MANDATORY REVIEWS INTO CHILD DEATHS

OCTOBER 1, 2021–MARCH 31, 2022

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OFFICE OF
THE CHILD AND
YOUTH ADVOCATE
ALBERTA

SEPTEMBER 2022

OFFICE OF
THE CHILD AND
YOUTH ADVOCATE
ALBERTA

September 27, 2022

The Honourable Nathan Cooper
Speaker
Office of the Speaker
325 Legislature Building
10800 97 Avenue NW
Edmonton, AB T5K 2B6

Dear Mr. Speaker:

Under my authority and duty as identified in Section 9.1(4) of the *Child and Youth Advocate Act*, I submit to you the Mandatory Reviews into Child Deaths report covering the period of October 1, 2021 to March 31, 2022.

This report reviews the circumstances of fifteen young people who passed away during this period and whose circumstances met the criteria for a mandatory review. Twelve were receiving child intervention services at the time of their deaths, and three within the previous two years. Two additional young people died during this period; however, their reviews have been stayed and will be released at a later date.

Each of these 15 young people had an immense impact on those who knew and loved them, and I send my heartfelt condolences to those mourning their loss.

Respectfully,

[Original signed by Terri Pelton]

Terri Pelton
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 her authority from the *Child and Youth Advocate Act*.

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

MANDATORY REVIEWS OF DEATH

The Advocate is mandated to publicly report on the death of any young person involved with Child Intervention Services as a child in need of intervention at the time of their death, or within two years.

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 explore 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, makes observations, and may identify recommendations that could prevent similar issues from occurring in the future. The reports are released twice a year, in March and September.

The investigation process includes, but is not limited to, reviewing records from child-serving ministries; informing and involving family members, caregivers, and professionals; and consulting with Elders.

Investigative reviews do not contain findings of legal responsibility or conclusions of law, nor replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of a review is not to find fault with specific individuals, but to identify key issues and meaningful findings, observations, and/or recommendations specific enough that progress made on recommendations can be evaluated, yet not so prescriptive as to direct the practice of Alberta government ministries.

It is expected that ministries will carefully consider 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 young people.

EXECUTIVE SUMMARY

Between October 1, 2021 and March 31, 2022, the Advocate received notifications regarding 15 young people who had passed away and whose circumstances met the criteria for a mandatory review. Twelve were receiving child intervention services at the time of their deaths, and three within the previous two years. There were stays requested regarding two additional young people and their reviews will be released at a later date.

Number of young people who were Indigenous:

The Child and Youth Advocate is deeply concerned about the exceptional number of notifications that continue to be received regarding children and youth who have passed away. Of significant concern is the number of Indigenous youth, highlighting the critical need for systemic changes to better support First Nation, Métis and Inuit young people, their families, and communities.

Manner of death:

There are also far too many young people dying from drug-related causes. Substance use is a pervasive issue that has devastating outcomes for many young people and their families. There is an urgent need for a full spectrum of services and supports, which should be tailored to meet each young person's unique needs and circumstances. The government must develop and implement a youth specific opioid and substance use strategy to address this issue.

In this report, three areas of discussion are highlighted:

Public assurance: instances where services and supports were delivered as intended by legislation and policy

- the positive impact relational practice can have on outcomes for young people

Services and supports: service delivery gaps that negatively impact young people

- the importance of practice support to promote critical thinking in sound decision-making

Systemic issues: gaps in systems that, if left unaddressed, will continue to impact service delivery for young people with similar circumstances

- the importance of availability and accessibility of appropriate resources to meet the service needs of young people with complex needs throughout their lifespan

The glossary of terms is provided in Appendix 1; terms in **bold font** are defined in the glossary. A list of those consulted is provided in Appendix 2. The terms of reference is provided in Appendix 3, and the bibliography is provided in Appendix 4.

1. 6-Year-Old Rodney

Rodney was a kind First Nation boy who loved to ride horses. He was polite, well-mannered and described as "a little gentleman."

The Advocate found that Rodney witnessed escalating family violence, parental substance use and mental health concerns. At times, he did not have his basic needs met. His family had multiple brief involvements with Child Intervention Services. This often resulted in Rodney staying with relatives and having to change schools. Rodney was six years old when he died in a house fire.

2. 11-Year-Old Daniel

Daniel was a cheerful, adventurous, and caring First Nation boy. He loved playing video games, puzzles, and jumping on his trampoline.

The Advocate found that Daniel was prenatally exposed to substances and had a learning disability. He was apprehended at birth in another province and went to live with a relative who became his guardian. His family subsequently moved to Alberta. When Daniel was eight years old, he became the subject of a temporary guardianship order. He was subsequently returned to his guardian and child intervention involvement ended. Daniel was 11 years old when he was found deceased in his bedroom. The Office of the Chief Medical Examiner continues to investigate.

3. 14-Year-Old Desa

Desa was an adventurous, outgoing, and artistic girl. She was a leader among her friends and organized gatherings with them. Desa was gentle and often took care of younger children. Although she craved connection to others, she was unable to maintain healthy relationships.

The Advocate found that Desa's father had cognitive delays. Desa frequently witnessed violence, parental substance use and often did not have a stable home. She had ongoing involvement with Child Intervention Services. Desa was 14 years old when she died from suspected drug toxicity. The Office of the Chief Medical Examiner continues to investigate.

4. 15-Year-Old Kino

Kino was a shy First Nation youth who had a great sense of humour and loved to make people laugh. He liked anime, was talented at drawing and skilled with electronics. Kino started to explore his gender identity in his adolescence.

The Advocate found that Kino witnessed parental substance use and family violence. At times, he did not have enough food or a stable home. Growing up, he lived with various relatives when his parents were unable to take care of him. When Kino was 15 years old, he was the subject of a custody order and was placed in secure services. That same year, he died from drug toxicity.

5. 15-Year-Old Shylo

Shylo was a soft-spoken First Nation youth. Although shy, she opened up to people she trusted. She was respectful and cared deeply for her family. She loved to bake and took pride in making food for others. Shylo had a daughter, Bryne.

The Advocate found that Shylo lost multiple loved ones, witnessed violence in her community and by 13 years old, she began to use substances. That same year, Shylo became the subject of a temporary guardianship order. Almost two years after child intervention involvement ended, 15-year-old Shylo died from drug toxicity.

6. 16-Year-Old Isa

Isa was an Indigenous youth who took pride in her appearance and had a unique sense of style. She was proud of her Indigenous heritage and participated in ceremony when she was able to. Some people found it difficult to connect with her because she could be guarded; however, she was loyal to those she cared about.

The Advocate found that Isa witnessed parental substance use and family violence. Their home was unkept, she was often left unsupervised and did not have enough food. She became the subject of a permanent guardianship order at eight years old. Isa was 16 years old when she died from suspected drug toxicity. The Office of the Chief Medical Examiner continues to investigate.

7. 16-Year-Old Len

Len was a fearless, energetic, Métis youth who had an amazing sense of humour. He enjoyed rap music, video games and was skilled at pickleball. He was a strong advocate for himself and others.

The Advocate found that Len had significant mental health diagnoses and could be easily frustrated and upset. In adolescence, he started using substances and engaging in high-risk behaviours. He received services from multiple child-serving systems. When Len was 16 years old, his mother entered into an enhancement agreement, and approximately one month later, Len was found deceased. The Office of the Chief Medical Examiner continues to investigate.

8. 16-Year-Old Remi

Remi was a polite, caring, and compassionate First Nation youth. He liked going to the movies and playing video games. Remi struggled with depression and generalized anxiety.

The Advocate found that Remi witnessed caregiver substance use and family violence and at times, his medical, educational and basic needs were not met. He became the subject of a permanent guardianship order at 13 years old. Approximately three years later, 16-year-old Remi died from suspected complications from a seizure. The Office of the Chief Medical Examiner continues to investigate.

9. 17-Year-Old Nav

Nav was an outgoing, artistic young person who had a good sense of humour and an infectious laugh. Nav's chosen pronouns were they/them and they started to explore their gender identity at ten years old.

The Advocate found that Nav had complex mental health issues, and extensive involvement with Alberta Health Services. Nav received services from a multi-disciplinary team and Child Intervention Services supported Nav through an enhancement agreement with youth. Nav was 17 years old when they died from drug toxicity.

10. 18-Year-Old Gemma

Gemma was a kind, confident, transgender First Nation woman. She loved fashion, modeling, and makeup. She was very private and quiet, and she had a special relationship with her sister.

The Advocate found that Gemma had impaired cognitive functioning. She became the subject of a permanent guardianship order when she was two years old, and required specialized placements and support. Gemma was 18 years old when she died from drug toxicity.

11. 18-Year-Old Jayem

Jayem was a polite young man who wore his heart on his sleeve. He was protective of others, especially those younger than him. As he grew up, he found a sense of belonging in Indigenous ceremony and self-identified as Métis.

The Advocate found that Jayem was exposed to parental substance use, mental health concerns, and family violence. He became the subject of a permanent guardianship order when he was six years old. Jayem received post-18 supports; however, appropriate housing options were limited and often, he did not have a stable home. Jayem was 18 years old when he was found unconscious in a building fire. He died from complications related to smoke inhalation.

12. 18-Year-Old Malcolm

Malcolm was an intelligent young man who loved to sing. He could fix mechanical equipment and dreamed of owning a car repair shop.

The Advocate found that Malcolm witnessed escalating family violence, parental substance use and mental health concerns. At times, he was physically abused and his educational and basic needs were not met. His mother entered into a custody agreement when he was approximately 12 years old. At 16 years old, Malcolm entered into an enhancement agreement with youth, which ended one year later. Malcolm was 18 years old when he died from drug toxicity.

13. 19-Year-Old Katniss

Katniss was a fun spirited, resilient First Nation young woman who loved butterflies, sports, singing and poetry. She had two children, Harper and Ethan.

The Advocate found Katniss had multiple losses and began to use substances at 13 years old. She witnessed parental substance use and family violence. She subsequently went to live with relatives who became her guardians. She entered into an enhancement agreement with youth when she was 17 years old, and received post-18 supports to address housing instability, substance use and family violence. Katniss was 19 years old when she passed away after being hit by a car while walking on the highway.

14. 19-Year-Old Langdon

Langdon was a happy Indigenous young man who was described as a gentle soul. He loved rap music, video games and fishing.

The Advocate found Langdon witnessed parental substance use and family violence. He went to live with relatives who subsequently became his guardians when he was two years old. At 17 years old, Langdon became involved with Child Intervention Services through an enhancement agreement with youth and received post-18 supports. Appropriate housing options were limited and often, he did not have a stable home. Langdon was 19 years old when he died from suspected drug toxicity. The Office of the Chief Medical Examiner continues to investigate.

15. 19-Year-Old Mel

Mel was an empathetic and funny First Nation young woman. She valued her family and friends and expressed herself through drawing, singing, and playing guitar. She liked to share her art with others. She loved cats, vanilla bean frappes and wanted to be a yoga instructor.

The Advocate found that Mel was exposed to parental substance use and family violence. She became the subject of a permanent guardianship order when she was 16 years old. Mel was 19 years old when she died from drug toxicity.

The Advocate is making one recommendation:

Recommendation 1

The Ministries of Health, Education, Children's Services, Community and Social Services and Justice and Solicitor General should develop and publicly report on a coordinated action plan to address service gaps for young people with complex needs while longer-term initiatives are under development. This plan should include targeted activities and milestones that meet the immediate needs of these young people.

Further comments

Child-serving ministries have acknowledged that service provision for young people with complex needs requires a coordinated approach to be effective. They have identified several cross-ministry initiatives, that when implemented, may adequately support these children and youth. However, these young people require immediate services to ensure their survival and well-being.

Expected outcomes

Young people with complex needs will have access to supports while initiatives are under development. Supports should be readily available and accessible by young people and their families.

The coordinated action plan should be completed and publicly available within six months of this recommendation.

The coordinated action plan should include access to appropriate housing, mental health and substance use supports from adolescence to early adulthood.

THE YOUNG PEOPLE

6-YEAR-OLD RODNEY

ABOUT RODNEY AND HIS FAMILY

Rodney[1] was a loving and kind Indigenous child. He was described as a "little gentleman." Rodney spent most of his life in his First Nation community. He loved riding horses and wanted to be a cowboy and a firefighter when he grew up.

Rodney was the youngest of Amy and Eric's two children together. He had two maternal half-siblings. His parents' relationship was volatile, and they separated one month before his birth. Rodney had a special relationship with his great-grandmother, Margaret, who is a respected Elder in their community. She was supportive of Amy and often cared for her children when Amy was unable to.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Child Intervention Services and police first became involved with Rodney and his family when he was an infant because of ongoing family violence and responded to his home a number of times. Each time, child intervention involvement ended because Margaret and other relatives agreed to temporarily care for Amy's children. When Rodney was 11 months old, he and his siblings were **apprehended** because they did not have a sober caregiver. They were placed in a group home and four days later, were returned to Amy after she agreed to keep her home free of substances and violence.

When Rodney was between 18 months and 3 years old, child intervention and police responded to Amy's home multiple times. Concerns were related to inadequate supervision, adults fighting while under the influence of substances and Amy's deteriorating mental health. Police arranged for Margaret to temporarily care for Rodney and his siblings and caseworkers supported Amy to address the concerns. Child intervention involvement ended following a referral to community-based counselling supports.

When Rodney was four years old, caseworkers and police responded to Amy's home because adults were fighting while under the influence of substances. Amy's mental health was declining, and Rodney's older siblings often cared for their mother. A six-month **supervision order** was obtained. During this time, Rodney went to live with his father and was not part of the supervision order. Caseworkers continued to support Amy and her other children and provided a family support worker, counselling, and addictions services. Child intervention involvement ended when the order expired. Approximately five months later, following a custody dispute, Amy obtained a **parenting order** and primary care of five-year-old Rodney.

1 All names in this report are pseudonyms.

Within a few months, Child Intervention Services received a report that Amy had assaulted her daughter while intoxicated. Amy was arrested and Rodney and his siblings stayed with relatives. Her children were subsequently returned to her care and Amy entered into a **family enhancement agreement**, accessed addictions services, and explored various treatment programs.

Approximately three months later, Amy and her children moved into supportive housing in an urban centre. Amy completed a parenting program, went to addictions recovery support meetings, met with her sponsor, and went to family counselling. Rodney went to a local school where he excelled and was liked by his classmates and teachers. Amy and her children often visited with relatives, who provided regular updates to caseworkers.

CIRCUMSTANCES SURROUNDING RODNEY'S DEATH

During a family visit to their First Nation community, there was a fire where they were staying and six-year-old Rodney passed away. The police and the Office of the Chief Medical Examiner continue to investigate. Rodney's family and friends are devastated by his passing and deeply miss him.

11-YEAR-OLD DANIEL

ABOUT DANIEL AND HIS FAMILY

Daniel[2] was a happy, adventurous, and caring First Nation boy. He loved puzzles, trampolines, and video games. Daniel was prenatally exposed to substances.

Prior to his birth, Daniel's mother asked Jasmine to care for him and his older sibling. She subsequently became his guardian.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Daniel was born in another province and was **apprehended** and placed in Jasmine's care at his mother's request. She obtained guardianship of Daniel under an order that included financial supports and monitoring to help ensure that his needs were met until he reached 18 years old.

Daniel was a restless baby and had difficulty sleeping. He often cried inconsolably as Jasmine supported him through withdrawal symptoms. He did not meet his developmental milestones. As he got older, Daniel was impulsive and had emotional and verbal outbursts that were challenging for Jasmine to manage.

Daniel's family relocated to Alberta when he was a toddler. Child Intervention Services had brief involvements with his family during Daniel's first seven years. Reports were related to inadequate supervision, substance use by his older siblings and allegations of physical and emotional abuse. The concerns were not substantiated, and child intervention involvement ended.

Daniel went to the same school for his early elementary years. Teachers identified that he required additional support to address speech delays and that he had difficulty understanding basic concepts. A **psycho-educational assessment** indicated that he had a **learning disability** and displayed traits consistent with **fetal alcohol spectrum disorder.** He had impaired cognitive functioning, as well as difficulty understanding social cues and regulating his emotions.

When Daniel was seven years old, Jasmine said that she could no longer care for him and asked that he be moved. Jasmine consulted with her out-of-province social services worker and Daniel remained in her care. The following year, Daniel was apprehended in Alberta because of physical and emotional abuse concerns while in Jasmine's care. He was placed in a foster home under a **temporary guardianship order** (**TGO**).

2 All names in the report are pseudonyms.

Approximately six months later, Daniel was returned to Jasmine's care with a plan that included professional and natural supports to help her. When the TGO ended, Jasmine agreed to access the **Family Support for Children with Disabilities** program and said that her out-of-province social services worker would provide supports and referrals as needed. Child intervention involvement ended. It does not appear that Jasmine accessed further supports to care for Daniel.

Daniel's family moved, and he was not enrolled in an educational program for 17 months. When he returned to school, education staff offered learning resources and in-home supports. Jasmine declined indicating that the services provided by her out-of-province social services worker were sufficient. School staff created a plan to meet Daniel's needs and worked closely with him. He was provided with informal supports in his classroom.

When Daniel was 10 years old, child intervention caseworkers in Alberta were asked to complete the required annual review as a courtesy to his out-of-province social services worker. Caseworkers met with Daniel and Jasmine and recommended an in-depth, private follow-up conversation occur with Daniel to obtain additional information about his family's circumstances.

CIRCUMSTANCES SURROUNDING DANIEL'S DEATH

Caseworkers were waiting for a response from his out-of-province social services worker when 11-year-old Daniel was found deceased in his bedroom. Emergency medical services responded and were unable to revive him. He died from suspected asphyxiation. The Office of the Chief Medical Examiner continues to investigate. Daniel's family, peers and the professionals who supported him miss him and are deeply impacted by his passing.

14-YEAR-OLD DESA

ABOUT DESA AND HER FAMILY

Desa[3] was an adventurous, outgoing, and artistic girl. She craved connection to others and was a leader among her friends. She had a strong sense of what she liked and preferred making her own choices.

Desa's parents, Rowan and Ester, struggled with their mental health and substance use, and separated when Desa was four years old. Ester's substance use, periods of incarceration and housing instability impacted her ability to care for her daughter. Desa was raised primarily by Rowan, who struggled to meet her needs because of his developmental and cognitive delays. Desa had two half-siblings whom she felt safe with and confided in. Despite not always living together, they maintained a close connection.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Desa spent her first few years living with her parents and two older siblings in a home that was unpredictable and chaotic. Caseworkers and police often responded to her home because of family violence, adult substance use and drug-related criminal activity. She was also exposed to adults in her home who had criminal histories of sexual abuse. When she was four years old, Desa was **apprehended** and placed in foster care. Her caregivers and early educators had a challenging time managing her behaviours because she was not used to following rules or routines. She had a significant speech impediment and often mimicked physical outbursts she had witnessed at home.

Caseworkers considered applying for a **permanent guardianship order**. Ester was incarcerated and a **psychological and parenting assessment** completed on Rowan indicated that he would be unable to care for her without intensive and ongoing support. Rowan worked with a support worker, completed parenting classes, and met with his counsellor and psychiatrist and six-year-old Desa was returned to live with him under a **supervision order**. Shortly after, Rowan began a relationship with Kimberly and he and Desa moved in with Kimberly and her two children. Desa did not adapt well to their relationship. Child Intervention Services and police responded frequently to their home because of reports of parental substance use and violence.

Desa was in Grade 2 when she had an **educational assessment** that indicated she had difficulty focusing and was easily overwhelmed by her emotions. She met the criteria for **oppositional defiant disorder** and a **learning disability.** She was moved into a specialized behavioural program in Grade 3 and received additional educational supports and accommodations for the duration of her elementary school years.

3 All names in this report are pseudonyms.

When Desa was 11 years old, she was the **victim of violence**. The perpetrator was charged but not convicted, which had a profound impact on her. Desa was afraid to sleep, became anxious, depressed, and was less engaged in school and at home. Rowan did not have the capacity to find the appropriate supports for his daughter and the conflict in their home escalated.

When Desa was 12 years old, she was apprehended because her caregivers could not protect her from physical and sexual abuse. She was placed in group care and received services under a **temporary guardianship order**. She began to leave her placement without permission and used substances. She was subsequently moved to **campus-based group care** where she was provided with the services and supervision she needed. She had school support and was connected to specialized therapy to help her address her trauma. She loved animals and this program gave her daily opportunities to care for them.

After living in her placement for approximately one year, 13-year-old Desa began to have conflict with her peers and told caseworkers that she wanted to be moved. Placement staff said they would work with Desa to teach her conflict resolution skills; however, she was moved to back to Rowan's care and a supervision order was subsequently obtained.

Rowan and Kimberly struggled to parent Desa. Her substance use escalated, and her grades began to decline. A **psycho-educational assessment** indicated that she had **conduct disorder** with characteristics of **depression** and **anxiety**. School staff were committed to providing her a safe place, even when she was not able to go to classes.

In the ten months after Desa was moved back to Rowan's care, she was taken to the hospital nine times because of escalating substance use, suicidal ideation, self-harm, **COVID-19** symptoms and to treat injuries from a physical altercation with peers. Approximately two months before she passed away, Desa was confined under the ***Protection of Children Abusing Drugs Act***.

Staff from health and education expressed concerns that Desa was not safe living with her father because he lacked the ability to care for her. Caseworkers provided Rowan with in-home supports but he declined to participate in planning, refused to go to counselling and stopped taking his medications. Desa asked caseworkers to remain involved but Rowan refused services. When the six-month supervision order expired, child intervention involvement ended.

CIRCUMSTANCES SURROUNDING DESA'S DEATH

A few days after child intervention involvement ended, 14-year-old Desa was using substances and overdosed. Emergency medical services were unable to revive her, and she passed away. She died from suspected drug toxicity. The Office of the Chief Medical Examiner continues to investigate. Desa's friends and family went to her funeral and continue to mourn her loss.

15-YEAR-OLD KINO

ABOUT KINO AND HIS FAMILY

Kino[4] was a shy First Nation youth who had a great sense of humour and loved to make people laugh. He liked anime, was talented at drawing and skilled with electronics. Kino started to explore his **gender identity** when he was an adolescent and then began using his chosen name and he/him pronouns.

Kino was Karen and Kyle's only child together. They were impacted by **intergenerational trauma** and were involved with Child Intervention Services when they were children. At approximately one year old, Kino's parents separated. In addition, his parents had children from other relationships, whom Kino was close to.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Kino witnessed parental substance use and family violence. He was cared for by various relatives during times when Karen sought treatment for substance use and Kyle was incarcerated. He moved often, resulting in school changes, which impacted his learning. At 12 years old, Kino returned to live with his mother. He had problems with poor mental health, online **exploitation**, substance use, and self-harm. He was hospitalized following a suicide attempt. He was diagnosed with an **unspecified depressive disorder** and **substance use disorder** and referred to community-based mental health services. He did not access supports because he moved to a new community.

When he was a teen, Kino began to explore his gender identity. He continued to engage in high-risk behaviours and became estranged from his mother, who was overwhelmed and unable to take care of him. He moved frequently between family members who tried to support him but were unable to meet his needs. At times, he did not have a home nor a caregiver to ensure his safety and well-being. He was 13 years old when Karen obtained a confinement order under the ***Protection of Children Abusing Drugs Act***. Upon his release, he returned to live with her and one of his siblings. They were subsequently evicted from their home after Kino damaged property during a physical outburst. He was sent to live with his paternal family in his First Nation community while his mother and sibling moved to an urban centre. Kino said that he was sad and upset that he was left behind.

Child Intervention Services became involved with 14-year-old Kino because he was abandoned. He was not in contact with his mother and was no longer staying with family. There were concerns about his substance use, housing instability and physical and mental well-being. One of Kino's younger siblings passed away and

4 All names in this report are pseudonyms.

his death had a significant impact on Kino and his family. Kino stopped going to school and would not engage in counselling or addictions treatment. Karen told caseworkers that she could not take care of him because of his escalating behaviours. His father made private arrangements for Kino to live with relatives. These arrangements broke down because his family was unable to manage his behaviours.

When Kino was 15 years old, he was missing for several days and found by police unconscious from severe intoxication. He was **apprehended** and confined in a **secure services** facility, and then moved to a group home under a **custody order**. He shared that he did not feel like he belonged anywhere. He cut his hair, identified as male, used he/him pronouns, and went by his chosen name. He was angry when workers **misgendered** him or referred to him by his birth name and he refused to seek further support from them.

CIRCUMSTANCES SURROUNDING KINO'S DEATH

Three months after he was taken into care, 15-year-old Kino was found unresponsive in his bedroom at the group home. The Office of the Chief Medical Examiner concluded that he died from drug toxicity. Kino was a beautiful soul and is missed dearly by his family and friends.

15-YEAR-OLD SHYLO

ABOUT SHYLO AND HER FAMILY

Shylo[5] was a soft-spoken First Nation youth who cared deeply for her family. She loved to bake and took pride in making food for others. She had many losses that deeply impacted her.

Shylo's parents, Chris and Dorothy, used substances and at times, their relationship was violent. Shylo and her two older siblings were raised primarily by their paternal grandparents, Nadalie and Bill, in their First Nation community. Nadalie and Bill were **residential school** survivors and struggled with the impact of the abuse they endured earlier in their lives. As part of their recovery, they reconnected to their culture and subsequently became caregivers to many of their grandchildren.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Child Intervention Services became involved with Shylo and her family when she was one year old because of parental substance use and lack of food. Dorothy and Chris separated, and Chris and their children moved in with his parents. He worked with supports on parenting strategies and approximately two months later, child intervention involvement ended. Two years later, Nadalie and Bill obtained guardianship of Shylo and her brothers.

For the following ten years, Shylo had minimal involvement with child-serving systems. She was eight years old when her father died from complications related to substance use. Shylo started using substances in her early adolescence and her school attendance declined. She often snuck out of her grandparents' house and witnessed physical altercations and substance use in her community.

When she was 13 years old, Shylo was the **victim of violence**. She also suffered the loss of her brother, who died unexpectedly. Shylo struggled to cope, and caseworkers encouraged her family to access mental health supports. She expressed thoughts of suicide and was taken to the hospital under the ***Mental Health Act***. She was subsequently **apprehended** and placed in an Indigenous **campus-based group care** facility where she remained for six months under a **temporary guardianship order** (**TGO**). A **psychological assessment** indicated that Shylo had limited cognitive functioning, used marijuana and alcohol to cope, and that she was easily influenced to participate in high-risk activities.

Shylo's mother lived in a nearby city with her three younger children and wanted her daughter back in her care, so she applied for access and a **parenting order**. Caseworkers helped Dorothy, and Nadalie and Bill with a co-parenting arrangement.

5 All names in this report are pseudonyms.

Shylo made progress through therapeutic services to address her trauma. When the TGO ended, Shylo chose to live with her grandparents, who had taken the necessary steps to ensure she would be supported. When Shylo returned to Nadalie and Bill's home, caseworkers planned to continue services under an agreement. However, the **COVID-19** pandemic restrictions took effect and many services closed. Her grandparents were provided a list of community-based resources they could access and were told to contact caseworkers if they needed additional support. Shylo's therapist continued to offer in-person services during the restrictions but Shylo did not attend her scheduled appointments.

Over the next two years, Shylo continued to use substances and engage in high-risk activities. Police and health services workers were involved with her a number of times because of substance use and fighting. Shylo was 14 years old when her cousin was murdered, which had an immense impact on her, and her family and community. Three months later, Shylo had a daughter, Bryne, and both lived with her grandparents. Her substance use and high-risk lifestyle continued.

CIRCUMSTANCES SURROUNDING SHYLO'S DEATH

Fifteen-year-old Shylo and a relative were using substances at home when she became unresponsive. Emergency medical services responded and administered **naloxone** but were unable to revive her. The Office of the Chief Medical Examiner concluded that she died from drug and alcohol toxicity. Shylo is missed dearly by her family and friends and her death has had a significant impact on those who loved her and on her community.

16-YEAR-OLD ISA

ABOUT ISA AND HER FAMILY

Isa[6] was an Indigenous youth who took pride in her appearance and had a unique sense of style. She was proud of her heritage and participated in ceremony when she was able to. Isa was loyal to those she cared about.

Isa was prenatally exposed to substances. Her parents, Beatrice and Justin, struggled with substance use, which at times, led to family violence. Isa was the second youngest of four siblings, and her parents separated when she was six years old.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

During her first six years, Child Intervention Services and police were involved with Isa's family several times because of parental substance use, family violence and inadequate supervision. Their home was unkept and often she did not have food. Most involvements ended after the immediate safety concerns were addressed. Twice, Isa's family received services through a **supervision order** and a brief **family enhancement agreement**. Her parents worked with in-home support workers and completed substance use treatment programs. Isa and two of her siblings were subsequently **apprehended** after an incident of family violence. Her parents were supported to address the concerns but were unable to maintain their sobriety or housing. At eight years old, Isa became the subject of a **permanent guardianship order**.

Isa had a mild **intellectual disability** and was diagnosed with **oppositional defiant disorder** and **attachment disorder**. She received extra support in school because she had difficulty managing her emotions, struggled to follow rules and became anxious when left alone. At times, she had physical outbursts and ran away. Isa had multiple placements because her caregivers were unable to meet her needs. Between 4 and 13 years old, the supports offered to her family and caregivers increased based on her needs.

Isa was 10 years old when she was placed with family and began to experiment with substances. Her substance use escalated and when she was an adolescent, she often refused to stay in her placements. By the time she was 14 years old, Isa was using **methamphetamine** and **fentanyl**. She stopped going to school, was gang affiliated and had considerable involvement with the youth justice system. Isa's casework team used a **harm-reduction** approach when working with her. When Isa reached out to her caseworkers, they made themselves available to connect with and support her.

6 All names in this report are pseudonyms.

At times, Isa asked caseworkers for a placement; however, there were limited resources with the capacity to support her because of her unaddressed substance use and deteriorating mental health. When her safety was at risk, she was confined in a **secure services** facility. When she was in crisis or needed food, Isa accessed after-hours child intervention supports. However, the **COVID-19** pandemic restrictions impacted after-hours caseworkers' ability to bring youth into their offices for services.

CIRCUMSTANCES SURROUNDING ISA'S DEATH

Isa was 16 years old when police and emergency medical services found her deceased in a known drug house. She died from suspected drug toxicity. The Office of the Chief Medical Examiner continues to investigate. Her friends and family gathered to celebrate her life and wore Isa's favourite colour in her honour. They continue to mourn her loss.

16-YEAR-OLD LEN

ABOUT LEN AND HIS FAMILY

Len[7] was a fearless and energetic Métis youth who had an amazing sense of humour. He enjoyed rap music, video games and was skilled at pickleball.

Len's parents, Al and Sandy, separated shortly after his birth, and their children were raised by their mother. Len's siblings were important to him; he looked up to his brother and was protective of his little sister. He was also close to his maternal grandparents, who provided ongoing support to his family.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Len was a healthy and active young child. Sandy began to worry about him when he was four years old. He had difficulty controlling his impulses and at times, acted out physically. These behaviours continued and he had challenges concentrating in school. He made friends easily but found it difficult to keep them. He was often suspended from school because of conflict with his peers.

When he reached adolescence, Len's challenges increased. The reduced structure and greater independence required in junior high school did not meet his needs. He was unable to regulate his emotions and when angry, he frequently lashed out physically at himself or others.

Len had two **psycho-educational assessments** and received supports from a child and adolescent mental health program. He was diagnosed with **attention-deficit/hyperactivity disorder** and severe **oppositional defiant disorder** and prescribed medication. He had limited success with the interventions provided by community-based mental health supports, and Sandy entered into an agreement with the **Family Support for Children with Disabilities** (**FSCD**) program to receive additional services.

When Len's aggression escalated, their FSCD caseworker arranged for him to live with alternative caregivers because his mother and siblings did not feel safe in their home. Len lived in many formal and informal placements but they were unable to meet his needs.

In early adolescence, Len began to use substances and became involved with the youth justice system. At times, he was incarcerated in a youth justice facility. At 15 years old, Len was **apprehended** and confined in a **secure services** facility. Sandy entered into a series of **custody** and **enhancement agreements**; however, caseworkers were unable to find placements equipped to meet Len's needs. He temporarily stayed in youth shelters but was asked to leave because his physical outbursts placed his peers and staff at risk.

7 All names in the report are pseudonyms.

Len's substance use, suicidal ideation and self-harming behaviours led to multiple hospital visits. At times, Len was not admitted to hospital because he did not meet the criteria for admission under the ***Mental Health Act***. Medical staff asked that community-based services and other child-serving ministries support Len. Sandy obtained multiple confinement orders under the ***Protection of Children Abusing Drugs Act***. During one confinement, Len did not receive services because he assaulted staff and was asked to leave. He received limited programming during a subsequent confinement when he tested positive for **COVID-19** and had to isolate. Sandy was a tireless advocate for her son and often raised concerns about the lack of available services and supports for young people with **complex needs**.

Len saw a variety of addictions, mental health, and forensic therapists. He was also supported by a high-risk youth worker. He often missed appointments and refused services. Len's case team tried to develop a relationship with him. They met him where he was at and offered him choices of services that were available to support him.

Len was 16 years old when he was hospitalized following a drug overdose. He met the criteria for admission to a youth mental health program but a placement was not available when he was discharged from the hospital. Len was temporarily incarcerated due to several breaches of his probation order. Upon his release, he went to stay with friends and did not engage with caseworkers.

CIRCUMSTANCES SURROUNDING LEN'S DEATH

Approximately one month later, 16-year-old Len was found deceased in a wooded area. The Office of the Chief Medical Examiner continues to investigate. Len's deep curiosity and entertaining personality has left a lasting joy in the hearts of everyone who loved him.

16-YEAR-OLD REMI

ABOUT REMI AND HIS FAMILY

Remi[8] was a polite, caring, and compassionate First Nation youth. He liked playing video games and going to the movies. He began to have seizures when he was an adolescent and at times, struggled with **depression**. Remi was overjoyed when he became a father at 15 years old. Being a good parent was important to him.

During his first eight years, Remi lived with his family and siblings in their father's First Nation community. He had a close relationship with his parents, Morgan and Jordan, who were impacted by poverty and **intergenerational trauma**.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

When he was a toddler, Remi and his siblings witnessed family violence, parental substance use and mental health concerns. They had ongoing involvement with Child Intervention Services during Remi's first six years and he spent time in foster and **kinship care** while his parents tried to address their substance use. Morgan and Jordan worked with a family support worker under several **family enhancement agreements**. Their substance use continued, and Remi and his siblings were **apprehended**. Morgan and Jordan accessed treatment programs, received relapse support planning and Morgan went to therapy and parenting classes. During relapses, their children were apprehended and consistently returned under **supervision orders** immediately following completion of treatment programs.

When Remi was nine years old, his parents ended their relationship. Morgan and her children moved into her mother, Bella's, home in her First Nation community. After his parents separated, Remi rarely saw his father, which deeply impacted him.

Morgan wanted to give her children a good life but at times, she found it challenging and felt overwhelmed. Abstaining from substance use was increasingly difficult for her. She reached out to caseworkers for support, and within weeks, she relapsed. She and her three youngest children went to a women's shelter while Remi and his two older siblings stayed with relatives in their father's First Nation community. Through a series of enhancement agreements, Morgan received help to obtain financial support, housing, and counselling services and her children received emotional and recreational supports through a youth worker. Child intervention involvement ended when the last agreement expired because Morgan said she did not need further support.

8 All names in this report are pseudonyms.

Child Intervention Services became involved again when Remi was an adolescent. There were concerns that Morgan used inappropriate discipline on her children. Remi and his siblings were placed in care with Bella. Approximately one month later, Remi was returned home. Morgan entered into the first of several enhancement agreements and was supported by a family support worker and youth workers for her children. Remi and his siblings often moved between their mother and grandmother's care, which resulted in frequent school changes. At 11 years old, Remi started talking about suicide. Caseworkers helped him identify supportive adults to talk with and provided him with contact numbers for crisis services. Remi was also connected with a counsellor through his school.

When Remi was 13 years old, he became the subject of a **permanent guardianship order**. He was placed in a group home for Indigenous youth for approximately four months. He responded well to the structure and routine of his placement. He had sporadic contact with his mother and longed to have a closer relationship with her. He missed his father and said that no one cared about him. He began using substances and harming himself.

His doctor noted that Remi had developmental, behavioural, and mental health challenges including depression, **disordered sleep, generalized anxiety**, inability to control his impulses and difficulty regulating his emotions. He began seeing a therapist and was prescribed medication for his depression. Fifteen-year-old Remi continued to have suicidal thoughts but refused to engage with counselling or supportive services. Between 14 and 16 years old, Remi had five significant seizure episodes that required hospitalization. He was diagnosed with **epilepsy** and prescribed medication but he did not take it consistently.

Remi was moved to a kinship placement with Tanner, a close family friend. He did well in Tanner's care and his substance use decreased. Approximately five months after moving, Remi and his girlfriend had a baby and caseworkers helped them with the essentials they needed for their baby.

CIRCUMSTANCES SURROUNDING REMI'S DEATH

Remi was 16 years old when he was found unresponsive in his bed. Emergency medical services responded, and he was pronounced deceased. The Office of the Chief Medical Examiner continues to investigate. Traditional wakes were held in his parents' communities as well as a funeral in his father's First Nation. Remi's family is devastated by his loss.

17-YEAR-OLD NAV

ABOUT NAV AND THEIR FAMILY

Nav[9] was an outgoing, artistic young person who expressed their feelings through art and music. They had a good sense of humour and an infectious laugh. Nav started to explore their gender identity when they were ten years old. At the time of their death, they used a chosen name and they/them pronouns.

Nav was the oldest of two children. Their parents, Sarah and Caleb, had mental health concerns and Caleb used substances. Nav's parents divorced when Nav was five years old, and they lived with their mother. Sarah remarried Brian, who had two children of his own, and a few years later, they had a baby boy together. Nav's paternal grandparents took an active role in their life.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Nav was a healthy and active baby. When their parents separated, there was a custody dispute, and Sarah was granted an **emergency protection order** against Caleb. Afterwards, Caleb was not consistently involved with his children.

When Nav first entered school, they were supported by a speech therapist, occupational therapist, and educational assistant to work on **speech and language delays**, **fine motor skills** and social interactions with peers. Despite their early challenges, Nav did well academically.

Nav was ten years old when they began talking about suicide. At 12 years old, Nav was diagnosed with **adjustment disorder** and a few years later, **borderline personality disorder**. Nav's complex mental health issues often resulted in extreme mood fluctuations. Nav did not like the emotional and mental instability, and at 13 years old, began to use substances.

Sarah and Brian tried to find support to manage Nav's mental health and substance use but could not find appropriate services. There was tension at home and at 16 years old, Nav could no longer remain and was moved to a youth shelter because other placement options were not available. Nav received support from community-based agencies, mental health and addiction services.

Nav's substance use escalated to include **methamphetamine**, which worsened their mental health concerns. When Nav was 17 years old, Child Intervention Services supported them through an **enhancement agreement with youth** and to live independently. Approximately one month after moving, Nav used heroin, overdosed, and was taken to the hospital. The overdose scared them, and Nav talked about wanting to be sober but the substance use continued.

9 All names in the report are pseudonyms.

CIRCUMSTANCES SURROUNDING NAV'S DEATH

After Nav disclosed the extent of their substance use, Nav's support team arranged for them to attend a voluntary **detox program**. At the same time, Sarah applied for an order under the ***Protection of Children Abusing Drugs Act*** in case Nav was unable to commit to the program. The court date was set for early the following week, and that weekend, 17-year-old Nav was found deceased in a friend's apartment. They died from drug toxicity. Nav was loved by many people who continue to miss them dearly.

18-YEAR-OLD GEMMA

ABOUT GEMMA AND HER FAMILY

Gemma[10] was a kind, confident **transgender** First Nation woman. She started to openly identify as female when she was 12 years old. Gemma loved fashion, modelling, and makeup. She took pride in her appearance and enjoyed performing for others.

Gemma was the fourth child in a large sibling group. Her parents, Destiny and Doug, had histories of trauma and used substances. Gemma had minimal contact with her family throughout her life but maintained a strong connection to her older sister, Ruby, whom she loved dearly and often visited.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Gemma was prenatally exposed to substances, and when she was an infant, witnessed parental substance use and family violence. Although her parents worked hard to improve their circumstances, they could not sustain the necessary changes to safely care for their children. Gemma was two years old when she became the subject of a **permanent guardianship order** and was placed in a foster home.

When Gemma was three years old, she was placed in **kinship care** with her **kokum** who did her best to support her granddaughter for several years. When she could no longer care for Gemma because of her own declining health, Gemma was moved to a group home where she lived for four years.

While in group care, Gemma shared that she wanted to be a girl. She started to wear makeup, wore her hair long and dressed in feminine clothing. She had many friends, school staff and a mental health counsellor who supported her **gender expression**. Group care staff were also accepting but continued to use male pronouns when referring to her. Gemma was 12 years old when she moved from her group home to another group home in her First Nation community.

Over the next five years, Gemma moved eight times. There were concerns that she was being exploited on the internet and leaving her placement without permission. These concerns often led to conflict with her caregivers and placement breakdowns. Her attendance at school became sporadic and she was academically behind her peers.

Thirteen-year-old Gemma was diagnosed with **gender dysphoria** and a year later, she was referred to a **pediatric endocrine clinic**. Her doctors were concerned

10 All names in this report are pseudonyms.

that she did not have the capacity to consent to medical treatment, including hormone treatment therapy because it was suspected that she had **fetal alcohol spectrum disorder**. A **neuropsychological** and **psycho-educational assessment** were completed when Gemma was 15 years old, which indicated she had significant **learning disabilities** and she also suffered from **anxiety** and **depression**. The assessing psychologist noted that she would require adult disability supports.

When Gemma was 16 years old, she was placed in a **supported independent living program** (**SIL**) in an urban community. Although caseworkers and SIL staff attempted to engage Gemma and offered her support from a therapist, Elder and a youth mentor, she declined. She did not go to school, work, or participate in the services offered. Gemma spent most of her time in her room on the internet and concerns about online **exploitation** continued. She expressed thoughts of suicide, used substances, and often called her sister crying when she was under the influence. Gemma was informed that she would not qualify for post-18 child intervention financial supports if she did not either work or go to school.

CIRCUMSTANCES SURROUNDING GEMMA'S DEATH

A week after her 18th birthday, Gemma was using substances in the community and overdosed. Emergency medical services transported her to the hospital where she passed away with her family by her side. The Office of the Chief Medical Examiner concluded that she died from drug toxicity. A wake and funeral service was held in Gemma's First Nation community. She is missed by many, including her sister, Ruby, who continues to honour Gemma's memory.

18-YEAR-OLD JAYEM

ABOUT JAYEM AND HIS FAMILY

Jayem[11] was a polite young man who wore his heart on his sleeve. He was protective of others, especially those younger than him. As he grew up, he found a sense of belonging in Indigenous ceremony and self-identified as Métis.

Jayem's parents separated when he was a toddler. He had limited contact with his father until they reconnected over social media when he was an adolescent. Jayem's mother, Amy, had periods of substance use, and was involved in violent relationships. Although Amy and Jayem had a complicated relationship, she remained involved with him throughout his life.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Jayem was two years old when he was **apprehended** and placed in a foster home because of parental substance use, mental health concerns and family violence. Seven months later, he was returned to his mother briefly then apprehended again for similar concerns and remained in care. His behaviours were challenging to manage. He was overactive and required constant supervision. His caregivers were unable to meet his needs and when he was four years old, Jayem was moved to group care. He lived in ten placements between three and nine years old.

When Jayem was between 5 and 12 years old, he received intensive psychological and psychiatric services to address behaviours associated with **complex post-traumatic stress disorder**. Supports were also provided to his caregivers and school staff. At six years old, Jayem became the subject of a **permanent guardianship order**. Three years later, he was transitioned to a **foster to adopt** home. Intensive supports were provided but after 15 months, his foster mother asked that he be moved because she could not manage his behaviours. Jayem was returned to his previous group home.

Jayem was moved to **campus-based group care** when he was 12 years old, where he received therapeutic supports. He lived there for almost two years before moving to a placement in an urban centre where he did not receive psychological services. He started to use substances, left his group home without permission, and became involved with the youth justice system. He had regular visits with his mother and siblings, until his siblings were adopted and moved out of province. He did not see them again, which had a profound impact on him.

11 All names in this report are pseudonyms.

At 15 years old, Jayem was moved to another group home where he remained until shortly after his 18th birthday. He established positive relationships with many of the staff. Jayem often left his placement for periods of time to use substances but he was always welcome to return. When he turned 18 years old, Jayem entered into a **support and financial assistance agreement**. Although group home staff initially agreed to have him remain past his 18th birthday, he was asked to leave because of his escalating substance use. Jayem stayed in youth shelters, with friends, and in abandoned buildings. There were times he returned to his former group home to eat and sleep.

CIRCUMSTANCES SURROUNDING JAYEM'S DEATH

Jayem was 18 years old when he was taken to the hospital after being found unresponsive in a building fire. He was placed on life support and two days later, passed away with family by his side. The Office of the Chief Medical Examiner concluded that he died from smoke inhalation. Drugs were found in his system and considered contributing factors to his death. He is deeply missed by his family, and those who knew and worked with him.

18-YEAR-OLD MALCOLM

ABOUT MALCOLM AND HIS FAMILY

Malcolm[12] was an intelligent young man who loved cars and dreamed of owning a vehicle repair shop. He excelled academically and was popular with his classmates and teachers. He loved to sing and was on the debate and basketball teams.

Malcolm was the oldest of Tanya's two children and he was protective of his younger brother, Jaime. He did not know his father but was close with his stepfather, Mark. He had a strong connection to Mark's parents, Peter and Rebecca, who raised him for many years. Mark and Tanya subsequently separated and Mark's new partner, Jenna, became an important support for Malcolm.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Child Intervention Services was involved with Malcolm and his family from infancy. Concerns were related to substance use, family violence and physical abuse. Tanya and Mark were initially referred to community-based parenting supports but as the concerns escalated, they entered into a **family enhancement agreement** and received additional supports including counselling. Mark and Tanya separated when Malcolm was three years old, and their children lived with Mark and his parents. Child intervention involvement ended after Malcolm's stepfather and step-grandmother obtained a **parenting order** for Malcolm and his brother. There was no child intervention involvement for the following four years.

When Malcolm was seven years old, he was diagnosed with **attention-deficit/hyperactivity disorder** and **oppositional defiant disorder**. He was supported by a behavioural specialist for the remainder of his elementary school years and his caregivers were provided strategies to implement at home.

Between 9 and 11 years old, Child Intervention Services was involved with Malcolm and his family through several enhancement agreements. Malcolm and his brother returned to Tanya's care following a report of physical discipline while living with their grandparents. They received services from a family support worker and went to therapy. There were additional reports of family violence, parent-teen conflict, and concerns that both Malcolm's and his mother's mental health were declining. Tanya entered into a **custody agreement** and 12-year-old Malcolm was placed in a group home. He remained in care, had supervised visits with his family and was hopeful that things would get better with his mother.

12 All names in this report are pseudonyms.

At 14 years old, Malcolm was returned home under the first of two consecutive enhancement agreements. Shortly after the second agreement ended, 15-year-old Malcolm called Child Intervention Services because of ongoing family violence, and Tanya's self-harming behaviours and declining mental health. A few months later, Malcolm moved out following a violent argument with his mother. He stayed with his stepmother, Jenna, until his 16th birthday and then entered into an **enhancement agreement with youth. Supported independent living** placements were not available in his community, so caseworkers provided funding for room and board until Malcolm was able to get his own apartment. Malcolm's family encouraged him to go to treatment after he told them he used substances.

Two months later, Malcolm was involved in a hit and run accident and was placed on probation. His probation officer developed a positive relationship with him and regularly connected with Malcolm's youth worker, stepmother, and caseworker to help monitor his progress. Caseworkers continued to support Malcolm financially and provided a youth worker who helped him find a job and enroll in an outreach school.

When the **COVID-19** pandemic restrictions were put in place, the life skills program that Malcolm was involved with closed, and he lost the connections he had made. He spent more time at his apartment, which was in an area known for drug trafficking. His substance use escalated, he stopped going to school and he lost his part-time job. He was charged with drug-related offences and soon after, was evicted and did not have a stable home. Caseworkers and probation officers tried to connect Malcolm to substance use treatment centres but he declined. Caseworkers entered into monthly enhancement agreements with Malcolm to ensure he remained in contact with them but he found this requirement stressful. Approximately two months later, child intervention involvement ended after 17-year-old Malcolm missed his monthly meeting with caseworkers.

The following year, Malcolm began to use more potent substances. At times, he stayed with his grandparents but he did not have a stable home. His family and friends administered **naloxone** several times when he overdosed and took him to the hospital. Malcolm agreed to **methadone** and **suboxone therapy** to address his substance use and he appeared sober at his last medical appointment.

CIRCUMSTANCES SURROUNDING MALCOLM'S DEATH

Approximately one month after his last medical appointment, 18-year-old Malcolm was found deceased in a known drug house. He died from suspected drug toxicity. The Office of the Chief Medical Examiner continues to investigate. Those who knew and cared for him are devastated by his passing. A funeral and celebration of life were held to remember Malcolm.

19-YEAR-OLD KATNISS

ABOUT KATNISS AND HER FAMILY

Katniss[13] was a fun spirited and resilient young First Nation woman who loved butterflies, sports, singing and poetry. She had two children, Harper and Ethan.

Katniss' parents separated when she was three years old because of family violence. Katniss lived between her mother and grandmother's homes. She had two younger siblings.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

During her first 13 years, Child Intervention Services was involved with Katniss and her family through several **intakes**, **assessments**, and agreements. Concerns were related to parental substance use and family violence. Between 10 and 13 years old, Katniss spent almost 3 years in care and lived in 4 placements.

In her early adolescence, Katniss started using substances. When she was 12 years old, her mother died by suicide. The following year, Katniss became the subject of a **permanent guardianship order**, and her aunt subsequently obtained a **private guardianship order**. Child intervention involvement ended and was not involved for three years.

Katniss was treated several times in hospital for substance use and injuries from physical altercations and **exploitation**. She said she was depressed and had difficulties dealing with her trauma. She was not motivated to go to school and did not spend significant time at home.

Katniss was 16 years old when her daughter, Harper, was born. Approximately one year later, she had her son, Ethan. Child Intervention Services became involved with Katniss and her children because of housing instability, substance use and family violence. Harper and Ethan were **apprehended** and placed in **kinship care**.

Katniss entered into an **enhancement agreement with youth** two days before her 18th birthday because of housing instability and substance use. On her 18th birthday, she entered into the first of three consecutive **support and financial assistance agreements**. Katniss had been involved with a community-based agency since she was a school-aged child, and staff there helped connect her to services. She found supported housing but she often had unsafe people in her home and had difficulty meeting tenancy expectations.

13 All names in the report are pseudonyms.

Over the next year and a half, Katniss was taken to the hospital several times because of escalating substance use and mental health concerns. She often left prior to receiving treatment. Katniss had sporadic contact with her support team, which made it difficult for her to access services. She wanted to go to treatment but was unable to complete the admission requirements. Katniss had many losses and significant trauma that impacted her emotional well-being throughout her life.

When Katniss was 19 years old, she was incarcerated for assault and breaching her probation order. Shortly after being released, she was evicted from her home. Although caseworkers explored supportive housing placements, Katniss did not respond to requests to meet and discuss housing or treatment options. A short time later, her father passed away. Her substance use escalated, and her support team was concerned for her mental health. She disengaged from safety planning and stayed in shelters.

CIRCUMSTANCES SURROUNDING KATNISS' DEATH

Approximately four months after her 19th birthday, Katniss was involved in a hit and run accident where she was struck by a car while walking on the highway. She passed away from her injuries. Katniss is deeply missed by her family and the many professionals who worked with her.

19-YEAR-OLD LANGDON

ABOUT LANGDON AND HIS FAMILY

Langdon[14] was a joyful First Nation young man who was polite and had a gentle soul. He loved rap music, video games and fishing. He spent most of his life in his caregiver's First Nation community.

Langdon was the third oldest of a large sibling group. His parents, Kelvin and Macy, often separated and reconciled. Macy chose Bailey to be Langdon's caregiver when he was **apprehended** as a toddler. Bailey subsequently obtained a **private guardianship order** when Langdon was two years old, and he lived with her until he was 17 years old.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Child Intervention Services became involved with Langdon and his family when he was five months old. Kelvin and Macy had a volatile relationship and used substances. Langdon and his siblings were apprehended multiple times because of parental substance use and family violence. During his time with Bailey, Langdon had limited involvement with child intervention.

Langdon went to school in Bailey's First Nation, and in a nearby community. In Grade 5, there were concerns that he did not listen well and would not follow direction. At 15 years old, Langdon began to have attendance issues; he was no longer making passing grades and was suspended for substance use. He also had physical outbursts toward other students. A **psycho-educational assessment** was completed, and Langdon was diagnosed with **disruptive mood dysregulation disorder** and **conduct disorder**. In Grade 10, he was suspended from school for an indefinite period, and he did not return.

When Langdon was 17 years old, Bailey could no longer meet his needs. Langdon entered into a **custody agreement with youth** for approximately six months. He had a **psychological assessment**, and he was diagnosed with **fetal alcohol spectrum disorder**. He also met the criteria for an **intellectual disability** diagnosis. The assessment indicated that Langdon required strategies, supports, and interventions as he transitioned to adulthood to address comprehension and cognitive challenges. He would need continued supports into adulthood.

As a young adult, Langdon moved from his community to an urban centre where he had limited contact with his siblings and relatives. Child Intervention Services continued to support him and at 18 years old, Langdon entered into the first of three consecutive **support and financial assistance agreements** and was placed in **supported independent living** (**SIL**).

14 All names in the report are pseudonyms.

On his 18th birthday, Langdon received a large sum of money from his First Nation. Without support to manage his finances, he spent it in less than two months. Caseworkers were committed to helping Langdon transition to adult supports including the **assured income for the severely handicapped** (**AISH**) and **persons with developmental disabilities** (**PDD**) programs. SIL staff reported concerns about his substance use and his well-being. He missed multiple intake appointments with PDD, and his **intake** was closed. Langdon's AISH application was approved, and he subsequently received a large back payment. He did not qualify for a **public trustee**, and a financial administrator through the AISH program was not in place. Without support, he spent the money quickly and concerns about his substance use increased.

Shortly after his 19th birthday, Langdon was asked to leave the SIL program because he continued to use substances in his apartment. He went to a youth shelter and was subsequently moved to a supported living program in the community. Caseworkers and program staff worked hard to support Langdon using a **harm-reduction** approach. They developed a relationship with him and tailored services to Langdon's functioning level.

CIRCUMSTANCES SURROUNDING LANGDON'S DEATH

Staff were concerned after Langdon left the program and did not return. After 10 days, he was reported missing to police and was found deceased. Nineteen-year-old Langdon died from suspected drug toxicity. The Office of the Chief Medical examiner continues to investigate. A wake and funeral were held in the community where he grew up. Langdon is missed by those who knew and loved him.

19-YEAR-OLD MEL

ABOUT MEL AND HER FAMILY

Mel[15] was a funny and caring First Nation young woman. She was creative and loved to express herself through drawing, singing, and playing guitar. She loved cats and vanilla bean frappes.

Mel was exposed to parental substance use and family violence. She was **apprehended** when she was four months old and remained in care. When she was seven years old, Mel and her younger sibling were adopted by their foster mother, Dakota, who was Métis.

SUMMARY OF GOVERNMENT SYSTEMS INVOLVEMENT

Mel became the subject of a **permanent guardianship order** at one year old and was moved to Dakota's foster home the following year. When Mel was a toddler, she received services from public health to address **separation anxiety** and support her motor skill development.

Mel went to the same school from Kindergarten to Grade 6. She received speech and language therapy and ongoing school accommodations to address her learning needs. She gravitated towards a negative peer group and at 13 years old, began to use substances and stopped going to school. As her substance use escalated, she often stayed out past her curfew. Within one year, Mel was confined under the ***Protection of Sexually Exploited Children's Act*** (***PSECA***) after she was exploited in exchange for substances. Mel and Dakota entered into **voluntary service agreements** and **family enhancement agreements**; however, Mel did not engage consistently with her case team.

Mel acted out physically, her health declined, and she found it difficult to safety plan or stay home. She was confined multiple times in **secure services** and *PSECA* facilities. She received programming that focused on reducing her substance use, high-risk behaviours, and sexual **exploitation**. Mel was hospitalized under the ***Mental Health Act*** after she began hallucinating and became incoherent. Caseworkers struggled to find a program that could keep her safe; when not confined, she left her placement to use substances. She was involved with the youth justice system and a probation officer became part of her support team. Clinicians said it would be difficult to find a form of therapy that would be effective because Mel's substance use had impacted her cognition. She continued to tell her workers that she wanted to use substances and declined most addictions services.

15 All names in the report are pseudonyms.

When Mel was between 15 and 17 years old, her case team worked hard to keep her safe. They provided youth workers and one-to-one workers, safety planned and encouraged her to access addictions supports. Professionals noted that the services required to support young people like Mel were not available. Her case team met regularly, and despite efforts by multiple professionals, she remained in a cycle of substance use, deteriorating health and confinement. By the time Mel was 17 years old, her diagnoses included **fetal alcohol spectrum disorder**, **attention-deficit/hyperactivity disorder**, **oppositional defiant disorder**, **conduct disorder, unspecified trauma and other stressor-related disorder**, **unspecified schizophrenia spectrum disorder**, as well as four **substance use disorders**. She was regularly seen by a psychiatrist and prescribed medication.

Doctors issued **community treatment orders** to address her declining mental health. Mel entered into the first of six consecutive **support and financial assistance agreements** when she turned 18 years old. She received adult supports that included **persons with developmental disabilities** (**PDD**) and **assured income for the severely handicapped**, as well as an **adult trustee** and **adult guardian**. At times, Mel went to detox centres but she did not stay. She was referred to several placement agencies through PDD but they were unable to find her a placement that could meet her needs. Caseworkers offered hotel accommodations, one-to-one workers, and vouchers for food and other necessities.

Mel became involved in an abusive relationship and at times, returned to Dakota's home where she ate, showered, and slept. Dakota continued to support Mel with what she could, and they had a loving relationship. Caseworkers tried to maintain contact with her and arranged for a youth worker; however, the **COVID-19** pandemic restrictions made meeting difficult. Shortly after Mel's 19th birthday, she received funding for **wrap-around services**; however, her circumstances made it difficult for her case team to contract service providers. She did not have a stable home and at times, stayed in shelters.

CIRCUMSTANCES SURROUNDING MEL'S DEATH

Three months before her 20th birthday, Mel was living in a tent where she was found unresponsive. Emergency medical services were unable to resuscitate her. The Office of the Chief Medical Examiner concluded that she died from drug toxicity. Mel's family, friends and the professionals who knew and cared for her are deeply impacted by her passing.

DISCUSSION

PURPOSE

The purpose of conducting a mandatory review is to explore the young person's experiences with government systems, identify systemic issues that might have been present, determine whether services and supports were appropriate, and provide public assurance. The Advocate comments on findings, makes observations, and may identify recommendations that could prevent similar issues from occurring in the future. The findings from the circumstances of the 15 young people are highlighted under 3 areas in the following discussion: public assurance, services and supports and systemic issues. As these young peoples' circumstances were dynamic, they may be referenced in more than one area of the discussion.

PUBLIC ASSURANCE

Public assurance explores instances where services and supports are provided as intended by legislation and policy. In reviewing the circumstances of these young people we noticed that although resources and/or service gaps persisted, there were times in each of these circumstances where those supporting them were agile and creative in their approach. The following young people's circumstances are explored in this section:

- Len
- Nav
- Kino
- Remi
- Malcolm
- Isa
- Langdon
- Desa
- Gemma
- Jayem
- Mel
- Daniel
- Shylo
- Katniss
- Rodney

THE IMPORTANCE OF RELATIONSHIP IN SUPPORTING YOUNG PEOPLE

The basic principles of the ***United Nations Convention on the Rights of the Child*** (***UNCRC***) indicate that "governments should do their best to help children live and grow to be the best they can be."[16] These principles afford children the right to life and development and highlight the importance of relational practice when appropriate services and supports are not available or accessible.

What we found

We heard throughout our investigative reviews that providing effective supports can be challenging because multiple and timely decisions are required, and resources may not be available or accessible. Despite these barriers, in reviewing the circumstances of these young people, we noted they had parents, siblings, caregivers, and service providers who were deeply invested and committed to finding ways to support them.

> "The bottom line is that healthy relational interactions with safe and familiar individuals can buffer and heal trauma-related problems…"
>
> **Ludy-Dobson & Perry, 2010**

16 Public Health Agency of Canada, 2021

We found that the following young people had strong relationships with family members, who did their best to support and advocate for them to get the services they needed:

- Len and Nav's parents advocated tirelessly for them, trying to find appropriate resources to meet their needs.
- Rodney, Kino and Shylo had large families who remained committed to helping in any way they could.
- Gemma and Desa's siblings were connected to them throughout their lives.

Five of these young people were connected to professionals who were agile and creative in finding ways to meet them where they were at.

- When Remi was young, his family was impacted by **intergenerational trauma** and substance use. His service team found timely resources to support his parents.
- Jayem had complex needs and when he was young, groups of professionals worked together to identify appropriate supports.
- Katniss had a strong relationship with staff from a community-based agency who connected her to resources and advocated for her needs.
- Mel and Nav both had complex mental health concerns and used substances that often placed them at fatal risk. At the time, resources were not available that had the capability to meet Mel and Nav's needs. However, both young people had teams of professionals from multiple child-serving systems who met regularly to case plan and were a constant in their lives.

Responding to trauma in children and youth

All of the young people reviewed in this report endured loss and trauma that impacted their development. Research indicates that children who have harmful early experiences are likely to have better outcomes if they are supported by positive relationships.[17] It is critical for professionals working with a young person to recognize and involve all of their familial, peer, academic and community supports.[18]

- Desa and Daniel's experiences highlight examples of how school staff exceeded their academic roles. They used a **trauma-informed** approach and intentionally focused on providing safety and finding creative ways to engage with these young people and identify appropriate supports.

17 Hambrick et al., 2019

18 Ibid

- Nav and Langdon were connected to youth shelters where staff understood the complexity of their needs and adapted their approach, which provided safety and housing. Staff maintained a relationship with Nav even after they left the program. Langdon was subsequently referred to a supported living program in the community that used a **harm-reduction** approach where staff developed a relationship with him and tailored services to his level of functioning.
- Staff at Jayem's placement built relationships with him, and he knew he was welcome even when he was struggling. This meant that even if he used substances, he always had a safe place to return.
- Len, Malcolm and Shylo received mental health services from therapists who offered creative solutions to ensure they did not lose in-person services during the **COVID-19** pandemic.
- Malcolm's probation officer helped avoid breaches by going to meet him, understanding that Malcolm could not make it to appointments. After child intervention involvement ended, Malcolm's youth worker continued to work with him, ensuring his basic needs were met.
- When Isa called, her caseworker found ways to connect with her immediately, understanding that it may be difficult to find Isa again. This provided opportunities to assess her immediate needs and provide supports.

The impact of the COVID-19 pandemic

Over the past two years, the COVID-19 pandemic has made it more difficult for families, caregivers, and service providers to appropriately support young people. The pandemic affected the availability of resources as service providers were challenged to provide care while abiding by the public health restrictions. Caseworkers had difficulties transitioning young people, like Shylo, home because in-home support services were unavailable due to the risk of exposure to COVID-19.

Some young people, like Len, were confined under the ***Protection of Children Abusing Drugs Act*** (***PChAD***) but were not able to fully participate or benefit from programming because a period of isolation was required when he arrived. After-hours caseworkers had to find creative ways to support youth, like Isa, while keeping both the young people and staff safe. School staff throughout the province had a number of challenges supporting young people after they moved to virtual learning. Many caseworkers were in similar circumstances to those of Malcolm's, where programming and resources that had been successfully established were paused because of the pandemic restrictions, leaving youth without the support they needed.

"I see how, when the system is overwhelmed and caseworkers have a lot of youth (on their caseloads), that it is impossible to develop human connection and be there … They should have more workers with less work so that they can advocate for the kids they are looking after."

Youth Council consultation, June 2022

What has been said in the past

The Office of the Child and Youth Advocate has highlighted instances where families and service providers display agility and persistence to meet young people where they are at while working within the confines of existing supports, which may not always be suitable.[19] We recognize that young people's needs have become increasingly difficult, complex, and require additional time to support. This has far-reaching effects, often stressing or overwhelming the capacity of existing services.

Many professionals we spoke with through our investigative reviews said they wanted to do good work but found it challenging to provide effective services. Some of the reasons included difficulty accessing resources and not always knowing how to help. During these times, frontline workers rely on supervisors to help them take the time to reflect and critically think about how best to support young people whose needs are complex. [20]

What needs to happen

In reviewing the circumstances of these young people, we recognize the commitment and dedication by their family members and the professionals who worked with them. Despite this, the necessary resources and supports were often not available or accessible. Over the past two years, the COVID-19 pandemic has magnified this issue.

It is critical that child-serving agencies and ministries provide adequate resources for young people and support their staff with the necessary tools to do this very difficult work.

The basic principles of the *United Nations Convention on the Rights of the Child* (*UNCRC*) indicate that "governments should do their best to help children live and grow to be the best they can be."

19 Discussion and recommendations on this topic can be found in previous Mandatory Review reports online: https://www.ocya.alberta.ca/adult/publications/investigative-review/

20 Snyder & Babins-Wagner, 2013

This section explores service delivery gaps that negatively impact children and youth. The following young people's circumstances are explored in this section:

- Rodney
- Desa
- Kino
- Gemma
- Daniel
- Shylo
- Remi
- Malcolm

GUIDANCE IN CHILD INTERVENTION DECISION-MAKING

Article 3 of the *UNCRC* states that in all actions and decisions made concerning a child, their best interests should be at the forefront.[21] This highlights the importance of comprehensive decision-making to ensure the safety and well-being of all young people.

What we found

Child intervention caseworkers and their supervisors work with children, youth and families who are in difficult situations. Often, life changing decisions for young people are made quickly to ensure their safety and well-being.

- Rodney, Desa, and Malcolm repeatedly came to the attention of Child Intervention Services. Interventions appeared to focus on addressing the presenting concerns with limited re-evaluation of the impact of the supports these young people and their families received. These patterns of multiple short-term involvements appeared to lead to problems escalating over time, leaving these young people in high-risk situations and continued exposure to traumatic events.

Research indicates that significant long-term consequences, including increased substance use, low self-esteem and mental health concerns, stem from experiencing reoccurring traumatizing circumstances.[22] Caseworkers must have strong assessment skills to appropriately determine the needs of and risks to families.[23] They should also ensure that young people are at the center of all interventions and decision-making.[24]

21 United Nations Convention on the Rights of the Child, 1989

22 Downey & Crummy, 2022

23 Alberta Union of Provincial Employees, 2012

24 Hallberg & Smith, 2018

- The services and supports provided to Desa and her family often appeared to be tailored to her father's needs. Her voice did not appear to be reflected in decisions that impacted her. She said that she did not feel safe living with her father and asked caseworkers for help. When her father refused to enter into a voluntary agreement, child intervention involvement ended. Desa temporarily stayed at a friend's place but was asked to leave. She refused to go home, her substance use escalated, and she began expressing suicidal thoughts. One week later, Desa was found deceased.
- Child Intervention Services and police were involved with Rodney and Malcolm's families because of escalating family violence, parental substance use and deteriorating mental health. Each time, child intervention involvement ended when Rodney and Malcolm's parents agreed to access community-based supports or when alternate short-term caregivers were identified. For both Rodney and Malcolm, as concerns escalated regarding their overall safety and well-being, there did not appear to be a re-evaluation of their family's circumstances. The services and supports provided appeared to remain unchanged over time and became incongruent with the escalating nature of the concerns.

> "My parents could not meet my needs; they could not take care of me, and I did not have anywhere to go. The caseworker had different meetings and kept going back to the same people who they already knew could not meet my needs."
>
> **Youth Council consultation, June 2022**

When working with Indigenous young people and their families, decision-making must include an understanding of the impacts of **intergenerational trauma**. Trauma-informed care providers need to recognize the importance of considering a young person's experiences and use them to inform interventions.[25] Daniel, Shylo, Kino, Remi and Gemma all had family members who went to residential schools. These five young people and their families may have benefited from adequate supports built on a foundation of trust, mutual respect, and open communication to account for and address the impacts of intergenerational trauma.[26]

- Shylo was the **victim of violence** and had a significant amount of loss. She was cared for by her grandparents who loved her deeply and did their best to provide a safe home. They were residential school survivors, and this trauma impacted their connection to culture and family, as well as their trust in government systems. This may have created barriers to accessing services.

25 Children's Bureau, 2020

26 Đurišic & Bunijevac, 2017

> "These are the most fragile kids we have, and systems just do not understand."
>
> **Committee consultation, July 2022**

Kino and Gemma had family members who wanted to care for them but were unable to meet their needs. These young people and their families were impacted by intergenerational trauma and required extensive support.

- For three years, Kino did not have a stable home. He was often responsible to find his own place to stay, which consistently broke down shortly after child intervention involvement ended. Kino used substances, and while not having a stable place to live, was exploited.
- Gemma's aunt provided a loving and long-term **kinship care** home but when Gemma's behaviours escalated, Gemma had to leave. It was not clear what supports were provided to maintain the placement. She had multiple placement breakdowns and was subsequently moved to a **supported independent living** (**SIL**) program. Gemma became isolated and there were concerns that she was exploited and did not go to school, work, or participate in SIL programming.

Daniel and Remi's circumstances highlight that better planning is required for young people and their families when children are returned home.[27] Child Intervention Services has policy so that this happens.[28] But for these young people, it was not reflected in the services they received.

- After Remi's caregivers completed treatment, it was unclear how they were supported upon his return. His mother struggled with substance use and often relapsed after he was returned. His family may have benefited from a gradual transition with additional supports.
- Daniel was **apprehended** because of physical and emotional abuse. When he was returned home at nine years old, a plan was developed to ensure his safety that included professionals and natural supports. After the **temporary guardianship order** expired, his caregiver declined further services and child intervention involvement ended. It does not appear that Daniel's family accessed community-based supports after he was returned to parental care.

27 Carlson et al., 2019

28 Ministry of Children's Services, 2022b

In 2012, the Alberta College of Social Workers recommended that skilled managerial and supervisory support to social workers be prioritized and to ensure supervisors receive adequate training.

In 2013, the Alberta Centre for Child, Family, and Community Research recommended reviewing the existing supervision model, developing organizational culture that acknowledges the importance of supervision and providing supervisors with training related to mentorship, peer support and case consultation.

In 2013, the Alberta Union of Provincial Employees reported on the stressors many caseworkers experience, including "poor supervision," which contributed to staff burnout and turnover.

What has been said in the past

Frontline child intervention work is challenging and can be focused on responding to crisis situations. It requires an experienced and well-trained workforce to increase engagement, competency, and productivity to provide adequate services for young people and their families.[29] Some Canadian provinces and territories have guidelines, and practice guides, which outline the tasks of supervisors. The Northwest Territories provides standards for the supervision of casework that include, consulting with caseworkers and providing direction, support, and administrative guidance.[30]

Providing supervision to child intervention staff is a requirement in each province, although policy across Canada is not consistent. In Alberta, the *Enhancement Policy Manual* sets out decision-making points when caseworkers must consult their supervisor but guidelines outlining the *elements* of supervision are not publicly available.

The Ministry of Children's Services has done work to build capacity in their workforce through amending policies, implementing practice frameworks, and adopting new practice approaches.[31] Most recently, the ministry has indicated they are working on updating their **casework supervision model** to help focus attention on child safety.[32] How this model is created and structured is important because it will directly impact decision-making and outcomes for young people and their families. Furthermore, high quality supervision is imperative to employee retention, psychological well-being and job satisfaction.[33]

One way to help ensure the casework supervision model is successful, is to consult with frontline staff during its creation. Research indicates that staff engagement is beneficial when there is a shift in practice expectations.[34] It helps to promote positive relationships, a sense of purpose and staff are more adaptable to change.[35]

29 Alberta Union of Provincial Employees, 2012

30 Ministry of Health and Social Services, 2015

31 Ministry of Children's Services, n.d.

32 Ministry of Children's Services, 2022c

33 Snyder & Babins-Wagner, 2013

34 Hudson et al., 2019

35 Kinjerski, 2012

When the model is in place, re-evaluation points should be implemented to determine its strengths and weaknesses. This can help identify areas for improvement, build worker capacity, and allow for modifications that may be needed.[36] The Advocate has previously recommended that child-serving ministries consider both **quantitative** and **qualitative measures** when evaluating their services.[37] We believe the same criteria would be beneficial to evaluate the efficacy of the new casework supervision model. These quality assurance measures can help improve the services and supports, which promote positive outcomes for those being served.[38]

> "Do not forget about how important informal practice support for supervision is. Relational practice is so important and hard when you have staff burn out. We need to encourage people to reach out to each other."
>
> **Committee consultation, July 2022**

> "Without regular access to high-quality supervision, workers are likely to have lower confidence, experience more stress and have less opportunity to develop their knowledge and skills. Children and families will as a result experience less effective service."
>
> **Wilkins et al., 2022**

It is also important to outline a timeframe in which casework supervision should occur. This helps to ensure there is time to review a caseworker's entire caseload, build worker competencies, and provide opportunities for reflection. Dedicating time for regular supervision supports a positive work environment and can enhance critical thinking and decision-making skills.[39] Some caseworkers have cited inadequate and insufficient supervision as a key factor in their decision to leave their job.[40]

During our committee consultation, we heard that there are times when child protection work, including providing supervision, should not be done in isolation.[41] Outcomes for young people are more likely to improve when caseworkers are able to access outside expertise.[42] **Group-based supervision**, which includes subject matter experts, should be considered when young people and their families have **complex needs** and persistently come to the attention of Child Intervention Services.[43] In 2018, the Advocate recommended that the Ministry of Children's

36 Hudson et al., 2019

37 Office of the Child and Youth Advocate, 2021b

38 Watt, 2018

39 Snyder & Babins-Wagner, 2013

40 Hallberg & Smith, 2018

41 Committee consultation, 2022

42 Ibid

43 Lietz, 2018

Services provide frontline staff with financial and organizational supports to have immediate access to subject matter experts, as needed.[44] This recommendation has been closed as unmet.[45]

What needs to happen

Article 3 of the *UNCRC* requires that a child's best interests inform decisions.

Young people depend on their caregivers to meet their needs and secure their safety. Child Intervention Services has the mandate to ensure children's safety when their caregivers are unable to do so. At times, in the circumstances of these eight young people, it was unclear how decisions regarding service delivery achieved this goal. They were often left with or returned to caregivers who were not able to meet their needs and faced reoccurring traumatic events, which impacted their well-being. Accountability for appropriate casework practice lies not only with frontline workers but also with leadership. Building capacity for adequate supervision can support casework practice and decision-making, which in turn, helps to ensure that high quality interventions are provided to young people and their families.[46]

"Child Welfare supervision is fundamental to advancing the quality of practice when seeking to ensure the safety, permanency, and well-being of children."

Lietz, 2018

The Ministry of Children's Services has recognized the need to support caseworkers to focus on child safety, improve decision-making, and provide coaching and mentoring[47] and is implementing a new casework supervision model. It is critical that, along with this new model, frontline staff have the appropriate resources they need to do their important work with young people and their families.

44 Office of the Child and Youth Advocate, 2019

45 Office of the Child and Youth Advocate, 2021a

46 Collins-Camargo & Antle, 2018

47 Ministry of Children's Services, 2022c

This section addresses gaps in systems that, if left unaddressed, will continue to impact service delivery for children and youth in similar situations. The following young people's circumstances are explored in this section:

- Len
- Langdon
- Mel
- Nav
- Isa
- Katniss
- Gemma
- Jayem

AVAILABLE AND ACCESSIBLE RESOURCES FOR YOUNG PEOPLE WITH COMPLEX NEEDS THROUGHOUT THEIR LIFESPAN

Article 39 of the *UNCRC* affords young people who have been the victim of neglect, abuse or **exploitation** the right to recovery in an environment, which fosters the health, self-respect and dignity of the young person.[48] **Adverse childhood experiences** and trauma can influence brain development, which affects a child's emotional, behavioural and cognitive functioning.[49] The impact of these experiences often leads to young people developing complex needs. This highlights the need for available and accessible resources for this population.

What we found

These eight young people had **complex needs** as a result of substance use, **intellectual and developmental disabilities**, and behavioural challenges, which compounded their mental health concerns. These factors made service delivery difficult and often, they did not have a stable home. Research indicates that these challenges can lead to a loss of connection to caregivers, community and schools, which can affect attachment and educational outcomes.[50]

> "[Young people] get.... bounced around from placement to placement. [Professionals] forget about the complex needs of the young person."
>
> **OCYA staff consultation, June 2022**

- Len was diagnosed with **attention-deficit/ hyperactivity disorder** and severe **oppositional defiant disorder**. He was often unable to manage his emotions, had physical outbursts, and started

48 United Nations Convention on the Rights of the Child, 1989

49 Hughes et al., 2018

50 Pecora, 2010

using substances when he was seven years old. He received community-based mental health supports and his family worked with a behavioural specialist through the **Family Support for Children with Disabilities** program. Len had disruptions in his education and multiple placement moves, in part, because appropriate resources to support his complex needs were not available through Community and Social Services, Alberta Health Services or Child Intervention Services.

- Isa was diagnosed with an intellectual disability, oppositional defiant disorder, and **attachment disorder**. Child Intervention Services became involved with Isa shortly after she was born. Her caregivers had difficulties managing her emotional and physical outbursts, which led to multiple placement moves. She received supports from an early education program, worked with a psychiatrist and was prescribed medications. Isa started using substances when she was 10 years old and stopped going to school when she was 13 years old. In adolescence, caseworkers had difficulty obtaining appropriate placements that could meet Isa's needs.

- Nav was diagnosed with developmental delays, **adjustment disorder** and **borderline personality disorder**. (Nav's chosen pronouns were they/them). At 10 years old, they talked about suicide and received mental health services. Nav started using substances at 13 years old, and school engagement declined. Child Intervention Services became involved with Nav when they were 16 years old. Nav's parents were unable to access appropriate resources to address Nav's mental health and substances use. When Nav started posing a safety risk to their siblings, Nav was moved to a shelter.

- As Jayem, Gemma, Mel, Langdon, and Katniss entered **emerging adulthood**, their level of supports decreased despite their service needs remaining the same. They had intellectual and behavioural challenges and used substances, which further impacted their mental health. As they got older, their behaviours were often viewed as choices instead of requiring therapeutic supports, and their basic needs were unmet. This was most evident in their housing situations, where all five experienced a lack of stability.

- Mel had a developmental disability and had multiple mental health diagnoses. As she entered adolescence, her substance use escalated, and her multi-disciplinary service team had difficulties finding placements that could provide the level of support she needed. In late adolescence, she had further challenges accessing services to address her mental health and substance use because she did not consistently take her medication.

- Jayem had challenging behaviours because of **complex post-traumatic stress disorder**. He received significant services and lived in highly structured placements but when he turned 18 years old, placement providers could no longer support him. Appropriate housing options were limited and there were lengthy waitlists. He stayed at youth shelters but was banned because of verbal outbursts.

> "You have to provide someone who has had past trauma with stability – even if they do use, we need to break the stigma and still support them."
>
> **Youth Council consultation, June 2022**

Adequate housing is a fundamental human right. It is essential to a person's health, safety, and ability to participate in society.[51] Lack of stable housing can be a barrier to employment, social supports, and continuity of health care.[52] These issues may be exacerbated for young people with complex needs.[53] Providing young people with stable housing might help to increase the effectiveness of supportive services and addictions treatment. [54] When they cannot access appropriate housing, youth may stay at a shelter, which provides short-term accommodation. However, shelters are not intended to provide the structure that young people with complex needs require nor the long-term stability they need to ensure continuity of services.

- Langdon had an intellectual disability, used substances, and had behavioural and mental health concerns. He was asked to leave his **supported independent living** (**SIL**) placement because staff could not manage his escalating needs. Although he slept at a shelter, he did not have a place to go during the day and he used substances. Caseworkers had difficulties locating him because he was not engaged in programming.

- Katniss had mental health challenges that were identified in elementary school. At 13 years old, she began to use substances. As her substance use escalated, her mental health deteriorated. She did not have the skills to live on her own, was evicted from her apartment and at times, stayed at shelters. Katniss did not feel safe there and used substances to stay awake at night. She was unable to function at school during the day and was asked to leave. She wanted to go to treatment but had difficulty meeting the requirements of the **detox program**.

51 Gaetz & Dej, 2017

52 Munn-Rivard, 2014

53 Homeless Hub, n.d.

54 Potter-King & De Jong, 2012

As Jayem, Gemma, Mel, Langdon, and Katniss transitioned to adult supports, their level of functioning had not changed but they were expected to be able to access services on their own.

- Gemma was diagnosed with cognitive disabilities and required extensive supports. Her caregivers were not equipped to meet her complex needs. She was subsequently placed in a SIL program that had limited direct supports. Gemma spent most of her time alone in her apartment on her computer and was exploited. She was expected to attend medical appointments on her own, despite her level of functioning and doctors indicating she did not have the capacity to consent to medical treatment.

> "Systems need to flex to meet the needs of a young person, or they become ineffective."
>
> **Committee consultation, July 2022**

What has been said in the past

The Advocate has reported extensively on the importance of appropriate supports for young people with complex needs throughout their lifespan.[55] Previous recommendations include having a definition of complex needs in policy, coordinated service plans, the ability to consult experts in decision-making, and the need for intensive resources for this population. Although most of these recommendations have been met,[56] our investigative reviews continue to demonstrate that more work needs to be done to ensure that young people with complex needs have timely access to appropriate resources.

55 Office of the Child and Youth Advocate Alberta, n.d.

56 Office of the Child and Youth Advocate, 2021a

In completing this mandatory report, we asked child-serving ministries about current work underway to address service gaps for young people with complex needs

The Ministry of Children's Services:

- several initiatives and partnerships including working with the Ministry of Health to implement the *Recovery Oriented System of Care*, and with the Ministry of Community and Social Services through a long-standing cross-ministry protocol that supports integrated service delivery for young people with disabilities and their caregivers.

The Ministry of Community and Social Services:

- long-standing cross-ministry and collaborative community-based partnerships such as the **fetal alcohol spectrum disorder networks** and **family resource centres**. In collaboration with Alberta Health Services, they have expanded their cross-ministry complex needs framework to include youth.

The Ministry of Health:

- implementation of the first three recommendations of the *Child and Youth Well-Being Panel* report in response to the impact of the **COVID-19** pandemic on children, youth, and families may address the gap for young people with complex needs.

The Ministry of Education:

- implementation of the *Child and Youth Well-Being Panel*'s recommendations. Some initiatives include mental health in schools, access to specialized assessments and learning supports, and the **WRaP 2.0** project. In partnership with Children's Services, they continue to be involved in the **Success in Schools** framework, which was implemented in 2010.

The Ministry of Justice and Solicitor General:

- As part of their case planning activities, they assess a young person's needs and collaborate with family and other service providers involved to identify appropriate supports.

In 2019 the **Persons with Developmental Disabilities** (**PDD**) program underwent a review that explored ways to improve supports for people with developmental disabilities.[57] Recommendations were intended to address service gaps for adults and included ministries working together, cost-sharing services and establishing additional shared living options. These recommendations should be expanded to include young people because as they transition to PDD services, they may require additional supports to address their behavioural, mental health and substance use difficulties.

In April 2022, the Ministry of Children's Services acknowledged the need for highly specialized placements for young people with complex needs and identified several actions, that when implemented, will hopefully address the gap that exists in appropriate service provision for this population.[58] These include ongoing work between Children's Services and Alberta Health Services to ensure timely mental health and addictions supports, the creation of 164 new therapeutic foster care spaces, and 8 new spaces through the **personalized community of care program** for young people up to 19 years old. This program provides intensive treatment for youth in care with significant addictions, mental health, and behavioural concerns. The ministry also recognized the need for more specialized placements for young adults between 18 and 23 years old with complex needs.

> "We don't stop needing support when we turn a certain age."
>
> **OCYA Youth Forum, 2022**

Around the same time, Children's Services launched the **transition to adulthood program** (**TAP**), which outlines service provision for young people who are 18 to 23 years old. The program offers an array of services from social and emotional to mental health and addictions supports, employment and life skills development, and post-secondary education for young adults who were in care.[59] The Ministry of Community and Social Services is supporting the implementation of this program to ensure a smooth transition to adult disability services for those young people who qualify.

The Office of the Child and Youth Advocate will not be made aware of the complete details of the TAP program until it is fully implemented, and the information is publicly available. We expect that it will incorporate a **housing first** approach, with intensive services that evolve to find ways to support young adults with complex needs. The Advocate is very interested in the roll out of this program and will pay close attention to what young people have to say about the services they receive.

57 Ministry of Community and Social Services, 2019

58 Ministry of Children's Services, 2022c

59 Government of Alberta, n.d.

What needs to happen

The eight young people identified in this section had significant complex needs, which included substance use, intellectual and developmental disabilities, and behavioural challenges. These impacted their ability to access and maintain supports and safe housing. The resources they required either did not exist, were inaccessible because of long waitlists, or these young people were not stable enough to meet the conditions of admission.

Article 39 of the *UNCRC* affords young people who have been the victim of neglect, abuse or exploitation the right to recovery in an environment, which fosters the health, self-respect and dignity of the young person.

Key OCYA recommendations related to adequate supports for young people with complex needs

"The Ministries of Health, Education, and Community and Social Services should develop a process to ensure collaborative and coordinated service delivery for young people with intellectual and behavioural challenges and their families."

Mandatory Review April 2021 to September 2021, March 2022

"Child Intervention Services should expand their proposed policy regarding escalation of complex case consultation and decision-making to include the definition of complex needs. Young people with complex needs should have access to experts and intensive resources to meet their needs."

19-Year-Old Dakota, October 2018

Child-serving ministries should have appropriate substance use intervention training to increase the capacity and knowledge among direct-service professionals to ensure young people get the right services at the right time. This should be part of the provincial youth strategy.

Into Focus: Calling attention to youth opioid use in Alberta, June 2018

For several years, the Advocate has highlighted the necessity to appropriately support young people with complex needs and has made 28 recommendations[60] to address this issue. We see that youth substance use continues to negatively impact every facet of a young person's life. Five of these eight young people died from substance related causes and all eight experienced barriers in accessing services because of their substance use. In June 2021, the Advocate recommended that child-serving ministries develop and implement a youth opioid and substance use strategy so young people receive more comprehensive and coordinated services.[61] It is critical that the government take immediate action on this recommendation so that fewer lives are lost.

It is widely recognized that young people with complex needs benefit from stable housing and lifelong intensive supports. Additionally, the services they receive should be comprehensive and appropriate for their developmental age.[62] Interventions should address multiple facets of their lives, including their social and emotional needs. They require assistance to engage with education and employment opportunities, discover their strengths and talents and be

60 Office of the Child and Youth Advocate Alberta, n.d.

61 Office of the Child and Youth Advocate, 2021c

62 Ungar et al., 2012

involved in their community. [63],[64] It is imperative that government incorporate these elements in service provision for young people.

Child-serving ministries have acknowledged that young people with complex needs require special attention. In addition to long-standing actions, they have identified several upcoming initiatives; however, most are in the planning or early implementation phases. Those young people currently lacking services or resources may not benefit from these initiatives and must be prioritized to ensure their needs are met.

The Advocate is making one recommendation:

Recommendation 1

The Ministries of Health, Education, Children's Services, Community and Social Services and Justice and Solicitor General should develop and publicly report on a coordinated action plan to address service gaps for young people with complex needs while longer-term initiatives are under development. This plan should include targeted activities and milestones that meet the immediate needs of these young people.

Further comments

- Child-serving ministries have acknowledged that service provision for young people with complex needs requires a coordinated approach to be effective. They have identified several cross-ministry initiatives, that when implemented, may adequately support these children and youth. However, these young people require immediate services to ensure their survival and well-being.

Expected outcomes

- Young people with complex needs will have access to supports while initiatives are under development. Supports should be readily available and accessible by young people and their families.
- The coordinated action plan should be completed and publicly available within six months of this recommendation.
- The coordinated action plan should include access to appropriate housing, mental health and substance use supports from adolescence to early adulthood.

63 Gaetz & Dej, 2017

64 Ungar et al., 2012

CLOSING REMARKS

Between October 1, 2021 and March 31, 2022, my office received 17 notifications of death regarding young people whose circumstances met the criteria for a mandatory review. In this report, we explored 15 of these circumstances because two matters were stayed at the request of a policing agency or Crown prosecutor. The sheer number of notifications is extremely troublesome – these are young people, loved by many, who had their whole lives in front of them.

Indigenous young people continue to be overrepresented in child-serving systems and in the notifications we receive. We believe in the inherent right of Indigenous communities to provide care for their own children. My hope is that as more communities assume governance through *An Act Respecting First Nation, Métis and Inuit Children, Youth and Families*, the Government of Alberta will adequately support this transition.

Thirteen of the fifteen young people in this report had significant issues with substance use. Nine died from suspected or confirmed drug toxicity. Since 2018, the Advocate has released two reports to address substance use among young people living in Alberta. A full range of strategies is required, including mental health care, treatment, harm-reduction and supportive housing. In 2021, the Advocate recommended that a dedicated body be established to develop and support the implementation of a youth opioid and substance use strategy. The number of young lives lost to drug toxicity during this six-month period highlights the continued and urgent need for a youth-focused response. It is critical that the government take action on this recommendation before more young lives are lost to this drug crisis.

We recognize that work is underway to address some of the issues that persist in service delivery. However, immediate action is required to address the current needs of children and youth. Child-serving systems must provide adequate guidance, supports and resources for young people to prevent similar service delivery outcomes and to help them be successful as they move into adulthood.

I would like to acknowledge the work and dedication of those who supported these 15 young people. Frontline service delivery is hard work that often goes unrecognized. Families and communities continue to be impacted by the passing of young people. My sincere condolences to those mourning the loss of these children and youth.

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate

APPENDICES

APPENDIX 1: GLOSSARY OF TERMS

adjustment disorder	A mental health disorder that occurs when a person is unable to cope with, or adjust to, a particular source of stress, such as a major life change, loss or event.
adult trustee	An adult who has legal authority to make financial decisions on behalf of an adult who does not have the capacity to make decisions about their financial matters.
adult guardian	An adult who has legal authority to make personal, non-financial decisions on behalf of an adult who does not have the capacity to make decisions about their personal matters.
adverse childhood experiences	Negative, stressful, traumatizing events that occur before the age of 18 and are linked to poor health outcomes, including the development of maladaptive behaviours.
anxiety disorder [anxiety, generalized anxiety]	A mental health disorder characterized by excessive worry or fear that impacts school, work and relationships.
apprehended [apprehend, apprehension, apprehension order]	The court grants Child Intervention Services temporary custody of the child on reasonable and probable grounds the child is in need of intervention in accordance with the *Child, Youth and Family Enhancement Act*.
assessment	The gathering and analysis of information to determine whether a child is in need of intervention under the *Child, Youth and Family Enhancement Act*.
Assured Income for the Severely Handicapped (AISH)	Provides financial and health benefits for eligible Albertans with permanent medical conditions.
attachment disorder	A mental health disorder marked by a child's difficulties in forming secure attachments to caregiving adults.

attention-deficit/ hyperactivity disorder	A mental health disorder, often diagnosed in childhood or adolescence, characterized by symptoms such as trouble focusing, hyperactivity and impulsivity.
borderline personality disorder	A mental health disorder that affects self-image, relationships, and self-regulation of emotions and behaviour.
campus-based group care	Residential care settings that provide services, such as intensive mental health supports and educational programming, on-site with the goal of transitioning the young person to a community-based setting with the skills and tools to be successful.
casework supervision model	A strategy to focus casework on child safety, improve decision-making, and develop better coaching and mentoring for caseworkers.
community treatment order	Orders that support community mental health treatment for individuals at risk of substantial mental or physical deterioration. Written according to criteria in the provincial *Mental Health Act*, the orders help these individuals comply with treatment while remaining in the community, ideally breaking cycles of involuntary hospitalization, health deterioration, and readmission to hospital.
complex needs	Children with complex needs are defined by the Government of Alberta as those: with multiple impairments, complex mental or physical health issues, and/or severe behavioural needs; for whom all currently available resources have been utilized with limited success; who require fiscal and human resources that strain the capacity of any one ministry; and, for whom there are questions about the safety of the child or others around them.

complex post-traumatic stress disorder	A mental, behavioural or neurodevelopmental disorder in which a person has experienced prolonged or repeated traumatic events. Symptoms are similar to **post-traumatic stress disorder** but may include additional symptoms like problems with memory, identity development, ability to regulate emotions, and difficulty forming relationships with others.
conduct disorder	A behavioural and emotional disorder in childhood and adolescence. Children with conduct disorder act inappropriately, infringe on other's rights and violate other's behavioural expectations.
COVID-19	An infectious disease caused by SARS-CoV-2, a coronavirus discovered in 2019. By March 2020, the World Health Organization declared a COVID-19 pandemic.
custody agreement [with youth, with guardian]	A voluntary agreement between a young person over 16 years old or a guardian and Child Intervention Services. Decision-making is shared and the young person is placed outside the home.
custody order	An order granted by the courts to provide Child Intervention Services temporary custody and guardianship of the child until legal status can be determined. The child is placed in an approved placement.
depression	A mental health disorder that causes a persistent feeling of sadness and loss of interest.
detox program	A treatment program that provides short-term residential care for individuals to withdraw from substance dependence safely and with medical support.
developmental disabilities [intellectual and developmental disabilities]	Can range from mild to severe, that cause physical impairments, cognitive disabilities, speech disorders, and/or medical conditions.

disordered sleep	A sleep disorder that affects the quality, timing, and length of sleep that can impact daily functioning.
disruptive mood dysregulation disorder	A childhood mental health condition that results in severe cases of irritability, anger, and temper outbursts that interfere with everyday functioning.
educational assessment	The process of documenting, usually in measurable terms, a student's knowledge, skill, attitudes and beliefs.
emergency protection order	An order granted by the police or court when there is violent or threatening behaviour between family members and there is evidence that immediate protection is necessary to prevent further incidences of violence.
emerging adulthood [emerging adults]	A distinct developmental stage, between the ages of 18 to 24, which is neither adolescence nor adulthood.
enhancement agreement with youth	A voluntary agreement that Child Intervention Services will provide supports to a young person aged 16 to 18. It is intended to address protection concerns while the young person lives independently.
epilepsy	A neurological disorder that causes recurrent seizures.
exploitation	The manipulation of young or vulnerable individuals for personal gain or gratification. Child exploitation can take many forms, including financial, online (sexual), or labour.
family enhancement agreement	A voluntary agreement that Child Intervention Services will provide supports to a family. It is intended to address protection concerns while the child remains with a guardian.

family resource centres	Centralized hubs that help individuals with disabilities and their families to access and navigate disability supports and services across the province. Centres provide support through information and resource sharing, tools, and helping to manage aspects of FSCD and PDD services.
Family Support for Children with Disabilities (FSCD)	A voluntary program that provides individually assessed family-centred supports to help strengthen families' abilities to promote children's healthy development and participation in activities. Parents remain guardians.
fentanyl	A prescription painkiller up to 100 times more potent than morphine. Fentanyl is often produced and sold illegally. It is frequently mixed with other drugs and is difficult to detect.
fetal alcohol spectrum disorders (FASD)	Disorders resulting from prenatal exposure to alcohol. People with FASD may experience a variety of physical, mental and behavioural effects.
fetal alcohol spectrum disorder (FASD) networks	A collection of FASD service agencies and partners working together to support individuals living with FASD and their families.
fine motor skills	An ability to use smaller muscles in the body to make precise movements. A child who lacks fine motor skills may not achieve development milestones, leading to limited strength required for independence, self-care (i.e., eating, dressing), and written communication.
foster to adopt	An approach to childcare by which a foster family cares for a child with the hope to adopt them permanently if biological family reunification is not possible.
gender dysphoria	A term to describe the distress a person feels when their sex assigned at birth does not match their gender identity.

gender expression	Cues used by an individual to publicly express their gender identity, for example through their name, pronouns, personal style, or body language.
gender identity	A person's internal understanding and experience of gender.
group-based supervision	A model where one supervisor meets with multiple staff to discuss work practices. It offers the opportunity to hear a range of perspectives, insight into a wider array of issues, and supports critical thinking peer learning and experience.
harm-reduction	An evidence-based public health approach to minimizing harms associated with substance use. Harm-reduction policies, services and practices offer people who use substances autonomy and choices to help them be safer and healthier, regardless of whether they continue to use substances.
housing first	An approach to ending homelessness that provides individuals with immediate access to permanent and independent housing without prerequisites or conditions. Once housed, additional supports are provided to address service needs.
intake	A report completed when Child Intervention Services receives a community or professional concern about possible risk to a child as per the *Child, Youth and Family Enhancement Act*.
intellectual behavioural disability [intellectual disability]	A disability with an onset in childhood, characterized by challenges in intellectual and adaptive functioning. Individuals with intellectual disabilities have difficulties with learning, problem-solving, planning and related skills, as well as communication and day-to-day tasks.
intergenerational trauma	Also referred to as generational, transgenerational, or historical trauma, intergenerational trauma refers to trauma that impacts multiple generations.

kinship care	Placement of a child with relatives or close community members by Child Intervention Services.
kokum	A Cree word meaning "grandmother."
learning disability	An information-processing disorder that affects a person's ability to learn and use skills such as reading, writing and math. While learning disabilities are often identified in childhood, they are present throughout a person's lifespan and can affect relationships and work in adulthood.
Mental Health Act	Provincial legislation that provides safeguards, supports and supervision for mentally ill individuals.
methadone	A long-acting opioid drug used for chronic pain or opioid addiction.
methamphetamine	A synthetic drug manufactured from chemical ingredients. Methamphetamine is an illegal and highly addictive substance with long-term health effects.
misgendered	Referring to an individual using terms (e.g., pronouns, names) that do not reflect their gender identity.
naloxone	A medication that can temporarily reverse opioid poisoning.
neuropsychological assessment	An in-depth assessment of skills and abilities linked to brain function. The evaluation measures areas such as attention, problem solving, memory, language, IQ, visual-spatial skills, academic skills and social-emotional functioning.
oppositional defiant disorder	A behavioural disorder diagnosed in children who display a pattern of irritable, defiant, vindictive behaviours for six months or longer, disrupting activities and relationships.

parenting order	An order that sets out for parents/guardians the decisions that need to be made for their child(ren), how the child(ren)'s time will be divided between them, and whether decisions will be made by one guardian or both.
pediatric endocrine clinic	An outpatient clinic to provide services to families with children who have endocrine (hormone) disorders and diseases.
permanent guardianship order	Under this order, Child Intervention Services becomes the sole guardian of a child. The order is sought when it is believed that the child cannot be safely returned to their guardian within a specified time frame.
Personalized Community of Care program	An intensive treatment program for youth in care who have significant addiction, mental health, and behavioural needs. The program is run in collaboration between Children's Services, Alberta Health, Alberta Health Services, and two community organizations.
Persons with Developmental Disabilities (PDD)	A voluntary program that helps adult Albertans with developmental disabilities live as independently as possible in their communities.
post-traumatic stress disorder	A mental health disorder where persistent mental and emotional stress occurs as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world.
private guardianship order	A court order that appoints a person to be the guardian of a child upon application by that person. The person applying should be an adult and have had care of the child for a period of more than six months or should be a parent other than a guardian of a child.
***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's Act* (*PSECA*)**	This legislation allows the Ministry of 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 programing to confinement.
psycho-educational assessment	Consists of an assessment of psychological aspects of learning and of academic skills.
psychological assessment [psychological and parenting assessment]	A process of testing that uses a combination of techniques to help arrive at some hypotheses about a person and their behaviour, personality and capabilities.
public assurance	Services and supports were provided as intended by legislation and policy and met a young person's needs.
public trustee	The Office of the Public Guardian and Trustee can be given the authority to make personal or financial decisions on behalf of people who do not have the capacity to make these decisions on their own.
qualitative measures	A descriptive measurement used in data collection that help evaluate the effectiveness and outcomes of programs and services. Data is collected through direct feedback from individuals (e.g., using surveys, interviews, focus groups, or observations).
quantitative measures	A numeric measurement used in data collection that can help analyze measurable outcomes of programs and services. Data can be compared and ranked.
residential schools	Established in Canada in the 1800s and operated until the late 1900s, residential schools were run by churches, with financial support from the federal government. Their mission was to assimilate Indigenous children into Euro-Canadian Christian society. Children were forcibly removed from their families and kept isolated from them for long periods. Harsh punishments and abuses were commonplace in the schools. As a source of intergenerational trauma and cultural destruction, residential schools continue to impact individuals and families.

secure services	The *Child, Youth and Family 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.
separation anxiety	Excessive distress experienced by young children when they are separated or anticipate separation from a trusted caregiver.
services and supports	Gaps in the way services and supports are delivered that impact service delivery to young people.
speech and language delays	Children with speech and language delays do not reach developmental milestones by the anticipated ages. Language delays refer to a broader range of communication difficulties (verbal, nonverbal, and written), while speech delays refer to issues with making sounds and words verbally. Speech and language delays may coincide.
suboxone [suboxone therapy]	A prescription medication containing buprenorphine and naloxone and is used to treat opioid dependency.
substance use disorder	A mental disorder that affects an individual's brain and behaviour and leads to the inability to control the use of a legal or illegal drug or medication despite the harm it causes.
Success in School	A collaboration between Alberta Education and Children's Service launched in 2010 to improve school outcomes and high school completion rates for children and youth in government care.
supervision order	A court order granting mandatory supervision of a young person to Child Intervention Services. Guardians retain custody.
support and financial assistance agreement	A voluntary agreement that Child Intervention Services will provide supports and financial assistance to a young person aged 18 to 22.

supported independent living (SIL)	Programming that supports young people while they live independently, learn life skills, and transition into adulthood.
systemic issues	Gaps in systems, that if left unaddressed, will continue to impact effective service delivery for those young people in similar circumstances
temporary guardianship order (TGO)	A court order that grants Child Intervention Services custody and guardianship of a child for a specific period. The child is in the care of Child Intervention Services and guardianship is shared with the parent/ legal guardian of the child.
transgender	A term used to describe individuals whose gender identity differs from the sex they were assigned at birth.
transition to adulthood program (TAP)	A provincial program launched in April 2022 that provides financial, educational, stability supports and connection to adult supports for young people transitioning to independence.
trauma-informed	Care or practice acknowledges that people's behaviours are the result of what has happened to them, rather than the result of who they are as individuals. Service providers recognize the signs and symptoms of trauma and utilize policies, procedures and practices informed by trauma knowledge.
***United Nations Convention on the Rights of the Child* (*UNCRC*)**	An international agreement that consists of 54 articles setting out children's rights and government responsibility in making them available to all children.
unspecified depressive disorder	A mental health disorder where symptoms of depression significantly impact an individual's functioning but do not meet the full criteria of other depressive disorder diagnoses.

unspecified schizophrenia spectrum disorder	A mental health disorder where symptoms experienced by an individual cause significant distress but do not match the full criteria for disorders within the schizophrenia spectrum or there is insufficient information to make a more specific diagnosis.
unspecified trauma and other stressor-related disorder	A mental health disorder where symptoms caused by traumatic or stressful events experienced by an individual do not meet the full criteria for other trauma-related disorders or there is insufficient information to make a more specific diagnosis.
victim of violence	An individual who has experienced harm as a result of a physical or sexual assault.
voluntary service agreement	A family's voluntary contract to receive child intervention services.
WRaP 2.0	The Wellness Resiliency and Partnership (WRaP) 2.0 project launched in February 2021 that provides school-based mentorship and coaching supports for individual children and youth with fetal alcohol spectrum disorder (FASD). It is a collaboration between the Ministry of Education, the Ministry Community and Social Services, and FASD services in Alberta.
wrap-around services	A strengths-based approach to support vulnerable people through collaborative case management and service provision.

APPENDIX 2: COMMITTEE CONSULTATION

Terri Pelton

Ms. Pelton is the Child and Youth Advocate for Alberta. She has worked in the social services sector for over 30 years, helping to create positive outcomes for young people, their families, and their communities. Her work includes developing and leading strategic initiatives aimed at advancing the rights and interests of young people, such as the OCYA's Legal Representation for Children and Youth program. Through her extensive experience in both frontline and leadership roles, she has seen firsthand the challenges children and youth in government systems encounter and is dedicated to elevating these voices and pushing for meaningful change.

Knowledge Keeper Brenda Sanderson

Ms. Sanderson is a Plains Cree from the Chakastaypasin Band in Treaty 6 territory. She is a survivor of the residential school system and a proud grandmother to three. Ms. Sanderson maintains a spiritual lifestyle to pass the knowledge her parents taught her on to younger generations. Her favourite activities include sewing star-blankets and crafting with her grandchildren. Ms. Sanderson enjoys interpreting her creative vision into star-blankets as well as interpreting their colour meanings. It has always been her dream to teach holistically about Mother Earth and Turtle Island, as well as the importance of the medicine wheel and how it can be applied to daily life.

Bjorn Johansson, MSW, RSW

Mr. Johansson is the chief executive officer of Wood's Homes, a children's mental health centre based in Calgary. He first joined the organization in 1992 as a youth and family counsellor and has held increasingly progressive leadership positions since then, including program manager, associate director, and director of programs and research. He is considered a leader in the field of children's mental health and is widely recognized as someone who believes that every child, youth, and family deserves an advocate. He is also an instructor with the University of Calgary's Faculty of Social Work and an ethics investigator with the Alberta College of Social Workers. He currently serves as a board member with both ALIGN Association of Community Services and the University of Calgary's Conjoint Faculties Research Ethics Board.

Dr. Glynnis Lieb, PhD

Dr. Lieb has a PhD in social and personality psychology and is the executive director of the Institute of Sexual Minority Studies and Services. She worked has worked for over 10 years with both government and non-profit social services. She has worked directly with people experiencing poverty, homelessness, and domestic violence; those living with chronic mental and/or physical illnesses and addiction; and vulnerable youth. She has been a university instructor for over 15 years, teaching courses in psychology, mental health, human development, and criminal justice. Dr. Lieb currently runs an organization that specializes in providing services to 2SLGBTQ+ youth, including a day shelter in central Edmonton for homeless and street-involved youth.

Dr. Jacqueline Pei, PhD, RPsych

Dr. Pei is a professor in the Department of Educational Psychology and an assistant clinical professor in the Department of Pediatrics at the University of Alberta. She leads the Intervention Network Action Team and is the senior research lead for the Canada FASD Research Network. She previously served on the FASD clinical diagnostic team at the Glenrose Rehabilitation Hospital. In these roles, Dr. Pei has facilitated a link between research, policy, and practice. Dr. Pei is also a practicing registered psychologist.

Dr. Jeannine Carrière, BA, BSW, MSW, PhD

Dr. Carrière is Métis and has been teaching social work since 1994. She currently teaches at the University of Victoria in the School of Social Work. She has also been chair of Indigenous specialization and oversaw the Indigenous Student Support Centre for the Faculty of Human and Social Development. Her research interests include Métis child identity and the need for cultural safety in adoptions and child welfare services. Dr. Carrière has been a researcher and practitioner for Indigenous child and family services for over 30 years. She has published several books on topics such as Indigenous knowledge-building, health equity, and the rights of sex workers and their families. In 2008, Dr. Carrière received an Adoption Activist award from the North American Council on Adoptable Children. In 2017, she received the Provost's Advocacy and Activism Award in Equity, Diversity and Inclusion from the University of Victoria for her work with Métis and First Nations People.

Dr. Judy Ustina, BMSc, MD, FRCP(C)

Dr. Ustina is the director of the Child and Family Psychiatric Unit day patient program and the cognitive health improvement program at the Glenrose Rehabilitation Hospital. She is a clinical lecturer at the University of Alberta and has worked in the field of child and adolescent psychiatry for the past 35 years. Dr. Ustina's experience has included working with young people in community, hospital, and school programs alongside a client-based private practice.

Marliss Taylor, RN, BScN

Ms. Taylor is the program manager for the Streetworks program and director of health services at Boyle Street Community Services in Edmonton. After working for 11 years in adult and pediatric intensive care units in Regina, Edmonton, and San Antonio, she moved to the high Arctic where she received a certificate in advanced practice nursing and worked in Nunavut as a nurse practitioner and a nurse manager. In 1995, she returned to Edmonton to join Streetworks and has worked in harm-reduction for the past 27 years. She has been involved in health promotion and harm-reduction initiatives in Siberia and Guyana, as well as a multitude of research and advocacy projects at local, provincial, and national levels. She was a member of the Alberta Health Services Board of Directors and the Minister's Opioid Emergency Response Commission. Ms. Taylor is currently chair of the Canadian Drug Policy Coalition.

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 her 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 the youth justice system.

The *CYAA* section 9.1(1) requires the Advocate to review the death of any child who was receiving intervention services at the time of their death, or 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 those of their families, with child-serving systems as related to:

- public assurance
- services and supports
- 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 contain any findings of legal responsibility or any conclusions of law, 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
- Other factors that may arise for consideration
- 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

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 a child's death.

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MANDATORY REVIEWS INTO CHILD DEATHS

October 1, 2021–March 31, 2022

ocya OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

NORTH OFFICE

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

SOUTH OFFICE

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

ocya.alberta.ca
1-800-661-3446