours. Darian did not have a support person with him during these meetings.

During his last incarceration, Darian talked more about his gang affiliation. He was separated from his peers for two days following a fight and then placed in individual programming where he was left in his cell for most of the day. Darian said he was lonely.

After his release, Darian refused to stay at his group home. He appeared different and he said that he could not see his life free from addictions, gangs and criminal activity. He randomly contacted group home staff and said he was using crystal methamphetamine.

Circumstances Surrounding Darian's Death

Approximately one month after his sixth incarceration, 16-year-old Darian was in a stolen vehicle when it was involved in a fatal car accident. He passed away from his injuries. In spite of his challenges, Darian could be an engaging young man with a good sense of humour. His family and those who knew him well miss him and continue to grieve.

52 Oleoresin Capsicum spray, isolation and restraints.

ABOUT THIS REVIEW

Darian's death met the criteria for a mandatory review by the Advocate because he was identified as a child in need of intervention at the time of his death. He was receiving intervention services through a Permanent Guardianship Order.

The purpose of the Advocate's mandatory review was to examine Darian's experiences with government systems throughout his life, specifically looking at the services and supports he received.

Through the investigation process, we spoke with Darian's relatives, caregivers and staff from Children's Services.

Finding

Fostering Healthy Connections

Darian's involvement with Child Intervention Services began at birth. He was neglected and exposed to domestic violence and his parents' substance use. Research indicates that unaddressed childhood trauma has negative life-long implications on physical, emotional and cognitive development in children.[53]

When he was three years old, Darian was taken into care and placed in a kinship home. For nine years, he lived in a stable and caring environment, and he had a strong bond with his caregiver. Supports were provided to help meet his complex needs (caused in part by his exposure to alcohol in utero).

The brain goes through a period of accelerated development in adolescence.[54] Young people become more aware of the world around them and need help to make sense of their experiences. Darian felt torn about staying with his kinship family as he reconnected with his biological family. When he finished elementary school, 12-year-old Darian asked to live with his father and he was able to move there. After he left his kinship home, he returned for family dinners, birthdays, and holidays. Darian considered this to be his home and knew that he was loved.

The placement with Brian did not last because he used substances and could not give Darian the structure he needed. Darian was assessed and diagnosed with Fetal Alcohol Spectrum Disorder (FASD) which meant that he was unable to predict consequences, had trouble understanding what was said to him, and had difficulty

53 National Child Traumatic Stress Network (2008)

54 North Carolina Division of Social Services and the Family and Children's Resource Program (2012)

expressing himself. Darian needed a predictable stable home environment with supports. In the absence of stability and predictability, Darian became involved in criminal activity and used substances. He connected with a gang, likely because it gave him a sense of belonging, structure and support.

Darian was torn between his kinship family and his biological family. For nine years, Darian felt safe and was stable in his kinship home. During this time, there were missed opportunities to foster a healthy connection to his biological family, community and culture while maintaining stability with his kinship caregivers.

Observation

Through various initiatives, Children's Services is enhancing its practice and amending policies and procedures to reflect the importance of family, connection and belonging. Creating a shift in any system is challenging and takes time. Research shows that knowledge-based training is not enough to effect systemic change because beliefs, not knowledge, drive practice.[55] Caseworkers must be challenged to look beyond immediate situations and be future-focused in planning for children.

There are promising current initiatives to connect children and youth, in safe and healthy ways, with their families, communities and culture. The Advocate will continue to monitor their implementation and progress.

Finding

Rehabilitation

Darian's substance use and criminal activity led to his incarcerations. While in jail, he had difficulty with rules and routines. His negative behaviours escalated, leading to fights with other youth that resulted in appearances before disciplinary committees. Darian was not supported during these meetings. His cognition and language delays impacted his ability to participate. The committees determined that Darian would be separated from other youth and his programming would be suspended. During his last incarceration, he was placed in a special progam and, at times, spent almost his entire day alone in a cell.

Young people housed together, in any facility, require order, safety, and predictable consequences. Separating a young person from others or from programming is sometimes needed when there is immediate danger. Extended separation, after a youth is calm, can be damaging. For young people to change and rehabilitate, youth justice staff need to have an understanding of the cause of the young person's behaviour. This can provide an opportunity for teaching positive ways to handle conflict and can lead to meaningful change for the young person.

55 Ribeiro & Carillo (2011)

Darian was exposed to early childhood trauma and he had FASD, which impacted his brain development.[56] This made him more vulnerable to stress, and he had trouble managing his behaviours. Youth like Darian need intensive and comprehensive supports for rehabilitation. Darian was desperate for connection, and these long periods of isolation likely had a negative impact on his mental health.

Historically, youth corrections has followed a justice model[57] that punishes for wrongdoing. Research shows that punishment alone is ineffective in changing behaviour.[58] The *Youth Criminal Justice Act* (*YCJA*) recognizes that young people have rights and freedoms. The *YCJA* principles are intended to protect the public; promote rehabilitation and reintegration; and support crime prevention by addressing the circumstances underlying offending behaviour.[59] In a recent Charter application decision,[60] the Judge said that isolating a young person in a correctional facility takes away opportunities for rehabilitation and reintegration. Practice in youth justice facilities needs to align with the restorative principles of the *YCJA*.

Observation

Youth justice workers may need to separate a young person from others to de-escalate a situation, but these methods of behaviour management should end when the immediate danger passes. Meaningful, long-term interventions that result in positive change for the young person should be used.

56 Maurier (2013)

57 Walen (2016)

58 Chamberlin (2009)

59 *Youth Criminal Justice Act* (2002)

60 *R v. CCN* (2018)

17-YEAR-OLD JAXON

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 2 years old	Screening/Investigation
4 – 6 years old	Apprehension Temporary Guardianship Order; foster home Supervision Order Apprehension; kinship home Supervision Order (x2)
7 – 12 years old	Safety Phase Assessment Apprehension/Temporary Guardianship; foster home Permanent Guardianship Order (8 years old) Moved to a new foster home Jaxon's mother passed away (11 years old) Kinship home Two foster homes
13 – 14 years old	Kinship home Foster home Two group homes
15 –16 years old	Two kinship homes Residential group home Secure services Two foster homes A number of informal placements
17 years old	Independent living Jaxon died by suicide

ABOUT JAXON AND HIS FAMILY

Jaxon[61] was a young man of First Nation heritage and a gifted basketball player. He mostly lived in his First Nation community, although there were periods when he lived in a city with his mother (Raylene) or in neighbouring communities with relatives. He came from a large family and had several half-siblings.

Jaxon was 17 years old when he died by suicide. At the time of his death, Jaxon was receiving Child Intervention Services through a Permanent Guardianship Order.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Jaxon from Birth to 2 Years Old

When Jaxon was 19 months old, Child Intervention Services received a report regarding parental substance use and violence. Child intervention involvement ended because Raylene was sober and could care for Jaxon, and his siblings were safe with their father.

Approximately one year later, a report was received that Raylene often left two-year-old Jaxon with relatives. She made a private arrangement for relatives to care for him and child intervention involvement ended.

Jaxon from 2 to 3 Years Old

There was no child intervention involvement for approximately one year.

Jaxon from 4 to 6 Years Old

When Jaxon was four years old, Child Intervention Services received a report that he and his three siblings (the oldest was 10 years old) were home alone with no food. Jaxon was covered with infected sores from untreated scabies. His siblings went to live with their paternal grandmother (Diana). Jaxon was apprehended, placed with a relative in his community and then moved to a foster home.

Jaxon was the subject of a Temporary Guardianship Order (TGO) for six months and then returned to Raylene under a three-month Supervision Order. Child intervention involvement ended when the Order expired.

Five months later, a report was received indicating that five-year-old Jaxon was exposed to violence between his mother and her partner. Raylene said that she

61 All names in this report are pseudonyms.

had been drinking and there was an argument. She entered into an Enhancement Agreement. Additional concerns were received that her partner had hit her on the head with a bottle. Jaxon and his younger brother were apprehended (his other siblings were with Diana). They were subsequently returned to their mother under a Supervision Order. Child intervention involvement ended approximately one year later when the Order expired.

Jaxon from 7 to 12 Years Old

When Jaxon was seven years old, Child Intervention Services received a report that he was exposed to family violence and had not been going to school regularly. An application for a Supervision Order was made, but Raylene and Jaxon returned to their First Nation. The application was withdrawn and an Intake was sent to the office where they were living. Raylene left her children with relatives and could not be located. There were concerns that she was drinking. A TGO was obtained and Jaxon was placed in a foster home in his community where he remained for almost four years.

When Jaxon was eight years old, he became the subject of a Permanent Guardianship Order. Raylene lived nearby and had regular weekend visits with him. During one visit, nine-year-old Jaxon witnessed his mother being assaulted by her new husband.

While living with his foster family, Jaxon was described as a bright boy who liked school. He had significant difficulties with reading and writing. He played hockey and went to hockey tournaments. Over time, his foster mother voiced concerns about his behaviours, and he said that he was no longer happy there.

Approximately one week before his 11th birthday, Jaxon was moved to another foster home to live with his younger brothers. On his 11th birthday, Raylene was hospitalized and put on life support. She passed away one month later. Shortly afterward, Jaxon was moved to Diana's foster home[62] to live with his older siblings. He stayed there for almost two years. He missed his mother and had behavioural issues at school. Diana became increasingly frustrated with his defiance. One month before his 13th birthday, Jaxon was moved to another placement.

Jaxon from 13 to 14 Years Old

In his early adolescence, Jaxon moved between foster homes two more times before he was placed with his 19-year-old sister (Cynthia). Cynthia said that they both needed grief counselling to help them deal with the loss of their mother. Referrals were made to community mental health services, but neither sibling went.

62 Diana was Jaxon's siblings' paternal grandmother and she was an approved foster parent.

Jaxon lived with Cynthia for about 18 months. They lived close to their First Nation and he went to school there. He played on a sports team and was particularly proud because he was the youngest member on the team.

A neuropsychological assessment found that Jaxon had suggestive features of Attention-Deficit/Hyperactivity Disorder (ADHD). Fetal Alcohol Spectrum Disorder (FASD) was not ruled out because of his mother's history of substance use.[63] Jaxon had learning difficulties in reading and comprehension. His strongest subject was math, but he worked at a Grade 4 level. Despite these challenges, he liked school, and he had counselling supports and an Indigenous youth mentor.

Jaxon and Cynthia began to argue. He had a girlfriend and skipped school, drank alcohol and did not come home. Efforts were made to salvage their relationship and the placement, but eventually both Cynthia and Jaxon asked that he be moved.

Jaxon did not have much contact with his father (Daryl), but when he was 14 years old, he went to stay with Daryl and his older brother. Caseworkers had concerns about this arrangement, but Jaxon did not want to live anywhere else. After two months, he moved to a foster home in his community. Shortly afterward, he was moved to a group home because he damaged property. Jaxon said that he was lonely and wanted to be with his family. A youth worker was provided to work with him.

Jaxon from 15 to 16 Years Old

When Jaxon was 15 years old, he was moved to a group home that was far from his community. Staff reported that he missed his mother. During his four months there, Jaxon's behaviour was described as positive and he displayed some good coping skills.

Jaxon moved back to his community to live with an uncle. He returned to his school and continued to play sports. He had difficulty reconnecting with school staff who had previously supported him. Jaxon struggled to control his emotions and complete his school work. His teachers did not know how to help and he spent most of his time outside of the classroom.

While he was living with his uncle, Jaxon often visited other relatives. There was minimal supervision and he drank alcohol. After four months, he was moved to a group home in his community. His caseworker was concerned about him because he was quick to anger, frequently left the group home without permission, and drank alcohol. Jaxon sent a picture of a noose to his caseworker, with the comment that he was "finally doing it." When asked about it, he said he was angry. He was confined in secure services[64] for five days.

63 Raylene denied using alcohol or drugs when she was pregnant.

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

Jaxon returned to his community where he moved between relatives' homes. Sometimes he was aggressive or refused to talk. His caregivers became frustrated and did not know how to help him. Jaxon's caseworker held a family group conference to find a placement for him, but it was unsuccessful.

When he was 16 years old, Jaxon was invited to play in the Indigenous Games in another province. An error in his paperwork resulted in him being unable to go. He was very disappointed.

Jaxon at 17 Years Old

Jaxon continued to move between placements in his community. When he was 17 years old, there were concerns that he was violent with his girlfriend. His whereabouts were unknown for over a month. His 20-year-old cousin (Kathie) told caseworkers that Jaxon was staying with her in the city. He was supported to live there under an independent living arrangement.

Jaxon was expected to enroll in a day program but he did not. His caseworker tried to meet with him and Kathie, but meetings were cancelled because of scheduling conflicts and illness.

Almost three months before his 18th birthday, Jaxon had an argument with his girlfriend. Later that day, he was found deceased. He died by suicide. Jaxon was a funny, likeable young man who was loved by many people and he is deeply missed.

ABOUT THIS REVIEW

Jaxon's death met the criteria for a mandatory review by the Advocate because he was identified as a child in need of intervention at the time of his death. He was receiving intervention services through a Permanent Guardianship Order.

The purpose of the Advocate's mandatory review was to examine Jaxon's experiences with government systems throughout his life, specifically looking at the services and supports he received.

Through the investigation process, we spoke with Jaxon's relatives, and staff from Children's Services and Education.

Findings

Importance of Stable Relationships

Jaxon was a First Nation youth who received services under a Permanent Guardianship Order. He experienced early childhood trauma from neglect and exposure to domestic violence and his parents' substance use. He was separated from his siblings and his mother, and when he was 11 years old, his mother passed away. Research refers to these kinds of circumstances as Adverse Childhood Experiences (ACEs), which have been linked to poor outcomes such as increased risk of suicide and addictions.[65]

After Jaxon was taken into permanent care, he often stayed with relatives or community members, but said that he did not feel like he belonged anywhere. He frequently moved; some moves were initiated by him and some happened because his caregivers could not manage his behaviours. Relationships seemed difficult for Jaxon, and he appeared to avoid emotional vulnerability by not staying in one place too long. Supporting his caregivers to learn strategies to better meet his needs could have prevented some of these placement breakdowns.

Since 2013, the Advocate has made five recommendations specific to enhancing kinship care by increasingly using kinship placements, and improving training, supports and resources for caregivers.[66] [67] [68] Child Intervention Services has

65 Centers for Disease Control and Prevention (n.d.)

66 Office of the Child and Youth Advocate (June 2013)

67 Office of the Child and Youth Advocate (July 2016)

68 Office of the Child and Youth Advocate (October 2016)

amended policy regarding kinship support plans and enhanced information in the foster care and kinship care handbooks. An online training resource for caseworkers (*Understanding Kinship Care*) has also been implemented to meet some of these recommendations. Mandatory kinship orientation training and a continuum of culturally relevant support services for kinship caregivers remain outstanding.[69]

The Advocate is not making new recommendations in this area, and looks forward to the implementation of outstanding recommendations to help improve outcomes for young people living in kinship care.

Although Jaxon mostly lived in his community, he would have benefitted from more connection to his culture and traditions. He did not want to speak with a counsellor about his feelings and his experiences, but he enjoyed learning about his culture and may have been more receptive to traditional healing practices.

Jaxon's grief and loss were not fully addressed, and this affected how he formed relationships. Regular information sharing, including communication with caregivers and other professionals, would have helped to identify times when Jaxon was not doing well. He needed a secure and lasting relationship with a nurturing adult who was able to be with him on a daily basis and provide guidance.

When Jaxon was 15 years old, he expressed thoughts of suicide. He sent his caseworker a picture of a noose, and he was assessed for suicidality. Caseworkers receive suicide intervention training, but may not feel the training adequately prepares them for the complex needs of young people whom they work with. Some studies have cast doubt on the effectiveness of risk assessment tools that predict the likelihood of suicide.[70]

There are usually signs (some subtle) that people are in distress. For example, losing interest in previously enjoyed activities. If these signs are not seen, suicide can appear to be an impulsive act, although impulsivity is not a strong predictor or cause of suicidal behaviour.[71] Jaxon's caregivers may not have been able to recognize and respond to subtle changes in his behaviour because he moved so frequently.

Importance of Supportive Environments

School was a stabilizing factor during Jaxon's adolescence. He had many friends and was liked by staff. He enjoyed playing sports, making Indigenous art, and learning about his culture. School staff met with Jaxon regularly and helped him

69 Recommendation progress can be found at: http://www.ocya.alberta.ca/wp-content/uploads/2015/04/Recomm_CurrentStatus_at2018Sept30.pdf

70 Large et al. (2016)

71 Klonsky & May (2015)

when he struggled. They involved his caregivers and caseworkers when his needs were not addressed. There were brief periods when Jaxon left his school because he moved, but efforts were made for his return because of his relationships there and the support he received.

Jaxon struggled academically and was frustrated with his school work. There were times when he could not manage his feelings and had to be outside of the classroom. It is critical that teachers understand the historical and intergenerational trauma that Indigenous people experience and create safe spaces for Indigenous young people.[72] This includes developing relationships, creating caring classroom environments, and being culturally knowledgeable.[73]

After Jaxon returned to school following a four-month assessment, staff felt that his behaviour had changed and he was not as open to connecting or talking with them. However, he still met with Indigenous staff. It is important that schools have Elders and Indigenous staff members who can provide cultural knowledge and mentorships for staff and students.[74]

Observations

When Jaxon reached adolescence, it appeared that he was looking for belonging and wanted to be connected with his community. He had unaddressed grief, loss and trauma that impacted his ability to cope with stressful situations and maintain relationships. At times, those involved with him did not know how to help. He needed more adult guidance related to decision-making about where he lived and the services that were right for him.

Caseworkers are expected to make complex decisions and are often required to make them quickly and with limited information. Decision-making includes consultation with supervisors, managers and, at times, senior-level child intervention staff. These layers of decision-making may improve accountability and provide an opportunity to reflect on biases and alternative approaches, but external subject matter expertise may be required.

Child intervention staff cannot be experts across all disciplines. Some service delivery areas have multidisciplinary consultation opportunities where caseworkers can present circumstances and receive input. However, these are not immediately available and are frequently initiated after a number of unsuccessful interventions. Caseworkers need access to expertise to help inform decision-making and case planning. This must be available on a timely, as needed, basis.

72 Day et al. (2015)

73 Anthony-Stevens & Stevens (2017)

74 OECD (2017)

RECOMMENDATION

Child Intervention Services should provide the financial and organizational supports for front-line staff to have immediate access to a variety of subject matter experts, as needed.

Additional Comments

This resource should be regionally tailored to reflect the young person's community. Proactive, timely access to expert advice should be available to all service delivery regions and Delegated First Nation Agencies, without negatively impacting their finances. This might be accomplished through a standing list of identified subject matter experts who are readily available for consultation. Implementation of this resource should include an evaluation process to assess if the expected outcomes are being achieved.

Expected Outcomes

- Critical thinking will be supported with subject matter expertise, resulting in high-quality services for young people.
- Caseworkers will have access to timely, reliable resources to support them in decision-making.
- Caregivers, service providers and other professionals working with young people will have the tools they need to provide the necessary supports and services for young people.
- Alternative perspectives (outside of child intervention practice) will broaden the knowledge and decision-making abilities of front-line staff.

18-YEAR-OLD FAITH

Mandatory Review

SUMMARY OF SIGNIFICANT EVENTS

Birth – 11 years old	Supervision Order Enhancement Agreement Attendance Board & Queen's Bench Orders Permanent Guardianship Order for Faith's brother Academic assessment
12 – 15 years old	14 Enhancement Agreements Domestic violence Faith disclosed historical abuse Faith often stayed with grandmother Faith's brother passed away Queen's Bench Orders (school attendance)
16 – 18 years old	Faith stopped going to school; stayed with her grandmother 4 Enhancement Agreements Counselling On her 18th birthday, Faith's child intervention involvement ended 4 hospital visits One mental health appointment Faith passed away when she was 18 years old

ABOUT FAITH AND HER FAMILY

Faith[75] was a young Métis woman who enjoyed singing, acting and playing guitar. She came from a large family and lived with her mother (Jenny) in a city. Faith was very close to her relatives and siblings.

Faith was 18 years old when she died from a suspected drug overdose. Her autopsy results are pending. It is not known if her death was accidental or an intentional overdose.

Faith and her family had involvement with Child Intervention Services within two years of her death through an Enhancement Agreement.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Faith from Birth to 11 Years Old

Child intervention first became involved with Faith when she was an infant. Jenny had undiagnosed cognitive delays and frequently needed extra help for rent and groceries. Faith's younger brother (Oscar) had a developmental disorder and needed extra support.

When Faith was five years old, Child Intervention Services received a report about her school attendance. Jenny said she did not send her children to school because they were often ill. She entered into an Enhancement Agreement. Shortly after it ended, additional reports were received. The Attendance Board issued orders[76] directing Jenny to send her children to school.

Jenny was especially overwhelmed with parenting Oscar. He was taken into care through a Custody Agreement and later became the subject of a Permanent Guardianship Order. Faith missed him and wanted to visit him as much as possible. A six-month Supervision Order was obtained for Faith and her other siblings because of ongoing concerns related to a lack of supervision, an unkempt house and poor school attendance. Jenny subsequently entered into an Enhancement Agreement.

When Faith was seven years old, she had an academic assessment that found her cognitive functioning was in the low to average range, likely because she did not go to school regularly.

75 All names in this report are pseudonyms.

76 The *School Act* gives an Attendance Board the ability to make an order directing a parent or guardian to send their child to school.

Child Intervention Services received reports about domestic violence between Jenny and her boyfriend, and the poor condition of their home. Jenny did not want involvement with child intervention and was referred to community resources. Faith and her siblings were not consistently going to school. The Attendance Board obtained orders from the Court of Queen's Bench directing Jenny to send them to school or she would be arrested. The children then briefly resumed going to school.

Faith from 12 to 15 Years Old

When Faith was 12 years old, Child Intervention Services received reports that Jenny's former partner (George) returned to the home and was drinking. There were concerns about Jenny's ability to take care of her children. She asked George to leave and entered into 14 consecutive Enhancement Agreements.

Jenny had a psychological assessment that found her cognitive functioning was in the borderline[77] to low-average range. She was diagnosed with Fetal Alcohol Spectrum Disorder (FASD). A support worker was arranged through Persons with Developmental Disabilities (PDD), but this service was targeted to Jenny's disability and did not help with parenting. Child intervention involvement ended.

Approximately one month later, Oscar passed away from medical complications related to his developmental disorder. This was very difficult for 15-year-old Faith. Three months after Oscar's death, Child Intervention Services received a report that Jenny was depressed and George had returned to the home. A Safety Plan was developed, and the children lived with relatives until George left and Jenny was able to take care of them.

Faith from 16 to 18 Years Old

When Faith was 16 years old, she told caseworkers that she was having panic attacks. She stopped going to school in Grade 10 because she was bullied by a peer and had anxiety. Her mother entered into another Enhancement Agreement and Faith was referred to a counsellor.[78]

One year later, Faith said that she was abused when she was younger.[79] She was not getting along with Jenny and frequently stayed with her grandmother. Faith went to the hospital with symptoms of anxiety that included dizziness, headaches, inability to sleep, and irregular heartbeat. She was referred to a mental health therapist, whom she met with once. Faith said that she was depressed because of her circumstances at home. It was suggested that she ask Child Intervention Services for supports to live independently.

77 A categorization of intelligence wherein a person has below average cognitive ability (generally an IQ of 70–85).

78 It appears that Faith went to counselling on her own, but it is unclear how often she went.

79 The abuse was reported to the police, but Faith was hesitant to pursue the matter.

Caseworkers referred Faith to adult community services, including housing and income supports, because she was almost 18 years old.

Two weeks before Faith's 18th birthday, her mother signed another Enhancement Agreement, but because of her age, Faith was not included in the Agreement.

Over the following five months, Faith went to the hospital twice because of anxiety. She was prescribed medication, but could not fill the prescription because she had no money.

Four days after her fourth visit to the hospital, 18-year-old Faith was found unresponsive in a hotel room. She passed away from a suspected drug overdose. Faith had been staying with a relative. There was no prior indication that she used substances. There is no information to determine whether her death was accidental or a suicide. Her family continues to grieve.

ABOUT THIS REVIEW

Faith's death met the criteria for a mandatory review by the Advocate because she was identified as a child in need of intervention within two years of her death. She and her family received intervention services through an Enhancement Agreement.

The purpose of the Advocate's mandatory review was to examine Faith's experiences with government systems throughout her life, specifically looking at the services and supports she received.

Through the investigation process, we spoke with Faith's relatives, service providers, and staff from Family Support for Children with Disabilities, the Ministries of Children's Services, and Education, as well as Alberta Health Services.

Findings

Supporting Parents with Cognitive Disabilities

Faith's mother (Jenny) was involved with Child Intervention Services over many years with no significant change to her family's circumstances. She was diagnosed with Fetal Alcohol Spectrum Disorder (FASD) and had a support worker through Persons with Developmental Disabilities (PDD). This worker was there to support Jenny and it was not their role to focus on the well-being of her children. Most of the conventional services arranged by Child Intervention Services to help Jenny parent were not adapted to her level of functioning.

People with FASD are frequently referred to mainstream programs that are not disability-focused or do not meet their needs. These individuals typically experience more difficulties with mental illness, social isolation, poverty, inadequate housing, family discord, and family violence. Services for parents with disabilities are most effective when they are person-centred and take into consideration their special needs.[80] Strategies such as memory aids, routine, setting boundaries, and focusing on the positives are effective ways to help parents diagnosed with FASD.[81]

With the appropriate intervention and support, parents with FASD can successfully take care of their children.[82] However, when services are being provided by multiple agencies, it is critical that collaborative partnerships between agencies are developed.[83] Jenny and her children would have benefitted from a strong working

80 Rutman (2016)

81 Rutman & Van Bibber (2010)

82 Choate (2013)

83 Aunos & Pacheco (2013)

relationship between PDD, Child Intervention Services and community-based programs tailored to help parents with cognitive disabilities.

There may be times when caseworkers need access to specialized case consultation, particularly when families have many needs. In 2015, the Advocate recommended that Child Intervention Services strengthen its capacity to provide relevant assessments, planning and intervention methods to support parents with cognitive challenges.[84] The Advocate has noted progress on this recommendation. However, more work needs to be done to ensure that parents with cognitive disabilities receive specific and effective help with their children.[85] [86]

Enhancing School Engagement

Schools can be safe places where young people have opportunities to learn, socialize with peers, become involved in their community, and enhance their self-esteem. Children are more comfortable receiving help from familiar faces and environments, emphasizing the importance of supportive connections in schools.[87] Students are more successful when a positive connection is made between school staff, the student and their family.

Faith seemed to enjoy school when she was younger, but it became difficult for her to be there. Unresolved trauma may have made it harder for her to concentrate, recall and learn what was being taught in the classroom.[88] As an older child in her family, she was responsible for caring for her younger siblings and, at times, could not go to school. Faith was academically behind her peers and was bullied. She dropped out of school when she was 16 years old.

Faith's mother appeared before the Attendance Board numerous times and was ordered to send Faith to school. This approach did not take into consideration the family's circumstances. The *Enhancement Act* does not identify absenteeism as a protection concern. In Faith's circumstance, child intervention involvement was independent of the Attendance Board. Without ongoing collaboration between these systems, it was difficult for educators to address how disability, family dynamics, poverty, loss, and trauma impacted Faith's school attendance.

Students who are chronically absent need robust, meaningful support, which requires strong collaboration between Education, Child Intervention Services and community partners. In 2017, The Office of Student Attendance and Re-engagement

84 Office of the Child and Youth Advocate (June 2015)

85 Alberta Human Services (September 2015)

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

87 Bell, Limberg & Robinson (2013)

88 Goodwin (2017/18)

was created to help schools address absenteeism differently, with attention to each child's unique situation.[89] The Advocate is encouraged by this shift in practice and looks forward to better educational outcomes for children and youth in the province.

Providing Services to Youth

Child intervention involvement focused on supporting Faith's family as a whole to address the ongoing concerns of neglect.

In a previous Investigative Review, the Advocate recommended that "intervention issues not only address the presenting issues in a family, but also fully examine and address the impacts those issues have had on children in the family."[90] Although this recommendation has been met,[91] [92] Faith was significantly affected by ongoing neglect and unresolved trauma and loss. Family preservation has been a primary guiding principle in the *Enhancement Act*. However, in 2019, *Bill 22* amended the legislation to make the safety and well-being of children a priority.

Research indicates that the loss of a family member during adolescence can have a profound effect on social functioning, development, and physical and mental health. Adolescents are more likely to experience a greater intensity of grief and distress.[93] The impact of unresolved trauma and abuse on young people varies, but can include learning difficulties, dissociation and mood dysregulation.[94] Faith became anxious and depressed which made it difficult for her to leave her home to access services.

When Faith was 17 years old, she asked her caseworker for help to live independently. She was in conflict with her mother, not going to school, and struggled with her mental health. Because of her age, she was referred to adult services, which were difficult for her to access on her own.

89 Alberta Education (n.d.)

90 Office of the Child and Youth Advocate (June 2013)

91 Alberta Human Services (September 2013)

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

93 Palmer, Saviet & Tourish (2016)

94 Morgan, Pendergast, Brown & Heck (2015)

Faith was not offered continued services through an Enhancement Agreement with Youth[95] because she was still living with Jenny.[96] Because Faith did not qualify for an Enhancement Agreement with Youth, she was not eligible for ongoing support through a Support and Financial Assistance Agreement after her 18th birthday. Child intervention continued to be involved with her mother and siblings, but Faith no longer met the requirement to receive services. Faith asked for help to improve her life, but policy and age constraints were barriers.

Recommendation

Child Intervention Services should amend their policy so that an Enhancement Agreement with Youth can be used, in exceptional circumstances, to support young people who live with their guardians.

Additional Comments

Youth who are 16 and 17 years old may benefit from child intervention supports and services even though they are still living with their parent or guardian. Current and historical child intervention involvement should be taken into consideration along with the guardian's capacity to support their child.

Expected Outcomes

- Caseworkers are able to provide youth (16 and 17 years old) with services tailored to their needs and distinct from the needs of their parents, guardians or siblings.

95 Enhancement Policy Manual (Intervention) 5.2.2 allows for Child Intervention Services to provide support in certain circumstances for youth who are 16 to 17 years of age to live independently, which helps transition them into adulthood.

96 The Enhancement Policy Manual states that a young person must first be living independent of their guardian before they qualify for this service.

CLOSING REMARKS

This report is the first "mandatory" reporting that the Office of the Child and Youth Advocate has completed since the changes to our legislation in 2018. Seven of the young people in this report were children in need of intervention when they passed away and two passed away within months of involvement ending. Their circumstances varied, and it is my sincere hope that we have honoured their lives and who they were by telling their experiences.

I am making five new recommendations:

1. Child Intervention Services should review and revise their policies so that the additional needs of substance-affected infants are identified and appropriate resources are provided.
2. Child Intervention Services should include young people, who are living in a foster home, in the annual foster home assessment process.
3. Child Intervention Services should coordinate with Family Supports for Children with Disabilities (FSCD) to implement a system that monitors the number of children placed in respite at any given time in a foster home so that young people receive the care they need. Numbers of children should not exceed a caregiver's capacity.
4. Child Intervention Services should provide financial and organizational supports for front-line staff to have immediate access to a variety of subject matter experts, as needed.
5. Child Intervention Services should amend their policy so that an Enhancement Agreement with Youth can be used, in exceptional circumstances, to support young people who live with their guardians.

Over the past six years, I have made a number of recommendations related to issues that were also apparent for these nine young people—risk assessment, the importance of connections, and mental health services to name a few. I have referenced them again and I cannot state strongly enough that they must be acted upon. Repeatedly making similar recommendations does not change the circumstances for young people—only a change in the systems that serve them, and a change in what young people and their families experience, will result in improving their outcomes.

In each young person's individual Investigative Review, I have made observations about promising practices and/or gaps in services. While I am pleased to note a number of promising initiatives and practices amongst service providers and ministries, I cannot help but think about the lives that these young people touched. I want to extend my heartfelt condolences to those who were close to these children and youth and who loved them dearly.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDICES

APPENDIX 1: GLOSSARY OF TERMS

Adverse Childhood Experiences	Negative, stressful, traumatizing events that occur before age 18 are referred to as Adverse Childhood Experiences (ACEs). ACEs are divided into 10 categories that fall under the umbrellas of abuse, neglect, and household dysfunction. These experiences create chronic stress. Children with unmitigated chronic stress develop patterns of adaptive and physiological disruptions that compromise health over the lifespan.
Alberta Vulnerable Infant Response Team (AVIRT)	A specialized and collaborative team that assesses at-risk infants who are under four months old. This team includes staff from Alberta Health Services, Child Intervention Services and the local police service.
Anxiety Disorder	A group of disorders characterized by persistent cognitive and physical symptoms such as excessive fear and worry, difficulty sleeping, heart palpitations and shortness of breath.
Assured Income for the Severely Handicapped (AISH)	Provides financial and health benefits to eligible Albertans with a disability.
Attendance Board	Takes referrals from public and private school authorities when chronic non-attendance cannot be resolved locally. The panel may give direction to the student and/or the parent/guardian that it considers appropriate and enforce the ruling by registering it as an Order of the Court of Queen's Bench.
Attention-Deficit/ Hyperactivity Disorder (ADHD)	A common childhood disorder often characterized by symptoms such as trouble focusing, hyperactivity and impulsivity.

Cerebral Palsy	A neurological disorder that affects a child's movement, motor skills, and muscle tone. In most cases, cerebral palsy is caused by brain damage that develops while the baby is still in utero, or during, or shortly after birth.
***Child, Youth and Family Enhancement Act* (*CYFEA* or *Enhancement Act*)**	The legislation governing Child Intervention Services, also known as the *Enhancement Act* or *CYFEA*.
Chronic Stress	The response to emotional pressure suffered for a prolonged period of time in which an individual perceives they have little or no control. It involves an endocrine system response in which corticosteroids are released.
Compassion Fatigue	Indifference to charitable appeals on behalf of those who are suffering, experienced as a result of the frequency or number of such appeals.
Custody Agreement	A voluntary agreement with Child Intervention Services to place a child in an approved placement. The Agreement can be with a guardian, or a young person between 16 and 18 years old.
Depression	A mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how a person feels, thinks and behaves, and can lead to a variety of emotional and physical problems.
Early Intervention Services	Provides a variety of services to engage and empower families to address emotional, social, physical, and general health aspects of their lives.

Enhancement Agreement (Family Enhancement Agreement)	A voluntary agreement with Child Intervention Services to provide supports, and intended to address protection concerns while the child remains with their guardian, or lives independently. The Agreement can be with a guardian or a young person between 16 and 18 years old.
Family Support for Children with Disabilities (FSCD)	A voluntary program that provides individually assessed family-centered supports to help strengthen families' ability to promote their children's healthy development and participation in activities. Guardianship remains with the parent.
Fentanyl	A prescription painkiller approximately 100 times more potent than morphine. Fentanyl is often mixed with other drugs and sold illegally. It is difficult to detect and comes in various forms.
Fetal Alcohol Spectrum Disorder (FASD)	A continuum of permanent birth defects caused by a mother's consumption of alcohol during pregnancy. FASD also includes fetal alcohol syndrome (FAS) which is the most severe form of the condition.
Findings	Information discovered as a result of an inquiry or investigation.
Foster Care Annual Assessment Form	A yearly evaluation of a foster child's placement based on the needs of the foster child and the foster parents' ability to meet those needs.
Foster Care Placement Needs Scoring Chart	A tool used by Child Intervention Services to determine the level of care needed by a child.

Foster home	A family home (facility) licensed in accordance with the *Enhancement Act* that provides an approved placement for a young person in the care of the Director.
Goals of Care	The aims for a person's care, as agreed between him/her, his/her family, caregivers, and healthcare team. A person's goals of care are not always restricted to medical care.
Group home	A residential placement (facility) licensed in accordance with the *Enhancement Act*, staffed by childcare workers, that provides an approved placement for a young person.
Indigenous Liaison Worker	Provides First Nations (Status and Non-Status), Métis and Inuit peoples and their families with support related to case management, patient advocacy, cultural teachings, health literacy support and discharge planning from hospital.
Indigenous Services Canada	A federal government program that provides funding for Indigenous Health. (Formerly known as Indigenous and Northern Affairs Canada).
Individual Program Plan	An education statement of intentions developed to address a child's/student's learning needs, and is based on individual assessment of needs.
Intake	Child Intervention Services' initial gathering and analysis of information to determine if a child is in need of intervention. Intake precedes the Safety Assessment.
Jordan's Principle	A child-first and needs-based principle used in Canada to ensure that First Nations children living on and off reserve have equitable access to all government funded services.

Kinship Care	A placement outside of parents' care with relatives or community members approved by Child Intervention Services to care for a specified child(ren).
Neonatal Abstinence Syndrome	A group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb.
Neurobehavioural Disorder (ND) Unknown Exposure to Alcohol	A group of disorders characterized by behavioural impairments associated with brain disease, including those related to prenatal exposure to alcohol.
Neuropsychological Assessment	An in-depth assessment of skills and abilities linked to brain function that measures areas such as: attention, problem solving, memory, language, I.Q., visual-spatial skills, academic skills, and social-emotional functioning.
No Contact Order	A prohibition of direct or indirect physical, verbal, and/or written contact with another individual or group; most commonly associated with family or household violence, stalking or sex offenses.
Observations	Remark, statement, or comment based on what someone has seen or, observed or noted.
Permanent Guardianship Order (PGO)	A court order granting sole guardianship of a young person to the Director. This Order is sought when it is believed that the child cannot be safely returned to their guardian within a specified period of time.
Persons with Developmental Disabilities (PDD)	Funds programs and services to help adult Albertans with developmental disabilities to be a part of their communities and live as independently as they can.

Private Guardianship Order	A court order granting a third party guardianship of a child. Other parties' guardianship rights may or may not be terminated.
Protection of Children Abusing Drugs Act (PChAD)	This legislation allows a legal guardian to obtain a protective order when it is believed that a young person's substance use is placing them in danger of physical or psychological harm. The young person can be confined in a protective safe house for up to 10 days.
Protection of Sexually Exploited Children Act (PSECA)	This legislation allows Children's Services and police to provide intervention and support to young people who have been sexually exploited. These interventions include a continuum from voluntary programming to confinement.
Public Assurance	In the opinion of the Advocate, the services and supports provided to the young person and their family were adequate and met their needs.
Restorative Justice	A theory of justice that emphasizes repairing the harm caused by criminal behaviour — best accomplished through cooperative processes that allow all willing stakeholders to meet.
Safety Plan	A plan completed between a caseworker and a family that identifies supports and resources to help reduce the likelihood of further child endangerment.
Secure Services	The provisions in the *Enhancement Act* allowing for the confinement of a young person for up to 30 days for stabilization and assessment when the young person is found to be an immediate danger to themselves or others.

Services and Supports	In the opinion of the Advocate, there were gaps in the services and supports provided to a young person and their family.
Sepsis	A serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock or death.
Shared Caregiver Agreement	An agreement between two caregivers regarding the care of a child.
Social Anxiety Disorder	An anxiety disorder characterized by fear or discomfort in social situations often affecting a person's ability to participate at school or work.
Supervision Order (SO)	A court order granting mandatory supervision of a young person to the Director. Guardianship and custody remains with the guardian.
Support and Financial Assistance Agreement (SFAA)	A voluntary agreement between a young person (18 to 24 years old) and Child Intervention Services for supports and financial assistance.
Supports for Permanency (SFP)	Provides financial support to families who adopt or obtain private guardianship of children in permanent government care.
Support Plan	A plan that identifies the supports required based on the needs of the child, the skill of the foster parent, and other factors specific to the child and the case plan.
Systemic Issues	In the Advocate's opinion, there are gaps in services and supports that likely impact more than one young person.

Telehealth	Involves the distribution of health-related services through telecommunication technologies.
Temporary Guardianship Order (TGO)	A court order granting custody and guardianship to the Director for a specified period of time. This Order is sought when it is believed that the young person can be safely returned to their guardian.

APPENDIX 2: EXPERTS CONSULTED

Del Graff, MSW, RSW

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

Danette Andersen, BEd, MEd

Danette has been an educator for over 37 years and has held a variety of positions within Edmonton Public Schools, including teacher, behavioural consultant, program coordinator, supervisor, and principal. Danette's passion is working with students who have been through traumatic and/or stressful situations.

Elder Ernest Arcand

Elder Ernest Arcand grew up on the Alexander First Nation. His grandfather began teaching him traditional ways when he was a young child. He has been actively involved in cultural events since he was 15 years old. Elder Arcand has over 30 years experience with the same company and has held a variety of positions where he helped create training programs, consulted, and provided support to Indigenous staff. Elder Arcand has sat on many boards, including the Yellowhead Tribal Council, Alberta Justice and Solicitor General, and the Headstart program on Alexander First Nation.

Elder Paul Daniels

Elder Paul Daniels is Iyarhe Nakoda and a member of the Bearspaw Band on Stoney First Nation. His traditional Nakoda name translates to Three White Buffalo Calves Spirit. He is a sought after spiritual leader and an active member of the Treaty 7 community. His Nakoda teachings began when he was a young child and come from his mother, who trained him in midwifery. Elder Daniels is knowledgeable in the traditional practices and medicines of the Stoney Nakoda people and was transferred rights to pipe holder, the sun dance, and the sweat lodge. He offers his knowledge of braiding sweetgrass to Hull Child and Family Services, and was the Stoney Nakoda Elder representative for the National Inquiry into Missing and Murdered Indigenous Women and Girls. He also sits on the Wisdom Council of Alberta Health Services, and the Elders Council of the Alberta College of Art and Design. Elder Daniels played an important role in the naming of the Lodgepole Indigenous Support Centre, where he facilitates Elder advice, support, traditional ceremonies, workshops and sharing circles.

Blake Desjarlais, BA

Blake is from the Fishing Lake Métis Settlement, one of the eight Métis Settlements in Alberta. Blake has worked with the Alberta Ministry of Enterprise and Advanced Education, as well as the Faculty of Law and the Department of Indigenous Studies at the University of Victoria. He is currently the director of public and national affairs for the Métis Settlements General Council. In this role, Blake is responsible for national/federal initiatives, rights negotiations, intergovernmental negotiations, national operations and special case files (including the implementation of the Truth and Reconciliation Commission Calls to Action). Blake regularly volunteers, and he supports the promotion of Indigenous youth initiatives, action against climate change, cultural learning/reclamation, and Indigenous arts.

Caara Goddard

Caara is one of seven Canadians certified as a Signs of Safety (SOS) consultant. She has been using the SOS approach for over five years, in all areas of her work, at Kxtunaxa Kinbasket Child and Family Services, a Delegated First Nation Agency in British Columbia. As a child protection and guardianship worker in an Indigenous community, one of her focus areas has been adapting SOS tools to better suit the needs of Indigenous people.

Mara Grunau, BEd, MPA

Mara is the executive director of the Centre for Suicide Prevention. The Centre provides education on suicide prevention and has the largest English-language library on suicide in the world. The Centre provides suicide prevention toolkits, webinars and workshops.

Kevin Hood, BSW, MEd

Kevin is an associate professor with Grant MacEwan University's Correctional Services program and the chair of the Public Safety and Justice Studies department. He has worked in a variety of roles, including child abuse investigations and social work with youth involved in high-risk behaviours. During his time with the public service, he managed the Protection of Children Involved in Prostitution program for Alberta Children's Services and was a senior manager responsible for Crime Prevention and Restorative Justice with Alberta Justice and Solicitor General.

Elder Gilbert Eagle Bear

Elder Eagle Bear has worked at the Lethbridge Correctional Centre for over 20 years, as both a coordinator and an Elder. He has also worked for Child Intervention Services. Elder Eagle Bear was an elected tribal leader for four terms. In addition, he worked for a company on the Blood Reserve, starting as a labourer and becoming the president.

Angelique Jenney, PhD, RSW

Angelique is an assistant professor and the Woods Homes research chair in Children's Mental Health in the Faculty of Social Work at the University of Calgary. She has over 20 years of experience in intervention and prevention services within the sectors of child protection, children's mental health, and prevention of violence against women. Her research and practice interests include: family-based interventions for childhood trauma; child protection responses to family violence cases; the experience of mothering in the context of violence/trauma; and reflective approaches to teaching and training social work students.

Dr. Catherine Macneil, MD, FRCPC

Dr. Macneil is a hospital pediatrician at Alberta Children's Hospital and clinical assistant professor at the Cumming School of Medicine at the University of Calgary. Dr. Macneil's career focuses on children with medical complexities. This interest includes making systems safer for these children, reducing hospital-acquired injuries, shortening length of stay, and advocating for families to have adequate support in their home and their community.

Joy Malloch, BA

Joy is the acting director at Alberta Education School and Community Supports. She has been instrumental in supporting school authorities to address chronic absenteeism and in the creation of the Office of the Student Attendance and Re-engagement. Her focus is to support students and their families with early intervention.

Dr. David McConnell, PhD

David is a professor and the director of the Family and Disability Studies Research Initiative at the University of Alberta. His research focuses on the connection between family, life-long disability and human service systems. He is chair of the International Association for the Scientific Study of Intellectual and Developmental Disabilities. David has conducted research on decision-making in child welfare matters and co-authored numerous scientific papers.

Elder Beatrice Morin

Elder Beatrice Morin was born and raised in Ermineskin, Alberta. She received a diploma from Maskwacis Cultural College and subsequently graduated from Athabasca University with a Bachelor of Arts. Beatrice has a Life Skills Coach diploma and was an addictions counsellor. She has been in the educational field for a number of years, mentoring and supporting young people. Beatrice has worked with the FASD program in Enoch and is a kinship care provider. Currently, she is working with Enoch's Cree Language Initiative, mentoring early childhood development staff and revitalizing language within the community. She is also an Elder resource for the community.

Ernie Pudwill

Ernie is a former police officer (Edmonton Police Service) and RCMP member. In his role with Children's Services as a family violence prevention coordinator, Ernie helped establish collaborative relationships between police, probation, and court services to help families suffering the effects of family violence. He has a certificate in addiction studies (University of Alberta) and has been training in the area of family violence for approximately 15 years.

Dr. Heather Leonard, MD, FRCPC

Dr. Leonard is a general pediatrician who works part-time as a hospitalist at the Stollery Children's Hospital. The remainder of her time is based out of River Valley Pediatrics, a general pediatric medical clinic. She has an interest in children with complex medical needs and most of her private practice focuses on this population of children. She is an associate clinical professor with the Department of Pediatrics at the University of Alberta and is actively involved in the residency teaching program.

Dr. Nicole Letourneau, RN, PhD

Nicole is a fellow of the Canadian Academy of Health Science. She is the author of two books and more than 150 peer-reviewed papers on topics ranging from parent-child relationships, child and adult mental health, and child development. As professor in the Faculty of Nursing and Cumming School of Medicine at the University of Calgary, she holds the Alberta Children's Hospital chair in Parent-Infant Mental Health and is director of RESOLVE Alberta, seeking solutions to family violence. She leads the Child Health Intervention and Longitudinal Development (CHILD) Studies Program, which examined parenting and child development in the context of maternal depression, family violence and other toxic stressors. Nicole is also president-elect of the College and Association of Registered Nurses of Alberta and founder of the ATTACH program.

Dr. Lenora Marcellus

Lenora is an associate professor in the School of Nursing at the University of Victoria. She has been a registered nurse for over 30 years in a range of maternal-infant settings and roles. Her current research interests include perinatal substance use, neonatal opioid withdrawal, and supporting infants in foster care. Lenora is a member of the Canada FASD Partnership Network Action Team on FASD Prevention from a Women's Determinants of Health Perspective, and she is an expert consultant on neonatal opioid withdrawal with the Vermont Oxford Network.

Nicole Mizzi, BSW, RSW

Nicole is a registered social worker and works at Legal Aid Alberta's Youth Criminal Defense Office. Since 2008, Nicole has developed and co-facilitated the Fetal Alcohol Spectrum Disorder (FASD) Justice Support Project for youth.

Dr. Jacqueline Pei, PhD, RPsych

Jacqueline is an associate professor in the Department of Educational Psychology and an assistant clinical professor in the Department of Pediatrics at the University of Alberta. She is a practicing registered psychologist. Jacqueline began her career as a criminologist and forensic counsellor working with incarcerated youth. She later returned to academia to study youth at risk, child development, and neuropsychology, leading to her current focus on interventions for individuals with FASD. Jaqueline has served on the FASD Clinical Diagnostic Team at the Glenrose Rehabilitation Hospital and currently leads the Intervention Network Action Team for the Canadian FASD Research Network—a role that facilitates the link between research, policy, and practice.

Dr. Lana Potts, BSN, MD

Dr. Potts is a family physician at the Siksika Health and Wellness Centre in Siksika First Nation, near Calgary. Dr. Potts is a charter class graduate of the Northern Ontario School of Medicine in Thunder Bay, Ontario. She also completed a Bachelor of Science with Distinction in Nursing from the University of Alberta. She completed her residency training in Indigenous Family Medicine at the University of British Columbia. Dr. Potts is a member of the Piikani Nation.

David Skakoon, RPsych

David is a registered psychologist, and started his work in in 1980, providing individual, marital, and family therapy in a community mental health setting. For a number of years, he has provided assessment and consultative support for students with severe multisensory and intellectual disabilities and/or Autism Spectrum Disorder. His current duties include working on a multidisciplinary team to provide support for students (and their families) with severe mental disorders transitioning to or from tertiary care facilities to programs in regular schools.

Sarah Skwarchuk

Sarah is a Métis knowledge keeper. She speaks Cree and attended the Holy Angels Residential School. She was one of the Indian Residential School resolution health support workers at Native Counselling Services of Alberta. Sarah also worked for the Ministries of Community and Social Services and Children's Services as a consultant on Indigenous issues. She was the project coordinator for the Society of Métis Literacy. Sarah has received training from Grant McEwan University, the Alternative Dispute Resolution Institute of Alberta and the University of Alberta. In 2001, she received her certificate in Local Government in Municipal Administration. Sarah is community-minded and has offered her skills to many committees and community service boards as member, parent, and professional.

Sharon Steinhauer, MSW, RSW

Sharon is the program lead for Social Work at the University nuhelot'ı̨ne thaiyots'ı̨ nistameyimâkanak Blue Quills. The university is committed to reclaiming Indigenous knowledge and practice and has established programs that students of all cultures describe as transformative, influenced significantly by the relational practice of engaging in circles to build common ground. She has proven leadership in prevention programs and asset-based community development and has completed work in the area of restoring families and communities to health.

Dr. Emily Wang, MSc, MA, PhD, RPsych

Emily is a registered psychologist. She is a fellow at the Child Trauma Academy and executive manager of Advancement and Integration of Trauma-Informed Practice at Hull Services (a flagship site for the Child Trauma Academy). She specializes in traumatology and early childhood mental health, provides training in the Neurosequential Model (NMT) concepts and implementation, and is responsible for overseeing the implementation of the NMT at Hull Services.

Michael Watts, MSW, RSW

Michael is a medical social worker at the Alberta Children's Hospital's Pediatric Centre for Weight and Health. He also teaches at the Department of Child and Youth Studies and Social Work at Mount Royal University and the Faculty of Social Work, University of Calgary. Michael is trained as a therapist and his areas of expertise include at-risk youth, mental health, individual, group and family therapy, and psychosocial issues related to adolescents and families impacted by Type 1 diabetes and weight and health issues.

Cheryl Whiskeyjack, CYC

Cheryl is the executive director of the Bent Arrow Traditional Healing Society. She has a diploma in Child and Youth Care from Grant MacEwan University and a certificate in Indigenous Leadership & Governance from the Banff Centre. She was a participant at the Aboriginal Round Table for the Mayor's Task Force on Poverty Elimination, participated in training for the Edmonton Police Service in preparation for the Truth & Reconciliation National Event, and presented at the National St. Vincent de Paul Conference on "Making Successful Transitions."

Elder Verna Wittigo, MSW, RSW

Elder Wittigo is a Cree Elder from Treaty 8 Territory. She has a Masters of Social Work degree with a clinical specialization and has worked in the field for 33 years. She has been recognized for her community involvement. Elder Wittigo received the Esquao Award for Community Development by the Institute of Advancement of Aboriginal Women, the Victim Services Award for 10 years of service, the Canadian Association of Social Workers Service Award, and the Charles S. Noble Award for Student Leadership at A.V. College. She has gathered knowledge, experience and education through her life journey. Elder Wittigo has a deep understanding and appreciation of her culture and respects spirituality and the sacred role of her people. Today she shares her role as Elder, cultural teacher and advisor. Elder Wittigo prays daily that all children find balance and harmony with a clear view of the future.

Sheila Yaremko, BA

Sheila worked with Children's Services for 30 years, and most of her career was spent as a foster care worker in the Edmonton region. Sheila helped design the current Foster Care Model and participated in the development of foster care programs and policies. She assisted in the development of the Competency Framework and the Workload Assessment Tool. Sheila participated in regional practice reviews of serious injuries and/or deaths of children and youth in the Child Intervention System. Sheila advocates for the continuous improvement of services offered to children and families and strongly believes in family reunification.

Marilyn Young, RN, BSN

Marilyn is the program manager for Prenatal and Postpartum Programs in Public Health, Alberta Health Services, Calgary Zone. Her responsibilities include program and policy development, quality improvement and staff education—urban and rural. She is also responsible for the operational management of the public health nurses who are members of the Alberta Vulnerable Infant Response Team (AVIRT). In Marilyn's 40 years of nursing experience, she has worked with families in acute care and community settings as a staff nurse, instructor, and manager. She has worked on projects involving multisectoral participation, believing that a collaborative approach is critical to supporting families.

APPENDIX 3: TERMS OF REFERENCE

Authority

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

The *CYAA* 9.1(1) requires the Advocate to review the death of a child who was receiving intervention services at the time of their death, or had received intervention services within two years of their death, as a child in need of intervention.

Objectives of the Mandatory Review

To review the experiences of children who have passed away and their families with child-serving systems as related to:

- Public assurance, and/or;
- Services and supports, and/or;
- Systemic issues.

To comment on relevant protocols, policies and procedures, standards and legislation.

To prepare and submit a public report that includes findings, observations, and/or recommendations arising from the Mandatory Review.

Scope/Limitations

A Mandatory Review does not assign legal responsibilities, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of a Mandatory Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of young people who receive Child Intervention Services.

Methodology

The review process will include:

- Examination of critical issues
- Review of documentation and reports
- Review of policy and casework practice
- Personal interviews
- Consultation with experts
- Notification and involvement, as the case may be, of the young person's family, Band, Delegated First Nation Agency, community or cultural group, relevant Ministry, law enforcement agency, Office of the Chief Medical Examiner, Alberta Health Services and any other person the Advocate considers appropriate.
- Other factors that may arise for consideration

Consultation with Experts

Relevant subject matter expertise will be obtained, either through individual consultation or by convening a committee—to be determined by the Advocate and the OCYA Director of Investigations. The purpose of consultation is to review the Mandatory Review report and to provide advice regarding findings, observations and/or recommendations.

Reporting Requirement

The Child and Youth Advocate will release a public report within 12 months of receiving notification of the child's death.

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MANDATORY REVIEWS INTO CHILD DEATHS

APRIL 1, 2018—SEPTEMBER 30, 2018

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