

Missing Pieces

Joshua's Story



REPRESENTATIVE FOR
CHILDREN AND YOUTH

October 2017

Oct. 4, 2017

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

Dear Mr. Speaker,

I have the honour of submitting the report *Missing Pieces: Joshua's Story* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, appearing to be 'B. Richard', written in a cursive style.

Bernard Richard
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Deputy Clerk and Clerk of Committees,
Legislative Assembly of British Columbia

Mr. Craig James
Clerk of the Legislative Assembly

Acknowledgement

The Representative acknowledges the deep loss suffered by the family of the youth who is the subject of this report and thanks them for their patience and assistance in its preparation.

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Executive Summary

In many ways, Joshua was like thousands of other teenagers in British Columbia. He was intelligent, caring and had a sharp wit. He loved his family and his cat. He dreamed of one day having a wife, children and a little house in which they would all live.

Tragically, Joshua's dreams were not fulfilled, and the Representative acknowledges the deep pain felt by his surviving family members. There is nothing that compares with the loss of a child and a brother. No reports, findings or recommendations can ease that pain.

However, there are surely lessons to be learned from Joshua's story – the story of a youth who, despite the considerable efforts of those in British Columbia's health care, education and child welfare systems, didn't receive the supports he needed to overcome his debilitating mental illness.

On July 31, 2015, Joshua jumped to his death from a construction crane located on the grounds of BC Children's Hospital (BCCCH) in Vancouver, where he had resided for 122 days. The BC Coroners Service ruled the death of the 17-year-old a suicide.

Following a recommendation from the coroner, the Representative launched an investigation into Joshua's life and the circumstances that led to his death. And despite an exhaustive review that included 43 interviews with family members, community professionals, hospital staff and government employees, the Representative cannot say conclusively that better services would have prevented this tragedy.

What this investigation does conclude, however, is that a truly clear and comprehensive youth mental health system would have given Joshua and his family a better chance to deal with his challenging illness.

Joshua exhibited signs of serious mental health issues at an extremely young age. He was just two-years-old when his mother sought help from the Ministry of Children and Family Development (MCFD) because her son was hitting himself and banging his head on walls. He did not receive the early intervention services that may have altered his life trajectory. Joshua's condition escalated to the point where, as an eight-year-old, he told school staff: *"I want to die . . . nobody cares, nothing can be done."* His first suicide attempt came at age 11, he began withdrawing from school at 13 and self-harming at 16. Joshua's symptoms of mental illness increased over the years as his social functioning decreased. This led to an inevitable decline in the well-being of Joshua and his family as time went on without the youth receiving comprehensive, early, long-term mental health interventions.

After being airlifted out of an isolated forest area following a third attempt to take his own life in March of 2015, Joshua was hospitalized and eventually admitted to BCCCH, where he would remain for four months as hospital staff and MCFD struggled to work out a post-discharge plan that would ensure Joshua could be safe in his community.

During that period, Joshua had a large team working on his case that included several health care professionals, clinicians and social workers. In fact, for much of his life, professionals in the health care, education and child welfare systems made multiple and laudable attempts to help.

However, as pointed out in this report, there were very significant gaps in the system. And the Representative is deeply concerned that unless these gaps are filled, there will be more children such as Joshua who fall through the cracks.

Multiple recommendations to create a clear and comprehensive system of mental health services for children and youth – including prevention services, support for families, a variety of residential and community services and appropriate emergency and acute care – have been made during the past 14 years. These recommendations have come from government’s own internal reviews, from the Representative’s Office and from the Select Standing Committee on Children and Youth.

Joshua’s story reinforces the desperate need for such a system. The fact that he languished in hospital for four months, potentially losing what remaining hope he possessed while psychiatrists and social workers wondered where he could be safely placed, clearly shows that there is a dire need in B.C. for “step-down” residential services – those that would enable a child or youth to ease out of a hospital setting and prepare for a return to their family and community.

The fact that Joshua was twice hospitalized and kept in an adult psychiatric ward because no appropriate facilities were available for youth shows that such acute care facilities are lacking. The fact that services were offered in Joshua’s early years but were inconsistent and often withdrawn whenever he exhibited signs of improving, shows that the full continuum of services for children and youth with mental illness – and the means of tracking such vulnerable youth to ensure they are receiving what they need – is not available in this province.

The fact that Joshua’s mother struggled to find a suitable caregiver for him and was continually called upon to pick him up from school despite having no ability to do this while still holding down a job is evidence that support services for families facing complex mental health challenges are lacking in B.C. And the fact that Joshua’s complete withdrawal from school as a young teenager was not a trigger for a more serious intervention is a sign that child welfare, health and education are not always working together the way they should for the benefit of young people in B.C. with mental health concerns.

Joshua was a complex young man and this report is not an attempt to deny the complexity of his illness or suggest that there was an easy remedy. But the Representative believes that government can do better for its children than what it did for Joshua and his family.

The formation by the provincial government of a new Ministry of Mental Health and Addictions in July of this year is a promising signal – a recognition that the system needs

work and that government takes the issue seriously. Through the lone recommendation of this report, the Representative calls upon that new ministry to lead government as a whole in the development and implementation of a comprehensive system that offers a full continuum of mental health services for children and youth.

Although led by the Ministry of Mental Health and Addictions, this system must span all of the other child- and youth-serving ministries as well as professional and service provider organizations and it must be fully resourced.

The Representative calls on the provincial government to follow through on early signs that it prioritizes the improvement of mental health services for children and youth to a standard similar to what is offered for physical health issues.

To do so would be to honour the memory of Joshua and to learn from his story.

The *United Nations Convention on the Rights of the Child*

The *United Nations Convention on the Rights of the Child* (1989) (*UNCRC*) is an international treaty that recognizes specific rights for all children in the world, in addition to the rights for all people outlined in the *UN Universal Declaration of Human Rights* (1948).¹ Canada ratified the *UNCRC* in 1990 and, in so doing, acknowledged that it is the Canadian government's responsibility to implement the articles in the convention and to ensure that children's rights are upheld in Canada.

The Representative uses a child rights lens when conducting investigations into critical injuries and deaths. In this report, Articles from the *UNCRC* will be highlighted in text boxes where they apply.

¹ *United Nations Convention on the Rights of the Child*, (Treaty Series 1577, 1989).

Methodology

The *Representative for Children and Youth Act (RCY Act)* (see Appendix A) requires a public body responsible for a reviewable service, such as mental health or child welfare services, to report to the Representative all critical injuries and deaths of children and youth who received a reviewable service in the year leading up to the incident. The Representative assesses these reports to determine if the incident meets the criteria for a case review which, once completed, assists the Representative in deciding if a full investigation is required.

In January 2016, the Representative completed a review of Joshua's death and determined that it met the standard for investigation because the review found that a reviewable service, or the policies or practices of a public body or director, may have contributed to the death and that the death was self-inflicted. The Representative began a full investigation at that time.

The investigation examined Joshua's life from his birth in 1998 until his death in 2015. A particular focus of the investigation was the final three-year period of Joshua's life, and the services and supports that were available – or not available – to him and his family during that time.

The Representative reviewed numerous documents from a variety of sources in the course of the investigation, including records from police departments, schools, hospitals and government ministries (see Appendix B). Forty-three recorded interviews were conducted with family members, community professionals, hospital staff and government employees (see Appendix C).

A preliminary report of the investigation's findings was made to the Representative's Multidisciplinary Team (see Appendix D). The team provided advice and guidance to the Representative based on the members' expert experience.

For the purpose of administrative fairness, those who provided evidence for this investigation were given the opportunity to review a draft version of this report and to provide feedback on the facts presented. Efforts have been made to anonymize this report in order to respect the privacy of those involved.

Chronology

1998 to 2002 – Joshua's Early Childhood

Joshua was born in 1998 in the Cariboo region of British Columbia. His father is from Europe and his mother was born in Canada but has lived in several other countries. Joshua's parents met and married outside of Canada in 1996. When his mother became pregnant, Joshua's parents relocated to the Cariboo region, where they settled into a small apartment but had trouble finding work. With no family to provide social supports in Canada, Joshua's parents struggled to cope with financial challenges and marital stress.

In 1999, Joshua's parents learned that they were expecting another child. Soon after the birth of Joshua's brother, the marital discord between Joshua's parents increased. By early 2000, Joshua's father had moved out of the family home. In March 2000, Joshua's parents filed a joint separation agreement giving Joshua's mother sole custody and guardianship of both boys with his father having reasonable and generous access.

Shortly after Joshua's second birthday, his mother attended her local MCFD office to request support as a single mother of two young children. The ministry's response was to suggest that Joshua's father could help more with the children, to offer a referral to Joshua's mother for counselling and to make a referral to daycare for the children. During this time, Joshua's mother was experiencing depression and she sought help through doctors and counsellors in her community. In her recollection of this time, Joshua's mother felt she received no support as an individual or as a mother of two young children.

In September 2000, a local women's resource centre called MCFD to report that Joshua's mother was requesting help with her children to cover times when Joshua's father could not provide care. MCFD advised the centre that it was the parents' responsibility to arrange for child care and to call MCFD again if the children were not being cared for adequately.

That same month, Joshua's mother called Child and Youth Mental Health (CYMH) to request services for two-year-old Joshua.² She was concerned with his behaviours, which included hitting himself and banging his head on walls when he was upset. A CYMH worker advised that Joshua's mother should call again if the behaviours persisted. CYMH did not complete a formal intake and Joshua's mother did not call back. Meanwhile, Joshua's mother continued to struggle with depression, economic challenges, social isolation and a fractured relationship with her ex-husband.

In the summer of 2002 when Joshua was four, his mother moved to a suburban Lower Mainland community with both children in order to pursue further education and a career that would allow for more financial stability. The family lived out of their car and

² CYMH is a part of MCFD and offers free, voluntary mental health services to infants, children and youth who are experiencing mental health challenges.

stayed with various acquaintances for a month before finding a place to live. Joshua's father, who remained in the Cariboo region, was upset by the move as he did not want to be separated from the boys for long periods of time.

2003 to 2007 – 5- to 8-years-old, Joshua's Early School Years

Joshua began attending Kindergarten at a local elementary school in the Lower Mainland in September 2003. Shortly after, Joshua's father moved to the Lower Mainland to be closer to the children. Although he initially resided with Joshua's mother and the boys, he was in a relationship with another woman at the time. Due to discord between Joshua's mother and father, Joshua's father and his girlfriend moved to another residence in the Lower Mainland. Despite the conflict between Joshua's parents, they ensured that the boys frequently saw their father.

Unfortunately, Joshua's father was unable to stay in the Lower Mainland as he could not find work. In early 2004, he and his girlfriend returned to the Cariboo region. In their interviews with RCY investigators, both parents remarked on the significant impact this departure seemed to have on Joshua, who was in the back of the car, screaming, "*Dad, don't go.*" Joshua's mother felt that, after this moment, Joshua seemed forever changed and that he blamed her for his father leaving. Although Joshua's mother remained his primary caregiver and was a single parent with no financial or emotional support, Joshua continued to have summertime visits and weekly phone contact with his father for most of his life.

In March 2004, a concerned neighbour called MCFD to report that the boys' babysitter left the children unsupervised for long periods of time in a basement that was unfit for children. MCFD visited the babysitter's home. The babysitter denied the report and added that she had stopped watching the children two months earlier. The babysitter said that Joshua's needs were too high and claimed that he required 24-hour supervision due to incidents that included fire-setting, property destruction and harming animals. No other person interviewed by RCY investigators substantiated the babysitter's claims.

An MCFD social worker spoke to Joshua's mother, who said that she had used the babysitter for two years. She did not report her own concerns about the treatment of the boys to the social worker. In her interview with RCY investigators, however, Joshua's mother explained that at this time she was attending school, very short on money and desperate to find care for the children. She did not think this babysitter was ideal, but felt she had no other choice. At that time, MCFD closed its file due to lack of evidence of abuse or neglect.

Later in his life, Joshua reported substantial physical and emotional abuse by this caregiver. He said that the caregiver left him alone, forced him to do labour, humiliated him, and physically abused him by poking him with sewing needles.

In September 2005, at the age of seven, Joshua started Grade 2. Although he was meeting the academic expectations for his age, his teachers had growing concerns

with Joshua's social skills. His school principal at the time described Joshua to RCY investigators as a quiet, bright boy who sometimes seemed to seethe with anger. When triggered, he would physically lash out, shout, cry and swear. He would also "bolt," running away from the school grounds when upset.

In response to Joshua's behaviour, the school developed an Individual Education Plan (IEP) (see text box) and brought in the school counsellor to work with him. Joshua had a dedicated school team, including counsellors, administrators and behavioural support workers. According to the principal, the school plan for Joshua at that time stated, *"If there were outbursts to the extent that we were no longer in charge, that we couldn't control, then a parent would be called and would have to come and pick up the child . . . We had to use that quite often."* Unfortunately, this placed Joshua's single, working mother – who had no social supports – in a challenging situation that persisted throughout his early school years. She was unable to repeatedly leave her workplace to pick up Joshua due to fear of losing the sole source of income for her family, and she did not have anybody else to pick him up.

Individual Education Plan

IEPs are created for students with special needs in the B.C. school system if, in order to meet learning outcomes, they:

- require more than minor adaptation to their educational methods
- are working on outcomes outside the prescribed curriculum or
- receive more than 25 hours of remedial help during the school year from a person who is not their classroom teacher.

IEPs are intended to document, summarize and record the student's education program with individual goals, means to achieve those goals and possible additional services. An IEP may be accompanied by a Behavioural Plan of Intervention which is a document that includes specific strategies to work with children to achieve school-based goals.³

In January 2006, Joshua's mother contacted the Child and Adolescent Program (CAP) to request help and CAP promptly connected Joshua to a psychiatrist for assessment and care. The psychiatrist evaluated seven-year-old Joshua and suggested that he showed signs of oppositional defiant disorder, an adjustment disorder, and a possible underlying dysthymic clinical depression.⁴ Although the school had wondered if Joshua was on the autism spectrum, the psychiatrist found that he did not meet the criteria for that diagnosis. The psychiatrist met with Joshua on a regular basis and asked that the school counsellors keep working with him as well.

³ Ministry of Education, *Individual Education Planning for Students with Special Needs: A Resource Guide for Teachers* (British Columbia, 2009).

⁴ Oppositional defiant disorder is a behavioural disorder diagnosis that involves patterns of disobedient and defiant behaviour to authority figures. Adjustment disorder characterizes a group of symptoms that occur in response to stress and that are stronger than may have been expected. It is now called stress response syndrome. Dysthymia is a term used to refer to chronic, mild depression. Symptoms can include gloominess, low self-esteem, low energy, social withdrawal and poor school performance.

Later that month, the school called MCFD to report concerns for Joshua based on his increasingly disruptive behaviours and his mother's struggle to meet his needs. The school reported that his mother occasionally did not pick up Joshua when called, and that she told the school she was breaking down, saying, *"I can't handle this, I don't know what I'm going to do."* At this time, Joshua's mother

Child and Youth Mental Health Services in Joshua's Region

Until 2016, child and youth mental health services in Joshua's region were provided by two different sources – by MCFD through CYMH and by the local health authority, which operated programs, including the CAP program. CAP offered mental health assessment and treatment for children and youth experiencing behavioural, emotional or social difficulties in both an office-based and outreach capacity.

This was a fairly unique configuration of community mental health services in the province. In order to prevent confusion with this two-stream system, CYMH and the local health authority's child and youth mental health services often shared intake calls and divided them based on a number of factors, including caseloads and previous involvement with a family. Since early 2016, all child and youth mental health services have been aligned with MCFD.

was frustrated by what she saw as an ineffective approach by the school to manage Joshua's behaviours. MCFD filled out a referral for Joshua's mother to receive a family preservation worker and closed its file. For unknown reasons, Joshua's mother did not connect with a family preservation worker at that time.

By March 2006, Joshua's mother had been working in her chosen field for two years, but she was still struggling to meet the needs of her children. To give herself time to organize and plan for the future, and for needed respite, she took Joshua and his little brother to another country to stay with their aunt and grandparents who lived there. The boys returned to their mother in Canada five months later, in August 2006. They resumed regular phone contact with their father.

Joshua began Grade 3 that September in the same school that he had previously attended. He continued with his IEP and regularly met with a CAP counsellor outside of school. Joshua's mother worked closely with this counsellor, reporting

concerning incidents and arranging for Joshua to maintain contact with the counsellor. She expressed a desire to receive whatever supports were available for her family. Joshua's CAP psychiatrist repeatedly suggested that his mother consider medications for Joshua's anxiety and aggression, but Joshua's mother was not comfortable with the medications proposed and no alternative medications were suggested.

The Social Responsibility Support Program

The SRSP is an elementary school behavioural support program offered in Joshua's region that is intended to target the complex individual needs of children exhibiting mental health distress or behavioural difficulties while keeping them enrolled in their mainstream school and attached to their community. The children spend half their day in SRSP working on skill-building and the other half in their class. This program is a joint project between the local health authority, MCFD and the school district.

In early 2007, noting their inability to meet Joshua's needs, his school team connected with both his CAP psychiatrist and counsellor, who acknowledged that Joshua would need intensive aid in school and recommended that he join the Social Responsibility Support Program (SRSP). He was placed on a wait list and joined the program by April 2007.

Both the school and the CAP employees at this time recognized that Joshua was able to talk about strategies to manage his feelings

but did not seem to be able to apply them. He was noted to be obsessive and self-critical, expecting perfection in his own work and exploding when he felt those expectations were not met. The school continued to deal with Joshua's major outbursts by sending him home, increasing the already significant stress on his mother.

2007 to 2011 – 8- to 13-years-old, Multiple Concerns Reported to MCFD about the Family's Need for Support

From March 2007 to January 2010, MCFD received six calls regarding the family's need for support services. The first call in March 2007 was made by the school, reporting that Joshua demonstrated severe aggression and that his mother said she could not do anything about it. This file remained open for more than a year while MCFD provided family preservation services to Joshua's family.

School and mental health professionals working with Joshua during these years described him as emotional, socially awkward and reserved, with a *"kind heart."* One school professional recalled eight-year-old Joshua frequently speaking of death, making statements such as, *"I want to die . . . nobody cares, nothing can be done."* At this time, Joshua was still frequently engaging with mental health professionals through CAP. They noted that his behaviours appeared to deteriorate significantly in times when he felt abandoned.

In response to the call made to MCFD in March 2007, Joshua's mother began accessing a family preservation worker. The worker met with Joshua's mother for two hours a week for several months. At this time, the family preservation worker focused on providing Joshua's mother with emotional support, suggesting parenting tools and connecting her to community supports.

In June 2007, the school made another call to MCFD. In this instance, the school had suspended Joshua and, when his mother arrived to pick him up, she physically dragged him out of the school. The school also contacted the CAP professionals working with Joshua to discuss what had happened. This call was assigned to the social worker who had been responsible for the family's file since March 2007 and was dealt with in conjunction with the already open family file.

The following month, MCFD received another call regarding Joshua after he disclosed to a service provider that his mother had physically punished him. MCFD opened an investigation into the report and found that the mother had at times used physical force to punish Joshua. Joshua's mother openly discussed the issue with MCFD, admitting that she was experiencing extreme stress and was open to any supports for her family. In response, MCFD liaised with the family preservation worker and assisted in connecting the family with more community services, including accessing a new daycare, referring the family to Big Brothers and connecting the mother with community support groups. The social worker left the family's MCFD file open to monitor their safety and well-being, and extended the contract for the family preservation worker.

At the end of July 2007, after several years of separation, the divorce order for Joshua's parents went through. In a joint filing agreed upon by both parents, the order reiterated the 2000 separation agreement, stating that Joshua's mother had sole custody and guardianship of the boys with their father having reasonable access to them.

In September 2007, Joshua began Grade 4 and his mother enrolled him and his younger brother in a new school. She did not feel that the previous school had adequately supported her family and was frustrated with the school's behavioural management strategy of demanding that she pick up her children during the work day. Despite the change in schools, Joshua continued in the SRSP program and with his weekly CAP counselling sessions. Joshua's academic scores remained high, but he continued to show significant social challenges which included strong fixations on individual children with occasionally violent reactions when those children wanted to play with others.

By the end of 2007, the school, the SRSP program and the CAP program noted that Joshua seemed to be showing progress. Joshua had completed the SRSP program and transitioned back to the regular classroom full-time. His CAP counsellor had a final session with Joshua in December 2007. A couple of months later, Joshua's mother seemed to be doing very well, so both MCFD and the family preservation worker closed their files.

Several months later, in July 2008, MCFD received the fourth call about Joshua's family during this time period from an after-school care provider who was concerned that Joshua had told her that he wanted to kill himself. Joshua had just turned 10. When the social worker called Joshua's mother a few days later, she was impressed to hear that Joshua's mother had already called CAP to have them renew counselling services. Joshua's mother asked MCFD to keep the file open for a few months in case she needed assistance. The CAP psychiatrist who had worked with Joshua saw him promptly in a session with Joshua and his father, who had come down to visit.

MCFD received a fifth call in October 2008. A school employee reported that Joshua continued to have constant challenges in the school and that he had disclosed physical punishment by his mother. When interviewed by MCFD, their mother admitted to physically punishing Joshua on two occasions and again said that she was open to any support that could be offered. MCFD made another referral to the family preservation worker with whom the mother had previously worked, as the mother felt they had a

strong connection. The family preservation worker worked with the family again until September 2009 and sent frequent positive progress reports to the assigned social worker.

During this time, the school noted improvements in Joshua's behaviours. He showed more self-regulation with fewer incidents of physical aggression or emotional outbursts. With positive reports on the family's functioning from the school, CAP program and family preservation worker, MCFD closed its file on the family in May 2009. That same month, CAP services ended again.

MCFD received a sixth call for support for Joshua's family in January 2010. A community daycare agency called to report that 11-year-old Joshua had concerning emotional outbursts and, after an incident at its facility, Joshua wrote an apology letter saying that he felt worthless and had tried to kill himself. The community agency employee felt that the family needed more support. Unfortunately, this request for service was not followed up on by MCFD until April 2011, one year and four months later. A social worker who was at the MCFD office at the time explained to RCY investigators that the office was chronically understaffed and had a very large list of incomplete cases.

Both the school and Joshua's mother contacted CYMH to request services for Joshua in January 2010. CYMH referred Joshua to a group for children with anxiety, although it does not appear Joshua was assessed prior to this referral, and placed him on a wait list to receive CYMH services.

In May 2010, while still waiting for CYMH services, his mother brought Joshua to a clinic to see a doctor due to her concerns that he was depressed. The doctor's notes from this visit indicate that Joshua's mother was going to follow up with the school and try to continue with counselling. It is unclear if the doctor concurred that Joshua was depressed. At this time, Joshua's mother also reached out to her previous family preservation worker for short-term assistance.

That summer, Joshua and his father had a disagreement while Joshua was visiting. When Joshua's mother heard about what had happened, she contacted her family preservation worker who advised that, as Joshua was with his father, his mother should let them solve the problem. Joshua refused to visit his father for two years after the disagreement.

In October 2010, 10 months after the referral, a CYMH clinician contacted Joshua's family. RCY investigators found no reason why Joshua waited this long given his obvious need for mental health services at this time. Over the following few months, the clinician saw Joshua four times. The clinician noted that Joshua would not discuss things with her, so she mainly worked on building rapport. In December 2010, after Joshua missed an appointment and Joshua's mother did not return several phone calls, the CYMH clinician sent Joshua's mother a letter advising that she would be closing the file if Joshua's mother did not contact her. Joshua's mother responded with a request that CYMH keep the file open and said she would connect with CYMH in January.

In January 2011, the CYMH clinician called Joshua's mother to follow up on his need for counselling. The CYMH clinician recommended that his mother bring Joshua in for an appointment, but Joshua's mother said that instead she would monitor his behaviours

and would call if she needed support. She did not call the clinician again, nor did she return the CYMH clinician's follow-up phone calls or messages. As a result, the CYMH file was closed in March 2011. Joshua's mother explained to RCY investigators that Joshua refused to leave the house to go to CYMH appointments and she could not physically force him to go, so she did not respond to CYMH's messages.

In April 2011, an MCFD social worker was finally assigned to the January 2010 call for support for Joshua's family. The social worker called Joshua's mother, who said things were now going well, that she did not require MCFD involvement and that she would connect with community support services if she required help. Since Joshua's mother declined the offer of support, MCFD closed the family service file.

Meanwhile, Joshua's school attendance and performance were in decline. When asked to complete assignments, he obsessively worked on them until he declared that he hated them and either ripped them up or started again. He began withdrawing from school, locking himself in his room and playing online computer games for hours. Despite this deterioration, Joshua completed Grade 7 and was enrolled in Grade 8 at the local high school.

2012 to 2014 – 13- to 15-years-old, Joshua Withdraws from School

Joshua's first semester in Grade 8 appeared to go well. However, in January 2012, at the age of 13, he refused to return to school. His mother called the school counsellor to let him know that she did not know what had happened or why, but that Joshua would not attend. The school team responded by referring Joshua to a program within the school that worked with children coming in from elementary school to resource, adapt and accommodate the school program to meet children's needs without transferring them.

According to interviews with school employees conducted by RCY investigators, both the school and Joshua's mother tried continuously to get Joshua to return to school. He refused. The school counsellor, teachers, youth engagement workers and the school principal all visited Joshua's home multiple times to try to convince him to return, but he would not. At times, he would lock himself in his room and would not even permit the school employees to see him. Other times, Joshua seemed well and would commit to coming back to school but, when the day came, he would not attend.

The school reached out to CYMH to request engagement from its urgent response team. The school's referral highlighted Joshua's depressed mood and isolation. It noted that Joshua locked himself in his room for days at a time and had not left his home for weeks. The assigned CYMH clinician went to school planning meetings and also visited Joshua's residence, but was unable to successfully engage with Joshua. After six months, he sent a letter to Joshua's mother, who had not returned his calls for two months. The letter informed Joshua's mother that CYMH would be closing Joshua's file, but that it would be re-opened if Joshua or his mother contacted CYMH. Joshua's mother informed RCY investigators that she did not recall receiving messages from

CYMH, and that she believed it was possible that Joshua deleted them while she was at work and he was home alone.

By May 2012, Joshua still refused to attend school, so the school referred him to the district resource team, a higher level of response within the school district for students experiencing difficulties. The school team noted that all of its attempts to reconnect with Joshua had been unsuccessful and that he refused all counselling and support services. The district resource team recommended that Joshua stay in his current school with at-home academic support and that the school counsellor and case manager keep encouraging his re-entry. The team also suggested that Joshua's mom consider trying to have Joshua hospitalized under the *Mental Health Act (MH Act)*. According to school employees, Joshua's mother constantly "*wrestled with the idea of calling the police [to apprehend Joshua under the MH Act], but she figured if she did she would forever damage her relationship with Joshua.*" Joshua's mother feared that she was one of Joshua's only consistent relationships and she did not want to destroy his trust. She shared this perspective with Joshua's school counsellor and felt that he agreed with her decision.

The *Mental Health Act (MH Act)*

The *MH Act* is the legislation that provides for the treatment and protection of people with severe mental illness in B.C. Under the *Act*, a person may be admitted to a designated treatment facility (such as a hospital) voluntarily or involuntarily. A person may be apprehended by police and taken to hospital involuntarily under Section 28 of the *MH Act* if the person is acting in a manner likely to endanger their own safety or the safety of others and appears to have a mental disorder.

Once apprehended, the person can be detained and treated at a hospital for 48 hours. This time limit can be extended if two physicians examine the person and both fill out medical certificates stating the reasons they believe the person has a mental disorder, requires treatment, cannot suitably be admitted voluntarily and "*requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others.*"⁵

Teachers from his school continued to visit Joshua's home and bring him schoolwork, which he would occasionally complete. His mother felt hopeless and unable to manage the situation as she believed she had tried everything she could to get help for Joshua. Exhausted with the continuous conflict and wanting to preserve her family to the best of her ability, Joshua's mother told RCY investigators that she "*just stopped fighting*". She chose to stop having constant disagreements with Joshua that did not lead to any change in his behaviours, and instead to use a new tactic of communicating but not trying to force Joshua to do what he did not want to do. Joshua was 14-years-old.

⁵ Province of British Columbia, *Mental Health Act* (Victoria: Queen's Printer, 1996).

In September 2012, Joshua was enrolled in Grade 9 at the same high school. Frequent planning meetings continued at the school level to try to find ways to engage with Joshua, and teachers and counsellors kept calling and visiting his house. His school evaluation from this time states, *“Student is resiliently entrenched in school refusal. Will not meet with any school personnel either in [school], at home or in another setting.”*

By October 2012, the school counsellor and principal were out of ideas about how to help Joshua. They went back to the district resource team and received approval to have Joshua transferred to an alternative school in a therapeutic day program. Joshua did not attend school for the remainder of his Grade 9 year.

In September 2013, Joshua, now 15, attended the first few weeks at his alternative school. This school had a wide variety of support services available to the youth who attended, with programs tailored to accommodate the needs of individual students. School employees observed that Joshua was sweet, but introverted and quiet, with very few friends.

After approximately two weeks, Joshua was once again ensconced in his house, unable to leave. The alternative school staff continued to try outreach support for Joshua, but he repeatedly told them to leave him alone. Staff described Joshua’s mother at this time as wanting to make things better, but also realistic about her own limitations as a working single mother with another child. She would tell the school, *“I know I should get him to a counsellor but he is refusing to leave and I’m not going to drag him.”* Neither Joshua’s mother nor the school team knew how to help him at this time.

2014 to March 2015 – Joshua’s Isolation Persists, Self-Harming Begins

In August 2014, Joshua, now 16, developed intense feelings for an adult woman from Texas whom he met online. The extent and nature of this relationship remains unclear to this day. Although he referred to her as his girlfriend, they never met in person and Joshua would also occasionally say that they were not actually in a relationship. Regardless, Joshua reported to his friends and later to professionals engaged in his care that he had fallen deeply, obsessively in love with this woman.

In September 2014, Joshua informed his mother that he wanted to go back to school, so she called the school and brought him in for his first day. The school team was hopeful as Joshua had organized his own intake and started off with strong attendance. The school team tried to support him without drawing too much attention to his presence, as they feared triggering his anxiety and causing him to withdraw again. The next month, his online relationship broke down and Joshua stopped attending school once again.

At the end of November 2014, Joshua sent messages to two acquaintances to inform them that he was planning on dying by suicide to *“leave the pain behind.”* Police visited Joshua’s residence, where he admitted that he had been thinking of suicide for years and had begun harming himself by hitting his own body and cutting his arms. The police apprehended Joshua under the *MH Act* and brought him to the nearest hospital.

The consulting psychiatrist who examined him believed that Joshua presented with symptoms of chronic depression and anxiety and required ongoing care in his community for his symptoms. He noted, *“I do not feel that [Joshua] is at imminent risk of harm to self, although he remains a chronic risk given the chronic nature of his self-harm behaviour and suicidality.”* The psychiatrist met with Joshua’s mother and explained that he would put in a referral for CYMH services for Joshua. Joshua was discharged from hospital that same day. At that time, CYMH had a liaison to the hospital that Joshua had attended. The liaison called Joshua twice in the first week of December. Joshua advised that he did not need services, so the CYMH liaison concluded the referral. The liaison did not communicate with Joshua’s mother about this decision, or about the support Joshua would need from her at home.

Chronic vs. Imminent Risk of Suicide

Doctors and other mental health professionals assess a person’s risk for suicide on a continuum of acuity based on risk and intent to commit suicide.⁶ Chronic risk refers to the ongoing likelihood of a future attempt of suicide and is based on numerous factors including background (such as previous suicide attempts), protective factors (such as social supports) and current risk factors (such as a relationship breakdown). An imminent risk of suicide refers to frequent and intense suicidal ideation with specific plans and clear intent.⁷

A person with a baseline of a high chronic risk of suicide may fluctuate in the acuity of their risk from minimal through to imminent risk, but, *“for a chronically suicidal patient, it is likely that the suicidal belief system will still be active, even during periods of . . . relative behavioural stability.”*⁸ For hospitals to hold a person under the *MH Act*, the assessing doctors must feel the person is at an imminent risk of harming themselves or others, or of significant deterioration to their condition were they to be released without medical care.

Joshua attended school sporadically every few weeks after December 2014. The school team recognized that Joshua was in a negative spiral and nobody knew what to do.

On Feb. 20, 2015, Joshua was hospitalized for a second time. Joshua had not heard from the woman from Texas in almost four months, but she messaged him in early February after he threatened to harm himself. The relationship quickly broke down again. Joshua informed a friend and the woman from Texas that he was going to kill himself and his friend reported the threat to the police. Joshua walked more than 15 kilometres to a park with a rope and razor blades before being located by police and apprehended once again under the *MH Act*. The police took him to the same local hospital that he had visited three months earlier.

⁶ Used in a medical sense, “acuity” refers to the acuteness, or level of severity, of an illness when doctors classify a patient’s presentation.

⁷ “Suicidal ideation” means thinking about suicide.

⁸ M.D. Rudd, “Fluid Vulnerability Theory: A Cognitive Approach to Understanding the Process of Acute and Chronic Suicide Risk,” in *Cognition and Suicide: Theory, Research, and Therapy*, ed. T.E. Ellis (American Psychological Association, 2006), 365.

This time, instead of being immediately released, Joshua was involuntarily certified under the *MH Act*. Joshua, now 16, was admitted to the hospital's secure adult psychiatric unit, as the hospital did not have a secure child and youth psychiatric unit. Joshua had ongoing suicidal ideation and was considered by doctors to be at a high risk for another attempt.

During his time in the hospital, Joshua's mood seemed to improve and he began denying having any suicidal ideation. Although the hospital team no longer felt he needed to be certified under the *MH Act* for his immediate safety, his doctors there believed that he would need considerable outpatient care. Joshua was released from the hospital on March 2, 2015. He was diagnosed with major depressive disorder.

The Acute Home Based Treatment Program (AHBT)

This program, offered through the local health authority, provides an out-of-hospital care option for people over the age of 17 who have experienced a worsening of symptoms or distress from mental illness and/or substance use. The AHBT has a short-term role with clients to ensure that they are not an acute risk to themselves or others once released from hospital. Clients must be referred by medical professionals. The AHBT team includes a psychiatrist and nurses. The team visits homes to monitor symptoms and medications and works to bridge possible gaps between hospital and community services.

Joshua returned to his mother, to be followed by the Acute Home Based Treatment Program (AHBT) and then by CYMH in the community after the AHBT program was complete. Joshua's mother called the CYMH liaison responsible for this referral multiple times and left messages, but never received any response. However, the hospital liaison did not have a record of receiving those messages. Again, his mother felt that she received insufficient guidance and support from the hospital team or the AHBT about the care and supervision Joshua would need when he was released back to her.

The AHBT nurse received the referral for Joshua on the day of his release. Although the AHBT service is primarily for adults, at this time the program also occasionally covered the gap in services between hospital release and CYMH intake for youth so that they would have continuous care. The team, including nurses and a psychiatrist, met Joshua almost daily both at home and

at the hospital. Joshua reported an ongoing low mood and passive suicidal ideation, with no stated plan to attempt suicide. He told the AHBT that he did not want his mother involved in his care in any way and continued to isolate himself at home. The AHBT noted that Joshua "*expressed interest in getting a specific counsellor as soon as possible.*" In response, the nurse called and left a message for the hospital's CYMH liaison to contact Joshua as soon as possible.

On March 13, 2015, the AHBT nurse discharged him with the understanding that he would be followed by a CYMH team, as organized by the hospital's CYMH liaison. The AHBT psychiatrist felt that Joshua was at his lowest possible risk of self-harm. Joshua's risk was always elevated compared to the general population, but at this time, the AHBT psychiatrist did not believe that Joshua needed the high level of emergency service available from AHBT. The AHBT nurse followed up with the hospital CYMH liaison, who contacted Joshua three days later and set up a follow-up appointment for March 19.

March 2015 – Joshua is certified under the *MH Act* a Second Time and His Mother Contacts MCFD for Help

On March 17, 2015, a week after his discharge from the AHBT, Joshua attempted suicide. He left his residence, telling his mother that he was going to a store. He then messaged a friend and the woman from Texas to let them know he was in the woods and was going to kill himself. Joshua's friend called the police, who promptly contacted Search and Rescue to assist in finding Joshua.

After two days of searching, Search and Rescue gained the cooperation of the woman from Texas and she forwarded them a file Joshua had sent her that she had been unable to open on her phone. The file held the coordinates to Joshua's location. Search and Rescue found him on March 19. He had taken a potentially lethal dose of prescription pills along with drinking two bottles of schnapps. He had hypothermia and wounds from self-harm. He was severely dehydrated and had to be flown out of his isolated forest location by helicopter.

For the third time since November 2014, Joshua was admitted to the same local hospital, where he was involuntarily certified under the *MH Act* for his acute risk of suicide. He was again placed on the adult psychiatric unit for treatment. His mother promptly called the hospital and advocated for them to keep Joshua longer this time for treatment and stabilization.

On March 20, Joshua's mother called MCFD asking for help. She let them know that Joshua was at the hospital for ongoing depression and suicidality. She asked MCFD to provide a transitional home for Joshua upon release. In explaining the situation to RCY investigators, Joshua's mother said that, as a single mother, she knew that she needed more support and could not provide the care Joshua required. No action was taken by MCFD on the call until a month later when a hospital social worker called MCFD again to request that the ministry get involved with the case.

Realizing that Joshua would require a longer stay in hospital for treatment, the local hospital worked to have him transferred to BC Children's Hospital (BCCH), which has more resources for intensive work with children and youth experiencing acute mental illness and distress. Joshua was transferred to BCCH on March 22, 2015.

Late March 2015 – Joshua's Admission to BCCH

When Joshua was admitted to BCCH, a psychiatrist there assessed him and found that he remained at a chronic, severe and occasionally imminent risk of suicide. The psychiatrist felt there was significant risk of deterioration if he was discharged before receiving further inpatient treatment.

The BCCH medical team worked on a treatment plan to keep Joshua safe and ultimately reduce his risk of suicide by addressing the stressors that contributed to his suicidality, including his depression, his rigid and rule-bound behaviour, his early childhood trauma and his social challenges. They hoped to enable him to safely return to his home

community. The plan included forming a care team of skilled professionals to work with Joshua and build a therapeutic relationship with him. It also included counselling, medication changes, engagement in the hospital's school program and connecting Joshua to community support services.

When speaking to psychiatrists at BCCH in his first month there, Joshua fixated on his relationship with the woman from Texas. He disclosed a lack of interest in anything other than her and playing video games for approximately 12 hours a day. While in hospital, he was self-harming by punching himself and continued to express that he was going to kill himself no matter what they did. The psychiatrists found him to be at a continuous high risk for suicide, but noted that he also seemed to use expressions of suicidality as a means to manipulate staff members. For example, he often threatened to kill himself if he could not contact the woman in Texas.

The BCCH social worker assigned to work with Joshua and his family began communicating with Joshua's mother to assess her needs and to help coordinate community supports for Joshua's eventual discharge. Her impression of Joshua's mother was that she was overwhelmed, but very committed to Joshua.

Joshua's overall well-being while in hospital did not appear to be improving despite ongoing work by his team. He frequently talked about his anxiety, his plan to kill himself upon discharge and his "constant agony" for the woman from Texas. His mother and brother regularly came to the unit to visit Joshua, although Joshua often refused to see them.

April 2015 – BCCH brings MCFD into the Planning Process

Hospital Passes

Passes form an essential part of inpatient mental health treatment and recovery planning, helping patients work toward discharge from hospital by practising their skills, increasing their independence and increasing their connection to their community. Types of passes include unescorted or escorted passes on hospital grounds for fresh air breaks, and escorted passes out of hospital including day passes, overnight passes or weekend passes. Doctors order passes for patients, and passes can be held or withdrawn if risk of harm to the patient increases. Prior to leaving the unit, staff members administer a pass safety assessment and plan with the patient. Nurses are able to cancel passes or call doctors for a second opinion if they are uncomfortable with the pass at any given time.

At the beginning of April 2015, Joshua's doctors at BCCH began allowing him to leave the hospital on limited passes with his mother, including overnight weekend passes. They continued to try different amounts of medications to alleviate Joshua's chronic depression.

As standard medical procedure dictates, patient discharge planning for youth begins as soon as they enter the hospital. As part of her role in the planning process, the BCCH social worker tried to connect with the North Shore Intensive Youth Outreach Services (iYos) team to have that team form a relationship with Joshua so that his eventual transition to community care would go smoothly. The social worker experienced considerable frustration in trying to reach the responsible iYos clinician. The team had just formed and the clinician's phone line was not working. The clinician told RCY investigators that he did not receive any of the BCCH social worker's messages for some time.

Intensive Youth Outreach Services

The health authority's child and youth mental health services in Joshua's area began offering iYos in April 2015. iYos provides outreach workers to support youth in the Lower Mainland experiencing acute mood or behavioural disturbances which may include suicidal ideation, moderate to severe substance use with or without mental illness and functional challenges as well as difficulties accessing services. This team often follows up with youth when they are discharged from hospitals after a mental health crisis.

BCCH also liaised with Joshua's former school to plan for his academic needs in hospital and post-discharge.

It was apparent to Joshua's BCCH care team that it would need extensive involvement from community support services, including MCFD, to plan for Joshua's eventual discharge. On April 23, 2015, the BCCH social worker called MCFD, requesting that the ministry become involved in the file. She informed MCFD that Joshua's mother was overwhelmed, needed support and did not have the ability to meet Joshua's needs at home. The BCCH social worker asked MCFD to send a social worker to the hospital to discuss possible placement options for Joshua. She was informed that MCFD would not bring Joshua into care at that time as there did not appear to be any protection concerns, and that MCFD would look into supports for Joshua's mother.

After further calls from the BCCH social worker, the intake MCFD social worker consulted her team leader and they decided to initiate a family development response to assess Joshua's mother's ability to care for Joshua given his high needs arising from his mental illness.

The *Child, Family and Community Service Act (CFCS Act)* and Family Development Responses

The *CFCS Act* provides the legal guidelines for ensuring the safety and well-being of children in B.C. Section 13 of the *Act* outlines when a child is considered in need of protection, including if a child is emotionally or physically harmed by their parent, or if a parent is unable or unwilling to care for their child and has not provided otherwise for the child's care. Any person in B.C. who believes a child needs protection under s. 13 has a duty to report those concerns to MCFD which, in turn, must assess the information in that report.

One possible response to a report made under s. 13 of the *Act* is for MCFD's social workers to conduct a family development response. This response is used as an alternative to a child protection investigation if the report does not involve severe abuse and if the parent is willing and able to collaborate with MCFD. A family development response includes an in-depth assessment phase and a possible protection services phase to provide monitoring and supports to families in need. These supports may include counselling, family preservation workers, care agreements or mediation.

May to June 2015 – Strained Communication between BCCH and MCFD; Joshua Remains in Hospital

At the beginning of May 2015, MCFD assigned a social worker to begin working with Joshua and his family and to initiate the family development response. He introduced himself to the BCCH social worker, who asked him to come to the hospital to meet with Joshua's care team and join in planning for Joshua's care.

In their initial discussions about Joshua, BCCH staff felt they were being clear to MCFD that Joshua's mother was unable to care for Joshua and that he would need to be discharged to MCFD for a placement. The MCFD team felt that the hospital was telling it to do something outside the scope of its mandate, as it had to first assess the family and Joshua to determine what they wanted and needed – a process that MCFD policy allots 30 days to complete. MCFD could not simply force a placement on Joshua's family because the hospital told it to do so. Members of the BCCH team quickly grew frustrated with what they perceived as inaction by MCFD and the MCFD team members began regularly consulting with each other about how to handle the situation. The MCFD team leader directed the MCFD social worker to offer supports to Joshua's mother and to continue doing his assessment of the family. The MCFD supervisors encouraged the team's social worker to get to know Joshua and find out if he would stay in a resource, and to connect with CYMH to gauge its involvement.

The MCFD social worker visited Joshua's home and met with his mother and brother. The ministry worker also began taking part in BCCH's weekly planning meetings for Joshua, and coming to the hospital to meet with Joshua every week in order to build a relationship with him.

Meanwhile, Joshua continued to express suicidal ideation and had escalating periods of self-harm, including punching himself, restricting his food and holding his hands under hot water until he burned himself. MCFD notes on May 8, 2015 indicate that *"It appears that Joshua is very high risk for suicide and that although [his mother] means well she is not able to meet his needs."* MCFD was still assessing the family's capacity during this period.

The hospital team noted Joshua's pervasive hopelessness and suicidal ideation, including a recent incident in the hospital unit when he had been found with a bag and a bedsheet over his head. The team began discussing the possibility of electroconvulsive therapy (ECT) with Joshua and his mother. Joshua often refused treatment from the hospital. He disclosed that he did not want to have ECT because it may be effective and he did not want to get better. Joshua's diary from this time included his step-by-step plan to get out of the hospital so that he could end his life. At the same time, he wrote of his desire to help others, stating, *"If I ever get better, I'll dedicate my life to helping people like me."* Eventually, Joshua agreed to ECT in order to show the woman from Texas that he was trying to get better for her sake.

Electroconvulsive Therapy

ECT is a procedure done under general anesthesia that may be used to treat certain mental illnesses, including major depressive disorder. It involves an electrical current passed through the brain to trigger a brief seizure. ECT has been shown to be effective in the short-term for patients, including those diagnosed as treatment-resistant, and to lead to a possible 80 per cent decrease in suicidal ideation.⁹

By the end of May, recognizing the complexity of Joshua's case, MCFD asked its regional CYMH consultant to take part in the BCCH case conferences. Joshua now had a large team of BCCH professionals, MCFD professionals, his mother and the iYos clinician meeting weekly to collaborate and plan for his ongoing care and eventual discharge from the hospital.

Although the MCFD team was aware that the hospital wanted Joshua placed in care, it remained focused on assessing his and his family's needs. MCFD believed that Joshua remained at far too high a risk for self-harm to be released from hospital and felt there was time to develop an appropriate plan. MCFD believed its primary role at this time was to build a strong relationship with Joshua so that Joshua would cooperate with the discharge plan. When the MCFD social worker tried to discuss post-hospital planning with Joshua during their weekly meetings, Joshua said there was no point in doing so because he intended to end his life as soon as he was able.

In early June 2015, Joshua began his ECT treatment. Weekly planning meetings continued, as did Joshua's regular passes outside of the hospital to be with his mother, his MCFD social worker and his iYos clinician. Although Joshua reported that the ECT treatment was not helping, his BCCH psychiatrists and nursing staff recognized an improvement in Joshua's depression throughout the month. He was still fixated on suicide and the woman from Texas, but began postponing his suicide plans and setting goals for the future. His mother bought him a guitar after he decided he wanted to learn to play one and he started participating more in the hospital's school program.

Still looking for a comprehensive discharge plan for Joshua, his BCCH team worked to get Joshua to agree to attend a voluntary day program for youth with mental illness once he returned to his community. If he agreed, they planned to place him on the wait list for that service. He did not agree. His main BCCH psychiatrist also referred Joshua to the BCCH dialectical behavioral therapy (DBT) program for treatment of what she believed was an emerging borderline personality disorder, in addition to his already-diagnosed

⁹ Felix Izci et al., "Impacts of the Duration and Number of Electroconvulsive Therapy (ECT) Sessions on Clinical Course and Treatment of the Patients with Major Depressive Disorder," *Journal of Mood Disorders* 6(3) (2016): 99-106.

major depressive disorder, dysthymic disorder and chronic high risk of suicide.¹⁰ Joshua was not accepted into the hospital's DBT program due to its lack of capacity to provide the level of service he needed for the length of time he required.

Another psychiatrist who specializes in suicidality was asked to provide consultation on Joshua's case. He found that Joshua showed strong indicators of obsessive compulsive disorder and borderline personality traits, while also presenting with major depressive disorder. He recommended working on Joshua's obsessive thoughts of the woman in Texas through cognitive behavioural therapy and a change in medications.

Dialectical Behavioural Therapy

Dialectical behavioural therapy (DBT) is a treatment method that may be used to treat patients who show signs of borderline personality disorder. DBT *"proposes that emotion dysregulation is the core dysregulation that drives the others . . . [leading] the individual to depend on others to an unusual degree to help regulate his or her emotions."* DBT treatment is highly structured with multiple stages and a team approach, and it includes the immediate, 24-hour availability of a skilled therapist for patients experiencing suicidal or self-harm urges.¹¹

DBT is an intensive therapeutic option for treating youth and adults who show signs of borderline personality disorder. DBT can include multiple components (individual therapy, multi-family skills training, family meetings and telephone coaching). DBT programs can deliver all of the components, based on individualized treatment needs. The elements of DBT draw from and overlap with other evidence-based approaches and "DBT-informed" approaches may use elements of DBT to support clients with other needs who may benefit from the DBT components. DBT is available through some CYMH offices, private counsellors or hospitals, but there is inconsistent availability throughout the province. Even where services exist, there can be waits for service and there is a need to improve timely and equitable access to DBT interventions. Currently, full DBT programs are accessed in B.C. primarily through privately funded treatment facilities, which can be prohibitively expensive for most families and are often not covered by medical service plans.

¹⁰ "Borderline Personality Disorder," *Canadian Mental Health Association*, <https://www.cmha.bc.ca/documents/borderline-personality-disorder-2/>. Borderline personality disorder is a currently used diagnosis with five groups of symptoms: unstable emotions (intense anger, extreme depression that is usually in response to a stressful event, mood swings), unstable behaviour (acts on urges such as suicide, self-harm or risky behaviours), unstable sense of identity (does not have a good idea of who they are and how they feel about themselves, feeling "empty"), unstable relationships (hard time maintaining relationships, doing anything they can to avoid abandonment, impulsively shifting how they see people), and awareness problems (may feel emotions not based in reality, often in response to a stressful event). Treatment for borderline personality disorder may include therapy, medication and self-help.

¹¹ C.J. Robins et al., "Dialectical Behaviour Therapy," in *Handbook of Personality Disorders: Theory, Research, and Treatment*, ed. J. Livesley (New York: the Guildford Press, 2001), 437-459.

Nearing Joshua's 17th birthday at the end of June, all of those involved in his care noticed a marked improvement in his presentation. He seemed happy and energetic. His psychiatrists focused on managing Joshua's chronic risk of suicide over time while slowly giving him more freedom to help him build a life he felt was worth living outside of the hospital. This included more freedom with passes outside of the hospital with family and independent passes within the hospital to be in the courtyard on his own. Joshua spent his birthday weekend with his mother and had his last conversation with his father on the telephone. His MCFD social worker took him out for a birthday lunch of pizza and Joshua informed him that he did not want to be in MCFD's care.

By the end of June 2015, BCCH psychiatrists began to express concerns that holding Joshua in hospital was starting to increase his risk of suicide, making him feel hopeless and frustrated about his situation. They believed that Joshua's depression had resolved, although he remained at risk for suicide, and there was little more they could do for him in the hospital setting. For many of the hospital experts involved, the goal was to balance Joshua's need for secure treatment and support with allowing him to have what they referred to as "*a life worth living*," which is also a part of treatment for mental illness.

July 2015 – Discharge Planning; Joshua Completes Suicide

In early July 2015, after the improvement of the final two weeks of June, BCCH psychiatrists noticed that Joshua began reporting that his depression was getting "*worse and worse*," and that he wanted out of the hospital. He began self-harming again after almost a month of being free from those behaviours. His previously successful passes home with his family were now going poorly and Joshua's mother told his main psychiatrist that she was very concerned that Joshua would be discharged to her home as she could not care for him at his level of risk. She wanted clear information about what MCFD could do to help her.

Joshua's BCCH team wanted a full review of Joshua's file with MCFD as the team felt the prolonged hospital stay was contributing to Joshua's deterioration. The team was concerned as MCFD had stated that Joshua was willing to return home and there were no protection concerns, so it would not be offering Joshua a placement. An email sent by the MCFD team leader to Joshua's MCFD team at this time confirms this understanding, saying, "*We do need to be clear at this time, we are not planning to take Joshua into care . . . Even if mother is wanting to sign a [Voluntary Care Agreement], given that we have not identified protection concerns, a [Voluntary Care Agreement] is not on the table.*" The MCFD manager was copied on the email.

Meanwhile, the MCFD social worker was still meeting Joshua regularly and consulting with both his manager and his team leader regarding the situation and what MCFD could actually offer the family. Unfortunately, the MCFD team did not contact Joshua's father at any point during its assessment of the family to understand the father's willingness and ability to care for Joshua. Joshua's father informed RCY investigators that, if asked, he would have been there for Joshua in any way he could "*in a heartbeat.*"

On July 14, 2015, frustrated by what it perceived to be an ongoing lack of appropriate action by MCFD to fulfill its part of discharge planning for Joshua, the BCCH care team wrote a letter to MCFD. The letter stated, “*We do not believe Joshua will succeed out of hospital without staffed supervision. We recommend that Joshua be placed in a supervised home to decrease social isolation, increase problem-solving and interpersonal relationship skills, increase community engagement, and assist in monitoring and managing Joshua’s mental health . . . while working towards a permanent return to his mother’s home.*” They outlined Joshua’s ongoing, chronic risk of suicide and emphasized that his mother could not provide the level of care he required.

The BCCH social worker discussed the impetus for this letter with RCY investigators, saying, “*I think the hospital was feeling stuck . . . They felt like they were repeating themselves . . . [MCFD] sounds like they were repeating themselves and no one was really moving forward even though everyone had the same goal of how can we best support this family.*” The intention of the letter was to clarify any miscommunication between BCCH and MCFD and to make the recommendations and concerns of BCCH staff very clear to allow for better collaboration between both sides.

The day after the letter was sent, Joshua’s care team, including BCCH, MCFD and iYos, held a conference to discuss its plan for Joshua. At this time, Joshua’s mother stated to all involved that she could not care for Joshua, given his needs. The professionals present at the meeting appeared to reach a common understanding at this time of their roles, abilities and responsibilities, and all began moving towards a concrete action plan for transitioning Joshua back into the community. This included getting MCFD resource social workers involved to look for placements for Joshua; connecting the family with a family preservation worker to support Joshua’s mother and help work towards eventual reunification of the family; and having iYos and CYMH work together to provide Joshua with a high level of community therapeutic support including twice-weekly visits with iYos and work with a CYMH clinician trained in DBT.

Initially, MCFD hoped to place Joshua in an existing skilled resource home in his region, but that plan fell through because another youth required the available bed before Joshua was to be released, and because of concerns around the other youth in the home, given Joshua’s history of problematic female attachments. On July 22, 2015, the MCFD team began searching for placements for Joshua outside of the Lower Mainland and discussing the possibility of creating a specialized resource for Joshua given his level of need. The next day, Joshua met with his MCFD social worker and, for the first time, Joshua said that he would be willing to stay in a placement if he was taken into MCFD’s care.

On July 29, BCCH hosted another case conference regarding planning for Joshua’s imminent discharge, with a date set for Aug. 13. MCFD confirmed that it was now in the process of building a specialized placement for Joshua in the community and that, while waiting for that to be completed, MCFD would ensure that Joshua’s mother had sufficient at-home supports to care for Joshua. The next night, Joshua went home to be with his mother and brother on a pass but had to be brought back to the hospital early when they grew concerned that he may harm himself because he stole his brother’s

knife. The BCCH nurses' notes indicate that the hospital was not aware of this concern.

On July 31, 2015, Joshua spent the day at the hospital. He met with his mother and his main psychiatrist and was agitated, threatening suicide unless he was allowed to communicate with a recently discharged female co-patient for whom he had developed feelings. A couple of hours later, his mood appeared to have stabilized. He was socializing with the nurses and his co-patients and was animated and appropriate. That evening, he asked to go to the hospital's fenced courtyard, which can be seen from the windows of the unit he lived on. Joshua was given an independent in-hospital pass, which was issued in accordance with hospital policy and his doctor's recommendations. When staff returned to get him a half-hour later, he was gone. The BCCH nursing staff followed procedure for missing patients, including calling the police, BCCH directors and psychiatrists, Joshua's mother and the hospital's security staff.

Despite extensive searches, Joshua was not found until Aug. 4, 2015. He had left the hospital courtyard and re-entered the hospital within a few minutes of beginning his pass. He then walked out of the hospital through an unlocked door and, covering a considerable distance, climbed the fence into the construction site located on hospital grounds and jumped off a construction crane. He is believed to have died the night he went missing but, as the base of the crane was below ground level and it was the weekend, his body was not located until construction crews returned to work the following week.

The coroner ruled Joshua's cause of death to be suicide. He was found to have elevated levels of his prescribed medication in his system. There are competing explanations for this level of medication, including that Joshua took additional doses of the medications. If that was the case, it remains unknown how Joshua accessed the additional medication. The Representative found no evidence to indicate that changes are necessary to the current hospital pass system based on the evidence collected for this specific investigation.

BCCH conducted an internal review of Joshua's death for the purpose of improving hospital practices. Under s. 51 of the *Evidence Act*, these reviews are highly confidential. The Representative requested access to this review, however BCCH was not legally able to share the information with RCY. This is in accordance with s. 10(4)(b) of the *RCY Act*, that expressly excludes access to information covered under s. 51 of the *Evidence Act*.

Analysis

Preamble

Joshua had many strengths. He was intelligent, kind and had a desire to help other people. He was also profoundly ill and, as a result, coped with chronic disordered moods, obsessive tendencies and persistent suicidal ideation. The people in his life struggled for many years to meet his needs. The Representative would like to acknowledge Joshua's friends and family, who loved him and did the best they could to help him. The Representative would also like to recognize the efforts of the multiple professionals engaged with Joshua throughout his life, who showed commitment and creativity in their attempts to provide services to meet his needs.

Joshua displayed signs of mental illness very early in his life. He was displaying symptoms at the age of two and, by the age of eight, he frequently spoke of his desire to die. At 11-years-old, he attempted suicide for the first time. He was a child with complex needs, and some of the responses to his behaviour by service providers over the years highlight systemic concerns with the current child-serving system. These concerns include the ongoing challenge of obtaining consistent and sustained mental health services over the long term for children and youth with chronic and complex mental health problems, and how the child-serving system as a whole responds to children and youth withdrawing from school.

The pathways for families with children who need mental health services can be prohibitively complex. In Joshua's case, he likely would have benefited from much earlier, consistent and appropriate mental health interventions, beginning at age two when his mother first sought help. His mother also appears to have been offered extremely limited support by any service providers between 2011 and 2015 to increase her own capacity to meet Joshua's considerable needs.

Of particular concern to the Representative is the lack of appropriate placement options for children and youth in B.C. who have significant needs arising from mental illness. Joshua was admitted to BCCH in March 2015, where he remained for 122 days, or approximately four months, before completing suicide. Although a majority of the time Joshua spent in

UN Convention on the Rights of the Child Article 3:

In all actions concerning children, the best interests of the child shall be a primary consideration. States shall ensure children are protected for their well-being, taking into account the rights and duties of those legally responsible for the child.

hospital was for treatment, his release was delayed due to a lack of concurrent discharge planning between MCFD and BCCH. In late April 2015, BCCH reached out to MCFD as the hospital professionals felt that Joshua's mother could not meet Joshua's significant needs in her home. By the end of May 2015, Joshua had a large group of professionals collaboratively planning for his eventual discharge. The key challenge that Joshua's team of caregivers faced was determining where Joshua could live after the hospital. The lack of available, appropriate, community-based residential services unnecessarily prolonged Joshua's stay in hospital,

which in turn may have contributed to an overall decline in his well-being by July 2015.

The Representative cannot say that, had the identified gaps been filled, Joshua would still be alive today. However, the Representative hopes that the provincial government, MCFD, and the other involved service providers can learn from what happened to Joshua and can work toward trying to prevent similar deaths in the future.

“After all this, I hope to God that the ministry does something and that something changes because, if it prevents another family going through what I’m going through – and I have changed as a person, something died inside of me when Joshua died, and everyone can see it in me. So if it helps, and something changes and there’s a positive outcome from all of this, then it’s worth it.”

– Joshua’s father

Findings

Lack of Appropriate Placement Options

Finding: *MCFD missed an opportunity to develop an appropriate community transition placement for Joshua earlier in his hospital stay by failing to adequately consider s. 13 of the CFCS Act regarding parents who are unable to care for their children.¹² The Representative believes that the narrow interpretation of this section applied by the MCFD team working with Joshua was totally inappropriate. Section 13 could have positively and proactively been applied by MCFD to facilitate access to the services Joshua needed.¹³*

The need to develop a customized community placement for Joshua through the *CFCS Act* and the child welfare system was a result of the lack of a comprehensive system of care for young people with complex mental health needs in B.C. As will be detailed, there has for decades been a complete absence in B.C. of evidence-based “step-down”¹⁴ community residential services that can take referrals from the inpatient units for children or youth preparing to leave the hospital who require additional support before returning to their families. Joshua needed the opportunity to stabilize in a structured community residential setting that had appropriate clinical and social supports available.

¹² Section 13 of the *CFCS Act* provides that, amongst other criteria, a child is in need of protection: “if the child’s parent is unable or unwilling to care for the child and has not made adequate provision for a child’s care.”

¹³ MCFD’s *Practice Guidelines for Using Structured Decision Making Tools* further details how Joshua’s mother’s ability to care for Joshua was a s. 13 child protection concern. Those tools provide an example for assessing whether a parent is unable and unwilling and has not made adequate provisions to care for a child who has attempted or is threatening suicide.

¹⁴ In this report, the term “step-down” refers to a complete system of community-based residential treatment options for children and youth experiencing mental illness and transitioning out of voluntary or involuntary hospital care prior to returning to their parent or guardian. Support is focused on stabilization of gains made in the more structured hospital setting and developing living skills and personal processes of recovery. The term “step-up” refers to community-based treatment options for children and youth experiencing mental illness as an alternative to hospitalization. Step-up supports focus on social skills and illness management techniques.

The opportunity was also missed for discharge planning with a full wraparound approach with family and community-based involvement to support and sustain Joshua's eventual return to his family.¹⁵

These two placement-related issues – the failure to secure a community transitional placement by bringing Joshua into care forthwith and the lack of a well-developed residential system of care for children and youth with serious mental health issues – left Joshua with no appropriate place to live safely in the community where he could also receive the treatment he desperately needed.

While Joshua was in hospital, the relationship between MCFD and BCCH was at times strained. At the root of this strained relationship was the tension between the hospital and MCFD over whether or not Joshua would be brought into the care of MCFD. Consequently, when Joshua was ready for discharge in June 2015, there were

“There are young people that are just really severely impaired by their mental health concerns and they need an opportunity in a positive, protected environment to move through rehabilitation and to be given an opportunity to define and achieve a meaningful life for them, whatever that looks like.”

– *BCCH psychiatrist*

no appropriate placement options available to support his transition back into his community. The result was a prolonged, 122-day hospital stay.

The severity of Joshua's mental illness and chronic risk of suicide was apparent as soon as he was admitted and assessed by a psychiatrist at BCCH in March 2015. His hospital care team quickly recognized that Joshua's needs surpassed his mother's abilities to care for him. The hospital social worker contacted MCFD to request its involvement with Joshua's case in April 2015. This message from BCCH staff was repeatedly communicated to MCFD staff throughout Joshua's hospital stay.

Tensions arose between MCFD and the hospital care team during their first meeting, when the hospital staff asked MCFD to plan a placement for Joshua once he was discharged. MCFD believed that it could not do so based solely on the hospital's request. The ministry chose to assess Joshua and his family first to determine what supports were needed and whether taking Joshua into care would be appropriate despite the existence of a substantial body of expert clinical assessment information and opinion on both Joshua's needs for support and his family's inability to adequately support his complex needs.

Although Joshua's mother loved him deeply, she was unable to meet his needs or care for him in 2015. His mother communicated her inability to meet Joshua's needs as early as 2006 and repeatedly throughout his long-term hospitalization. Joshua's father was not given serious consideration or assessed by the MCFD team as a potential placement for Joshua.

There are multiple routes for children to come into the care of MCFD. One route is through a Voluntary Care Agreement (VCA). This is a written agreement between MCFD and a parent who is temporarily unable to look after their child. The *CFCS Act* states that, if possible, MCFD must find out the child's views on a VCA and take them into account,

¹⁵ Wraparound community supports refer to support services that are individualized to meet the needs of each child or youth and their family. Wraparound services are community-based, culturally relevant and include a team of service providers working collaboratively to develop and implement plans of care.

and must consider whether the agreement is in the child's best interest. Similar to a VCA, MCFD may also enter into a written agreement known as a Special Needs Agreement (SNA) with a parent to take care of a child with special needs. Either a VCA or an SNA could have been an appropriate option for MCFD to pursue in Joshua's case.

Taking a child into care because the parent is unable to meet the needs of their child under s. 13 of the *CFCS Act* does not have to be seen as a judgement on the parent, their love for their child or their willingness to care for their child. Joshua was a child with exceptionally high needs due to his mental illness. The Representative believes that, in this case, MCFD ought to have acted sooner to secure an appropriate community residential placement for Joshua as an alternative to his mother's care. It appears to the Representative that the prolonged and arguably unnecessary focus by MCFD on an extended process of assessing the family's capacity to manage Joshua's needs and on building rapport with Joshua only served to help MCFD avoid the responsibility and costs of appropriate services for this youth and his family.

The Representative recognizes that such decisions are made within a broader context of an under-resourced child welfare system that strains against a high demand

UN Convention on the Rights of the Child Article 19:

States shall take all appropriate measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or maltreatment. Such protective measures should include effective social programs to provide necessary support for the child and their guardians, as well as other forms of prevention and identification.

for specialized and expensive child welfare residential placements. They also occur within the context of laudable efforts to maintain family integrity and an understandable reluctance to bring a child into care, especially given the potentially damaging effects of separation in involuntary cases. A different lens, however, is required when the circumstances involve children and youth with complex special needs and when bringing children into care may in fact be a necessary and constructive bridge to eventual family reunification.

MCFD should have taken Joshua into care in May 2015 and begun searching for a placement for Joshua, as it was clear to all involved that he would need one. Instead, a placement

search was delayed until July 2015, meaning that when the hospital felt Joshua was ready to transition out of hospital in June 2015, he had to stay there for several more weeks due to MCFD's inaction, with the attendant anxiety of not knowing when and where he was going to be placed.

While the BCCH team worked over the months to treat Joshua and to prepare him for discharge into his community, the focus for MCFD was on case planning for his post-discharge. MCFD's goal was to form a connection with Joshua to gain his cooperation with a possible future MCFD placement, and the ministry felt it had the time to do so as Joshua was still involuntarily certified under the *MH Act* at BCCH. When the MCFD social worker met with Joshua every week, Joshua continued to say that he did not want to come into care and that he was going to kill himself. Joshua's MCFD social worker told RCY interviewers that he felt that "*none of us [knew] what to do, what would be the appropriate thing for this kid.*"

UN Convention on the Rights of the Child Article 9:

States shall ensure that a child shall not be separated from his or her parents against their will, except when such separation is necessary for the best interests of the child.

Members of Joshua's BCCH care team informed RCY investigators that they felt Joshua's period of stability in June 2015 would have been the ideal time to discharge him, had an appropriate community resource been available. They were not comfortable releasing Joshua to his mother, who had told them she did not feel able to meet his needs. They were exasperated by what they perceived as inaction by MCFD and by the MCFD team leader's insistence that they would not take Joshua into care at that time.

BCCH team members responded appropriately to this frustration by writing a letter outlining why they felt that MCFD should consider taking Joshua into care. MCFD replied promptly and, the next day, the complete care team met and discussed the plan for Joshua. The team began forming a concrete plan to safely transition Joshua back to the community. The BCCH social worker noted that this meeting was a key turning point in the relationship between the hospital and MCFD. It was during this meeting that it finally became clear that both BCCH and the community service providers, including MCFD and iYos, were concerned with the length of Joshua's stay and had been trying all along to make choices that were in Joshua's best interest and that would offer him the best support.

UN Convention on the Rights of the Child Article 12:

States shall ensure that children capable of forming their own views have the right to express those views freely in all matters that affect them, and that their views are given due weight in accordance with their age and maturity.

The Representative would like to note that, despite the issues around placing Joshua throughout his stay in hospital,

his extended care team showed strong collaboration and willingness to employ creative practices to work toward an appropriate discharge plan for him that would provide wraparound community supports. That said, given the severity and intractability of Joshua's mental illness and his prolonged hospital stay, his case should have been escalated to the Provincial Director of Child Welfare. His extended stay in hospital had a potentially detrimental effect on his already very complex mental illness with tragic results, and his case clearly merited the personal attention of those at the highest levels, who should have been actively supporting staff and ensuring that the necessary resources were in place to protect Joshua and help him work toward recovery. That this did not happen despite an existing protocol agreement and memorandum of understanding between the hospital and MCFD points to a systemic lack of training for front-line workers that must be addressed.

Some professionals at BCCH highlighted in their interviews with the Representative's investigators that Joshua's case was not the only one in which they have experienced challenges working with MCFD when a parent cannot care for a youth with extremely high needs and the hospital is planning for discharge. One psychiatrist remarked that they have had similar cases that took "*months of serious conflict and advocacy,*" and that the psychiatrist "*wasn't surprised by this response [from MCFD].*"

Protocol Agreement, Memorandum of Understanding

MCFD has a succinct protocol agreement with BCCH, established in 2011, laying out the roles and responsibilities for collaborative practice. The agreement is meant to clarify the roles of involved professionals, facilitate cooperation and information-sharing and outline the expectations for conflict resolution.

MCFD, BCCH, and Sunny Hill Health Centre for Children also have a 2013 Memorandum of Understanding for discharge planning to the community for children and youth in care, which may also be applied to children with ministry involvement (not just those in care). This document clarifies the roles of all parties in discharge planning, ensures structures are in place to enable collaboration and timely communication, and provides mechanisms to resolve disputes through escalation to higher levels of responsibility in the decision-making chain of both organizations.

From July 15 to July 31, 2015, Joshua's MCFD team worked to identify an appropriate placement for Joshua, who had agreed to come into care under a VCA. Recognizing that there were no MCFD resources available that could meet his needs, his MCFD team began the process of developing a specialized resource for Joshua, a process that can take several months. Given Joshua's long history of serious mental health issues, his repeated hospitalizations and the understanding that the community-based options were very limited, the Representative finds it unacceptable that this work began so late.

The considerable challenges Joshua's MCFD and BCCH care teams faced in trying to plan for Joshua's discharge arose primarily because of a lack of dedicated community-based transitional resource homes for children and youth with complex mental health needs, the absence of which forced the care team to look to placements through the child protection system because that, unfortunately, was the only option. The very few resources that are available in this province can only be accessed by children in the care of MCFD. This is a key issue in B.C., as the Ministry of Health and MCFD have

very different mandates and systems. In the current environment, parents of children with needs similar to Joshua's only have one option to access these few community-based mental health placements: putting their child in the care of MCFD. This is unacceptable, and has been allowed to carry on for far too long.

When interviewed for this investigation, both MCFD and BCCH staff identified this gap as a chronic, systemic challenge they face in serving children and families. One BCCH psychiatrist emphasized that Joshua's case is not the only one that highlights this concern, stating, "*We have youth that have mental health needs that are greater than what the family can provide, but it's not child protection . . . This isn't a huge group of kids, but they*

UN Convention on the Rights of the Child Article 23:

States recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

tend to have very complex psychiatric needs and there's not really a place for them to go." Many MCFD and BCCH employees interviewed identified the need for a step-down community residential program for children and youth leaving hospital that would allow them to gradually transition from the acute, intensive hospital environment back to their communities and then eventually to their families. These community residential transition resources would ideally also provide support and training to caregivers to enable the children to return to their families.

“We don’t have step-down units where these kids could be transitioned smoothly in a fully supported way, where families can be supported, and it’s not hospital, but it’s supported in a community environment . . . I think that’s how we support youth, in their natural environment with other youth.”

– *BCCH social worker*

The provincial government has known about this significant gap in the child and youth mental health system for many years. The lack of step-up and step-down beds has been the subject of several key government reports. Despite well-intentioned reviews and plans, there has been no real progress in addressing this gap. The Representative believes this is a serious and unacceptable situation. Had this well-known issue been resolved by the provincial government during the last 15 years, Joshua may have not been in a situation where he was waiting in a hospital, potentially dealing with the anxiety of not knowing where he would live and what he would do once released.

In 2003, MCFD launched the five-year Child and Youth Mental Health Plan for British Columbia,¹⁶ which was informed in part by a province-wide consultation with service providers, stakeholders and service recipients conducted in 2000. That plan identified the absence of dedicated community residential mental health treatment resources as a key gap in the service-delivery system. MCFD intended to fill this gap by “re-focusing” existing contracted child welfare community residential resources so that those resources could provide specialized mental health treatment that would not require a child to be brought into MCFD care. This aspect of the Child and Youth Mental Health Plan was never realized because of budget cuts to MCFD in the early 2000s that decimated contracted community residential services.

MCFD commissioned a review of the implementation of the 2003 CYMH Plan in 2008.¹⁷ That review found that insufficient access to community residential programs remained a significant provincial concern. The report recommended that MCFD prioritize the provision of additional resources for step-down residential facilities. Instead of providing additional resources, MCFD’s strategic plan stated its intention to redesign existing residential resources to include residential mental health resources.¹⁸

In 2010, the Ministry of Health and MCFD released a 10-year plan to address mental health and substance use.¹⁹ That plan yet again identified the need to strengthen community residential treatment options for children and youth and promised action to “*enhance appropriate access to evidence-based community placements and community residential therapeutic options for children and youth with mental disorders.*” Annual monitoring reports of progress in implementing this 10-year joint ministry plan were publicly released for the first two years and then abandoned. The most recent annual report, from 2012, stated that the goal of enhancing residential therapeutic options for

¹⁶ Ministry of Children and Family Development, *Child and Youth Mental Health Plan for British Columbia* (Victoria, 2003).

¹⁷ A. Berland, *Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC* (Victoria, Ministry of Children and Family Development, 2008).

¹⁸ Ministry of Children and Family Development, *Strong Safe and Supported Operational Plan* (Victoria, 2008).

¹⁹ Ministry of Health and Ministry of Children and Family Development, *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia* (Victoria, 2010).

children and youth was achieved by the completion of the above-mentioned 2008 review. No actual resources were created or enhanced.

In 2012, the final report of the Residential Review Project, a joint project between MCFD and the Federation of Community Social Services of BC, was released.²⁰ That review reported that there were no intermediate community residential mental health treatment beds at all in the province.²¹ The report identified the need for the current system of intermediate care and treatment to be systemically planned, re-focused and re-invested in. The report specifically recommended evidence-based residential treatment programs be developed and implemented through redeployment of existing resources and new investments.

MCFD's subsequent Operational and Strategic Directional Plan incorporated reference to development of a child and youth mental health "service delivery template" that would include assessing the need for out-of-home care services, "especially 'step-up' and 'step-down' facilities, ideally distributed across BC."²² There was, however, no actual resource commitment or implementation follow-through to go along with this needs assessment.

Following the release of earlier reports that flagged significant shortcomings in child and youth mental health services, the Representative issued a comprehensive review of mental health services for 16- to 19-year-old youth in B.C. in 2013.²³ That review found, again, that intensive, intermediate mental health services such as community residential treatment programs were "virtually non-existent."²⁴ The report recommended that the provincial government develop a detailed three-year operational plan to improve mental health service delivery to youth which would include, among other things, community-based intensive intermediate care. Government did not develop the recommended three-year plan, nor did it commit resources to address the identified gap in intermediate mental health services for youth.

In 2016, MCFD announced the funding and implementation of two contracted resources in Vernon and Prince George with five beds each for children in care from ages seven to 18 with complex emotional, mental health, developmental and/or behavioural problems.²⁵ However, these resources were not designed to serve as step-down resources that could serve as a bridge between acute hospital care and a return to community, although they may occasionally be used to support children in care making this transition. A lack of step-up and step-down resources therefore remains a very significant

²⁰ The Federation of Community Social Services of BC and Ministry of Children and Family Development, *Residential Review Project: Final Report* (Victoria, 2012).

²¹ Ninety-five tertiary care (hospital-based) beds and 20 supported independent living child and youth mental health beds were identified.

²² Ministry of Children and Family Development, *MCFD Operational and Strategic Directional Plan 2012/13 – 2014/15* (Victoria, 2012).

²³ Representative for Children and Youth, *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (Victoria, 2013).

²⁴ One narrow targeted exception is the Woodstone Residence for treatment of young people age 17- to 24-years-old with eating disorders.

²⁵ B.C. Government Communications and Public Engagement, "New Care Beds Available for Kids with Complex Needs" (Victoria, 2016).

“For cases like this case and other cases where they’ve had really significant mental illness and it’s been challenging to find effective treatment or it’s highly complex like his presentation was, having a step-down unit with more of a mobilization, rehabilitation for this population would be tremendous. And it’s not available.”

– BCCH psychiatrist

gap throughout the province and access to such resources should not be limited only to children in care, as this is unnecessary, unduly restrictive and some parents find it to be stigmatizing.

Joshua’s story illustrates the effect that this systemic issue can have on individual lives, and the effect it can have on the work of those trying to provide comprehensive, responsive and appropriate services to children and youth with complex mental illnesses. The Representative believes it is time for government and its provincial partners to prioritize the need for step-up and step-down beds that are accessible to all children and youth in B.C., regardless of whether they are in the care of MCFD.

Ongoing Challenges with Obtaining Long-Term Mental Health Services for Children and Youth

Finding: *Despite experiencing significant and chronic mental health issues from an early age, Joshua did not receive the sustained and integrated mental health interventions and treatments that he required over the long term.*

“I don’t think that enough of that budget is allocated to mental health. I know that it’s six to seven per cent of the budget; the Deputy was very clear about that. And I don’t think that’s a Ministry of Children and Family Development problem; I think that’s a government problem. And that’s true in Health as well . . . Government has to make funding child and youth mental health adequately a priority.”

– Psychiatrist

There were signs that indicated the severity of Joshua’s mental health issues well before his first hospitalization for suicidal ideation in 2014 at the age of 16. He received some early assessments and services, but did not receive the kind of long-term, intensive help that was warranted.

The Representative has issued several investigative reports highlighting the chronic underfunding to provincial mental health services for children and youth that can lead to an inability of front-line service providers to offer long-term, intensive mental health services. Recent reports on the subject include *Broken Promises: Alex’s Story*, *A Tragedy in Waiting: How B.C.’s Mental Health System Failed One First Nations Youth*, and *Who Protected Him? How B.C.’s Child Welfare System Failed One of Its Most Vulnerable Children*, as well as the previously mentioned report, *Still Waiting: First-hand Experiences with*

*Youth Mental Health Services in B.C.*²⁶

²⁶ Representative for Children and Youth, *Broken Promises: Alex’s Story* (Victoria, 2017).

Representative for Children and Youth, *A Tragedy in Waiting: How B.C.’s Mental Health System Failed One First Nations Youth* (Victoria, 2016).

Representative for Children and Youth, *Who Protected Him? How B.C.’s Child Welfare System Failed One of Its Most Vulnerable Children* (Victoria, 2013).

Representative for Children and Youth, *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (Victoria, 2013).

Still Waiting

In 2013, the Representative issued the report *Still Waiting: First-Hand Experiences with Youth Mental Health Services in B.C.*²⁷ This report reviewed mental health services for youth in B.C. and included surveys, focus groups and interviews with youth, families and service providers. The review revealed “a fractured youth mental health system in B.C. that is confusing and frustrating for youth and their families to navigate.”²⁸ It showed that significant barriers existed for youth trying to receive help, including long waits, a lack of understanding about mental health as a whole, gaps in communication and services for transitioning youth and a lack of intensive, intermediate supports in B.C. communities outside of the hospital system. The review also pointed out that families did not feel supported and informed about their children’s needs and available community supports, and that communication lapses between service providers, such as hospital practitioners and community professionals, were a major concern.

Joshua’s family first had contact with CYMH in November 2000, when his mother called CYMH requesting services for two-year-old Joshua, as she was concerned about behaviours including hitting himself on the head. Then, in the 2005/06 school year, a planning team was put together to assist Joshua in getting through the school year. The team consisted of a counsellor, a school administrator, a school department head, a teacher, a social worker and a psychiatrist. Despite the involvement of professionals focused on his mental health for much of his early childhood, Joshua continued to show a range of mental health difficulties for many years until he reached his teens and the issues intensified and exhibited as chronic suicidal ideation.

A recurrent pattern in Joshua’s case was the withdrawal of services whenever he began to do well, or when the voluntary mental health services were unable to successfully engage with him. This occurred in 2007, 2008 and 2009. CYMH services were initiated and then withdrawn again in early 2011 when, after three months of engagement, Joshua’s mother discontinued services for Joshua, saying she would monitor his mental health herself. There is no indication that Joshua’s mother was informed of support programs to assist her to do so effectively. Again in 2012, with Joshua now 13, CYMH received a referral due to his isolation, depression and school withdrawal. The CYMH clinician attempted to engage with Joshua for six months and then closed the CYMH file because he did not succeed in doing so, even though Joshua clearly still needed mental health services. This was Joshua’s last involvement with CYMH until two years later when he was hospitalized for suicidal ideation.

The Representative recognizes that these case worker decisions to withdraw services occurred within the broader context of a child and youth mental health service system that has been, and remains, vastly under-resourced, with lengthy waiting lists for services. Consequently, these scarce resources require that policies regarding caseload management and withdrawal of services be put in place to make room for waiting cases.

²⁷ Representative for Children and Youth, *Still Waiting*.

²⁸ Representative for Children and Youth, *Still Waiting*, 3.

An appropriately resourced mental health service system would not only retain the capacity to maintain consistent services but also to proactively and assertively reach out with services in cases involving chronic and/or complex needs.

Mental health challenges are one of the most common health issues among youth and children. Estimates derived from recent prevalence surveys in other countries, suggest that 12.6 per cent of children and youth in B.C. ages four to 17 years (approximately 84,000) experience clinically significant mental disorders at any given time.²⁹ The report that provided this estimate also found that “*effective prevention programs are imperative to lessen the burden of avoidable mental disorders and to reduce the need for treatment services over time.*” This report notes that there are “*unacceptable service shortfalls*” for young people that “*would not be tolerated for physical health problems . . . and should no longer be tolerated for mental health problems.*”

Many mental health issues emerge before age 25 and can become chronic with potentially negative short- and long-term impacts. These impacts can include interpersonal and family difficulties, problems in school, increased risk of physical illness and shorter life expectancy.³⁰

In B.C., children, youth and their families experience too many barriers to mental health services, including a lack of understanding of mental health problems, long wait times and services that are not designed for youth. Mental health services are fragmented, difficult to navigate, and too often do not support and involve families in caring for children and youth who are experiencing mental health problems. There are also significant gaps in the continuum of mental health services, including a lack of specialized emergency mental health services, a lack of community-based intensive intermediate mental health care and a lack of services for key child and youth populations including Indigenous youth, LGBTQ2S+ youth, and youth between 16 and 25. Stigma against those with mental health issues also remains a barrier to services.³¹

When Joshua was hospitalized in February 2015 after a suicide attempt, he remained at a local hospital on its secure adult psychiatric unit, although he was only 16. Although records and interviews indicate no issues with the treatment Joshua received while on this unit, it was not the ideal placement for a youth. Again, this placement demonstrates ongoing resourcing challenges within child and youth mental health in the province. The hospital he was in did not have a secure mental health unit for children and youth at that time. As a result, if children or youth are not transferred to BCCCH, able to be placed at the dedicated adolescent psychiatric units in Surrey, Kelowna or Prince George, or referred to the Maples (Burnaby) or Ledger House (Victoria), they are either placed on

²⁹ C. Waddell et al., *Child and youth mental disorders: prevalence and evidence-based interventions* (Vancouver: Children’s Health Policy Centre, Simon Fraser University, 2014), p.2.

³⁰ S. Kutcher and A. McLuckie for the Child and Youth Advisory Committee of the Mental Health Commission of Canada, *Evergreen: A Child and Youth Mental Health Framework for Canada: Summary* (Calgary, AB: Mental Health Commission of Canada, 2010), p.5.

³¹ S. Kutcher and A. McLuckie, Evergreen; Representative for Children and Youth, *Still Waiting; Select Standing Committee on Children and Youth, Final report: Child and youth mental health in British Columbia, Concrete Actions for Systemic Change* (Victoria: Legislative Assembly of British Columbia, 2016).

the pediatric unit, which is not designed for mental health crises, or they are placed on the adult unit, which may not be appropriate to meet their needs.

A common theme in interviews conducted with hospital employees by RCY investigators was the challenge in transferring youth to BCCH. According to those interviewed, once a child leaves the Emergency ward, it is challenging to transfer them to BCCH. Hospital administrators interviewed for this investigation acknowledged that most hospitals are busy and over-capacity and, once a child or youth in need has been admitted to a unit, it is more difficult to transfer them, as Emergency patients are given priority. Patients admitted to wards are assigned a lower level of urgency for transfer to other hospitals. This places hospital professionals in the position of deciding between keeping the child or youth in the Emergency ward until they can secure a possible transfer to BCCH, or transferring the child or youth to a more appropriate ward within their hospital, which then reduces their chance of getting into BCCH. After Joshua's second suicide attempt and subsequent hospitalization in March 2015, he did get transferred to BCCH.

Given BCCH is one of the key tertiary care centres in the province that provides services for involuntary patients and has the best resources to care for children and youth in mental health crisis, these potential challenges in hospital transfers are problematic and should be reviewed by the Ministry of Health and the health authorities.

Another clear gap in Joshua's ability to access community mental health services can be seen in the lack of services provided to Joshua after his releases from hospital in

“So, for the kids that are the most reclusive, that are the most challenging to engage and to treat, we're saying ‘Well, unless you volunteer for this, thanks’ . . . It doesn't make any sense and I recognize that young people have to engage but we've got to have some capacity to reach out, to maintain some connection with these young people, so at the moment that they do decide to engage, there's somebody there to pick them up.”

– *Psychiatrist*

November 2014 and again in March 2015. In both cases, once Joshua was discharged, his family was informed he would receive follow-up from CYMH. This follow-up was to come from the one CYMH liaison embedded within the hospital. In the year he received Joshua's intake, this single liaison received approximately 300 reports of children who had presented to the hospital with mental health and/or substance use concerns, an unreasonable and unmanageable workload for one person. He explained to RCY investigators that his capacity, combined with the voluntary nature of services in B.C., meant he was only able to call each youth, talk to them and provide them an option of services if they wanted to access them.

For a youth with Joshua's presentation and isolation, the post-hospital discharge mental health services he received in late 2014 and early 2015 were insufficient and unacceptable. The iYos team, a partnership between MCFD and the health authority, may serve to better bridge this gap given that part of its role is to facilitate links to community mental health services when children and youth are discharged, to keep following youth until those services are connected and to provide intensive case management and outreach services for youth for up to two years if needed. When Joshua was initially released from hospital in early 2015, this team was still being

formed, so he was unable to access this service. However, its role and collaboration with CYMH can be seen in its involvement with Joshua during the last few months of his life in the summer of 2015.

Numerous hospital professionals interviewed also highlighted the unique and more complex nature of child and youth mental health services when compared to adult services. With adults, professionals are dealing primarily with the individual. With children and youth, they often need to support the whole family, a task that the current provincial mental health model is not resourced to do. As one BCCH doctor stated in her interview with RCY investigators, *“If I had anything it would be that the Ministry of Health recognized that children are the niche market and we’re not ever just looking after the patient, we’ve got a whole family . . . [We’re] not resourced for that.”*

RCY Advocacy

One of the legislative functions of the Office of the Representative for Children and Youth is advocating for children and youth receiving reviewable services (such as mental health services or services under the *CFCS Act*) to ensure they are receiving programs and services that meet their needs, that their rights are upheld and protected and that their views are heard and considered by decision-makers.

In 2015, RCY advocates received 2,056 calls for service. Of those calls, 108 involved the need for advocacy for family support services or mental health services. These calls for advocacy support are coming from children, youth and their families who experience great challenges in navigating the complex system of child and youth services in the province. The challenges Joshua's mother faced when Joshua stopped attending school is a common theme in advocacy work. Single, working parents of children with special needs or behavioural or mental health issues are often left with minimal supports as there is no clear mandate under any MCFD service stream to intervene and offer support. Schools are also very limited in what they can offer in the home. Consequently, the home situation can be left to deteriorate such that it becomes a significant protection concern, initiating MCFD involvement at that point of crisis. Such was the case in Joshua's home, where MCFD finally responded with a family development response.

With little to no prevention or early intervention focus, the crisis-driven child-serving system suffers a chronic lack of long-term, family-oriented ongoing support services. Further, the lack of residential services in the child and youth mental health system, coupled with a limited capacity for outreach mental health clinicians for children and youth, means that single parents are left struggling to know where to go for help in a fragmented system.

Had hospitals and community mental health teams been better resourced, Joshua's mother may have felt more supported during his ongoing state of crisis. She told RCY investigators that she received little information from hospitals during Joshua's first

UN Convention on the Rights of the Child Article 23:

States recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

two admissions, and that she did not know what she was supposed to do to support Joshua and help increase his safety. This lack of awareness reduced Joshua's mother's ability to care for him, as she felt she was never given the tools or support to do so by BCCH or MCFD.

The provincial government has recognized the need to do better in supporting families in its planning framework for family inclusion entitled *Families at the Centre: Reducing the Impact of Mental Health and Substance Use Problems on Families – A Planning Framework for Public Systems in B.C.*

This framework recognizes the need for “services and supports that promote good mental health and prevent or lessen the impact of mental health and substance use challenges for the whole family.”³²

The lack of consistent, long-term mental health services to children and youth with complex and/or chronic needs, including youth such as Joshua, has been a long-standing issue in B.C. and has been recognized in many government and external-to-government reports. Recently, a report by the provincial Select Standing Committee on Children and Youth (SSCCY),³³ *Final Report Child and Youth Mental Health in British Columbia: Concrete Actions for Systemic Change* recognized that, although the province may have many services available, “they are often not necessarily easily accessible or well integrated as a system of care. Children, youth, young adults, and their families are suffering as a result of significant weaknesses and gaps in services.”³⁴

One core recommendation from this report was that a Minister for Mental Health be appointed to ensure provincial coordination and effectiveness of services. The report also made recommendations to improve access to services provided by child and adolescent psychiatrists and psychologists; to encourage effective and durable linkages between health authorities, health care providers and school districts; and to set targets to ensure services are delivered in a timely manner, with targets of a 60-day intake, assessment and initiation of treatment for children and young adults exhibiting signs of behavioural, emotional or mental health issues. In its report, the committee urged the provincial government as a whole to assign a high priority to the overall improvement of child and youth mental health services.

³² Family Mental Health and Substance Use Task Force, *Families at the Centre: Reducing the Impact of Mental Health and Substance Use Problems on Families – A Planning Framework for Public Systems in B.C.* (Victoria, 2015), 2.

³³ The Select Standing Committee on Children and Youth (SSCCY) is an all-party committee and one of nine permanent committees of the Legislative Assembly of British Columbia. The committee meets to foster awareness and understanding of the child- and youth-serving system in B.C., and to discuss reports by the Representative for Children and Youth. The SSCCY is the committee to which the Representative reports.

³⁴ SSCCY, *Final Report*, iv.

In February 2017, the former government's budget for the three-year period beginning in 2017/18 provided for enhancements in funding of child and youth mental health services: \$15 million annually for MCFD to hire more than 120 additional CYMH staff, along with an additional \$3 million in annualized funding for additional integrated youth services centres (the "Foundry" programs) and \$1 million in annual funding for additional "youth and Aboriginal" mental health services. While appreciable and certainly needed, this limited allocation of new funding will fall well short of what is needed to establish a comprehensive mental health service system for children and youth. For example, there was, yet again, no funding allocation for step-up/step-down residential services nor other intensive, intermediate services such as day programs or specifically targeted early intervention and school-based services.

In July 2017, the provincial government announced the creation of the Ministry for Mental Health and Addictions and appointed a minister responsible. That new minister's mandate letter requires her ministry to create a mental health and addictions strategy to guide the transformation of B.C.'s mental health care system and includes, as part of that strategy: *"a focus on improving access, investing in early prevention and youth mental health"*. As a result of these developments, the Representative is hopeful that there will be progress in addressing these serious concerns going forward. However, the Representative does note that this new ministry's budget, as laid out in the September 2017 *Budget Update*, includes only \$5 million this fiscal year and then \$10 million in annual funding thereafter. This is because the new ministry's role is limited to providing strategic leadership and planning; actual child and youth mental health service delivery will remain with MCFD and the health authorities. In this regard, there was no additional funding allocated for child and youth mental health services beyond that already identified in the February 2017 budget, noted above.

The Representative hopes that this new ministry will be given authority to set policy and direct significantly enhanced new resources in other ministries, including MCFD and Health, that will be required to make a real difference in B.C.'s child and youth mental health system.

UN Convention on the Rights of the Child Article 24:

States recognize the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

Joshua needed sustained, long-term and effective community mental health services to help him and his family cope with his depression and suicidal ideation. An increased and vigorous regimen of treatment may not have altered the eventual outcome of Joshua's suicide, but early and constant mental health intervention may have helped diminish his overall risk of attempting suicide and may have provided Joshua and his family with the community supports they needed to live healthier, safer lives.

As with every child's life, Joshua's story is unique in many ways. However, Joshua and his family's struggle to receive consistent, long-term mental health services will likely resonate with many of the other B.C. children, youth and families coping with mental health challenges. Direct action must be taken by the province to remedy the long-

recognized shortcomings in the current mental health system in B.C. and to do so in a way that optimizes evidence-based approaches and integrated services.

Lack of a Collaborative, Systemic Response to Children and Youth Withdrawing from School

Finding: *The child-serving system in B.C. was unable to adequately respond to Joshua's withdrawal from school, which was a clear warning sign that his mental health was in decline.*

“The huge gap is not going to school, not connecting with services, not going anywhere, not threatening to kill themselves – just sitting at home doing nothing . . . That doesn't sound urgent, but Joshua is a great example . . . Maybe it didn't look urgent, but if you use the outcome at the end, maybe looking backwards, we should've been doing more at this stage.”

– School employee

The Representative has remarked in previous investigative reports, including *A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth*, that school employees are often the first people outside of the family to see emerging mental illness and to provide consistent support to young people in need.³⁵ The SSCCY's report *Concrete Actions for Systemic Change* echoed similar findings, stating, “Educators are well positioned to observe emerging behavioural disorders and symptoms of mental illness. Children may display behaviors indicating stress with the demands of education, bullying, or a difficult family life.”³⁶

In Joshua's early childhood, his school frequently reported concerns for his well-being and offered support in the form of counselling, specialized learning plans and collaborative service provision with mental health services offered by the local health authority. One major issue in Joshua's early childhood that is beyond the scope of this report is his elementary school's practice of repeatedly sending him home when the school could not manage his behaviours, putting undue pressure on Joshua's struggling single, working mother. This eventually resolved, and Joshua's school supported him to remain in class from 2007 to 2012. Unfortunately, when Joshua withdrew from school in early 2012, the school system and Joshua's community lacked the capacity to respond to his needs.

UN Convention on the Rights of the Child Article 28:

States recognize the right of the child to education. They shall, in particular, take measures to encourage regular attendance at schools and the reduction of drop-out rates.

In Grade 8, at the age of 13, Joshua began refusing to attend school. His mother and school staff members tried repeatedly to re-engage him with no success. They partnered with local CYMH services for outreach to Joshua's home,

but the CYMH worker assigned was also unsuccessful in connecting with Joshua. In keeping with the *School Act*, although Joshua was not attending school, the local district maintained his enrollment and continued to try to work with him. They changed his IEP to include alternative school options and distance education to try to better meet Joshua's needs. The *School Act* states that children under 16 must enrol and participate

³⁵ Representative for Children and Youth, *A Tragedy in Waiting*.

³⁶ SSCCY, *Final Report*, 28.

“I think people cared, but I don’t know if there was enough of a safety net to catch the kids like this . . . He’s not the only one that’s sitting at home locked inside a room.”

– *Joshua’s mother*

in an education program, but the legislation does not provide any guidance or directives to school districts or the Ministry of Education for means to ensure that this participation occurs. Joshua’s lack of attendance and engagement with school persisted for three years, despite his mother’s and the school district’s ongoing attempts to address it.

The School Act

The *School Act* is the legislation in B.C. that compels school attendance for children and youth. Under Part 2, s. 3 of the *School Act*, students from the ages of five to 16 must enrol in an educational program and students must participate in that educational program. Section 14 allows any person who believes that a child is not receiving an education program to report that belief and, after receiving that report, the superintendent of the school district in which the child resides “*must take such action as is required by the orders of the minister.*”³⁷ Although the *School Act* dictates that students must attend and engage in school, the *Act* does not give schools or other service providers any real power to enforce this legislation.

The lack of capacity for schools and communities to respond to youth such as Joshua is a concerning limitation in the current child-serving system in B.C. In Joshua’s school district alone, one school employee identified approximately 20 youth who were not engaged in school despite ongoing efforts. That school employee has taken it upon himself to check in with those youth monthly because he is aware that, in the current system in B.C., all of the ministries involved in providing care to youth are prioritizing cases. Youth such as Joshua, who are alone at home not receiving any services but who do not appear to be in active crisis, are essentially ignored. The alternative school that Joshua was enrolled in from 2013 to 2015 had an abundance of mental health support services that Joshua could have accessed, but he needed to leave his room to get them. His school team was left in frustration, aware of Joshua’s need for more support but limited by its own mandate and by the lack of resources to meet Joshua’s needs.

Part of the issue with serving children and youth who are not engaged in school is that social withdrawal is not recognized as the major warning sign that it, in fact, is. As a starting point, social withdrawal should be recognized by all the provincial ministries and organizations that support children as a red flag that a child is not doing well. Ministries should be afforded the capacity to respond to that concern promptly and collaboratively.

This responsibility cannot solely lie with the Ministry of Education. Educational professionals interviewed for this investigation outlined their continual frustration with the system as it is. They said that currently their main response to school withdrawal is to call the parents. They said that they have tried to call MCFD, but are told that

³⁷ Province of British Columbia, *School Act* (Victoria, 1996).

non-attendance is not considered a protection concern, so there is little MCFD can do. As one school employee stated, *“They make it really clear when I phone that it’s not their problem which is fascinating because in other areas not attending school for a length of time without a reasonable explanation can be considered some kind of crisis.”* A school principal

“I would like to see the school challenge become a community one . . . to have shared responsibility and accountability from Health, school, municipality, MCFD. These kids, [they’re] not anybody’s. Not school, don’t go. Not Health, don’t go. Not MCFD, [these kids are] not seeking help or hurt. Not police, it’s not illegal. All the services don’t touch them. They all say they don’t have the resources to move to this set of kids.”

– School employee

echoed this concern, stating, *“Call MCFD and it’s not on their list of priorities. We’ve been told this explicitly – non-attendance at school is not an at-risk behaviour . . . But from our end, we use attendance as one of the primary markers of concern for mental health, for addiction, for family dynamics.”*

The school employees’ views of attendance as an indicator of overall well-being was echoed by medical professionals interviewed from BCCH. One psychiatrist noted, *“It’s against the law to not be in school . . . I consider school avoidance a psychiatric emergency and that, once kids have missed even one to two weeks of school, they’ll get referred to the crisis*

service . . . The longer you’re out of school, the worse it is.” The same psychiatrist emphasized the need for the government and service providers to recognize and better respond to the serious implications of school resistance in youth.

“When a child misses school, there can be different degrees: poor attendance, lack of attendance, and the most severe is school failure [defined by weeks of complete absence]. Children develop physically, socially, and mentally [at school], and school failure represents a halting of that trajectory. Any failure to attend school for more than a couple of weeks is absolutely a red flag and should be treated as an emergency.”

– Psychiatrist

B.C. school systems do have a wide variety of outreach and alternative programs, and the professionals working within those programs deserve recognition for their skills and commitment. However, these programs do not have the capacity, or the full integration of services from multiple ministries, to meet the needs of children such as Joshua. One school administrator interviewed for this investigation suggested that the Ministry of Health, MCFD and the Ministry of Education work together to develop, resource and test-run an interdisciplinary, wraparound team that exists solely to address this small cohort of children

who are completely disengaged from school and who, like Joshua, are on *“a pathway to a despairing situation.”* In doing so, the child-serving system in B.C. would be positioned to respond better to children and youth who are challenging to reach.

Fully integrated services from the main child-serving ministries in response to children such as Joshua would allow the formation of a preventative team, potentially facilitated or driven by the child’s school team, to work together and react earlier to situations that clearly have the potential to turn into life-threatening crises. For Joshua, this could have led to a team assigned to work specifically with him, providing the outreach, comprehensive supports and time commitment necessary to treat him before his suicide attempts in 2015.

In recent years, models of integrated service delivery have emerged with the aim of providing services in a child-, youth- and family-friendly manner. Integrated services can be coordinated across providers and settings and delivered either through co-located programs or through well-functioning collaborative arrangements across two or more service providers. Ideally, services are offered in a tiered manner where individuals with more complex mental health issues are referred to appropriate tertiary level supports such as residential programs. Integrated services can include not only mental health, but substance use services as well as physician-based health care.³⁸

New Brunswick has established an Integrated Service Delivery (ISD) framework for children and youth with emotional, behavioural and mental health issues. The goal of the ISD approach is to overcome the challenges many children and families experience when they try to access mental health and other supports, particularly for children and youth with multiple needs. This approach is meant to ensure that children and youth receive an integrated approach to case management with the aim of preventing issues from reaching a crisis.

The ISD framework requires that professionals such as counsellors, social workers, educators, nurses, mental health and substance use professionals work together in teams to offer a range of services and supports. To improve access to these services, many of these teams are located in schools and other community settings. These teams can provide assessment, support and intervention services to reduce the need for delivery of more intrusive supports; the goal is to have one case file for each child or youth to ensure planning has been conducted in a collaborative manner and that all professionals are aware of the goals and service options. The ISD model also relies on a tiered governance structure where coordination of services occurs at the regional as well as the provincial level.³⁹

The framework also establishes the requirement that regions create integrated child and youth teams with professionals from all of the identified service groups, and that:

“Following a child-centered approach, Education and Early Childhood Development will provide programming support and resources to realize the articulated goals for the child’s program. This allocation of support and resources will be based on the premise that it is imperative for school and district professionals to serve as a guide to the professional knowledge, skill and judgment needed to be part of the Child and Youth Team.”⁴⁰

This approach by New Brunswick recognizes the unique place schools have in the lives of children and youth and the ability of school professionals to recognize when children are in need. In response to the centrality of schools in children’s lives, the framework clearly states, “Each C&Y team is assigned to provide services to a cluster of schools within a given

³⁸ B. Rush & L. Nadeau, “On the integration of mental health and substance use services and systems,” in *Responding in mental health and substance use*, ed. D. Cooper (Oxford: Radcliffe Publishing, 2011), 148-175.

³⁹ See New Brunswick, *Integrated service delivery (ISD) for children and youth with emotional, behavioural, and mental health issues*, <http://www2.gnb.ca/content/gnb/en/departments/education/isd.html>.

⁴⁰ Province of New Brunswick, *Framework*, 27.

region . . . Partners in each region will determine the number of C&Y teams required for each region, as well as the number of resources required for each team.”⁴¹

Currently, B.C. does not have a true integrated service model such as New Brunswick’s. Such a model could have allowed for a much greater overall response to Joshua prior to his state of crisis in 2015. There are some encouraging examples of integrated mental health services for children and youth in B.C., such as school-based hubs where physical and mental health services are offered at one site located either adjacent to or within schools. The mandates of school-based health hubs vary, but in general these services are meant to provide low-barrier, seamlessly integrated health and wellness services for students who are provided a range of services (addressing physical ailments, sexual health and mental health) in a private, safe environment.⁴²

Another example of service integration in B.C. can be seen in the Foundry project – a newly established set of integrated health and social service centres for young people ages 12 to 24. Foundry centres provide one-stop access to mental health care, substance use services, primary care, social services and youth and family peer support. The Granville Youth Centre in downtown Vancouver was the first of these integrated services, with more centres opening in Campbell River, Abbotsford, Kelowna, the North Shore and Prince George.⁴³

These B.C. pilot projects are in keeping with the recommendations of the previously mentioned Select Standing Committee report *Concrete Actions for Systemic Change*, in which the committee made a core recommendation to integrate and coordinate child and youth mental health services with a “one child, one file” approach as a foundational design principal.⁴⁴

The Representative commends the creative approaches underway in B.C. to respond to the need for more accessible, inclusive, youth-friendly health and substance use services. However, these approaches would not have reached Joshua, who would not leave his home. The Representative believes that B.C. could do much more to prioritize integrated mental health services by establishing a clear model of true collaboration between the child-serving ministries. If the province commits to developing a true integrated service strategy, children such as Joshua, who clearly needed more help than he received in the three years prior to his hospital admission, may no longer fall through the cracks.

⁴¹ Province of New Brunswick, *Framework*, 27-28.

⁴² For more information on school-based hubs, see the SSCCY report, *Final Report*, pp. 27-29.

⁴³ See <http://www.foundry.bc.ca> for more information.

⁴⁴ SSCCY, *Final Report*, v.

Recommendation

Recommendation

That the Ministry of Mental Health and Addictions lead the planning and implementation of a full continuum of mental health services for children and youth in British Columbia – in partnership with the Ministries of Children and Family Development, Health and Education – and that the provincial government provide the resources needed to support this comprehensive system.

The comprehensive plan to be developed within 12 months and implementation of the components to begin within 24 months.

Glossary

Acute Home Based Treatment Program: A program offered through the local health authority that provides an outpatient care option for people over 17 experiencing worsening symptoms from mental illness or substance use.

Borderline Personality Disorder: A personality disorder relating to the ability to regulate emotions and impulses, often regarding personal relationships.

Child and Youth Mental Health (CYMH): CYMH is a part of MCFD that offers free, voluntary mental health services to infants, children and youth who are experiencing mental health challenges.

Dialectical Behavioural Therapy: A treatment method that has demonstrated success in treating patients who show signs of having borderline personality disorder. The treatment is highly structured with a wraparound, team approach and ideally includes the 24-hour availability of a skilled therapist.

Dysthymia: This is a term used to refer to chronic, mild depression.

Individual Education Plan: A plan created for students with special needs in B.C. to document, summarize, and record their individual education program, including goals and the planned provision of additional services.

Intensive Youth Outreach Services: An outreach mental health and substance use service for youth provided by the local health authority.

Electroconvulsive Therapy: A procedure used to treat certain mental illnesses, including major depressive disorder, which involves an electrical current passing through the brain to trigger a brief seizure.

Family Development Response: A possible response by MCFD to s. 13 protection concerns under the *Child, Family and Community Service Act*. This is intended to be a collaborative response to protection concerns that includes an in-depth assessment phase and a possible service-provision phase.

Mental Health Act: The legislation covering the treatment and protection of people with mental illness in B.C. This *Act* includes the ability to voluntarily and involuntarily admit people experiencing mental illness to designated hospitals.

Oppositional Defiant Disorder: This is a behavioural disorder diagnosis for patterns of disobedient and defiant behaviour to authority figures.

School Act: The legislation in B.C. covering the public K to 12 school system. This *Act* includes the requirement that children from the ages of five to 16 must be enrolled and engaged in school.

The Select Standing Committee on Children and Youth: This is one of nine permanent committees of the Legislative Assembly of British Columbia. The committee meets to foster awareness and understanding of the child- and youth-serving system in B.C., and to discuss reports by the Representative for Children and Youth.

Social Responsibility Support Program: A joint program between the local health authority and the school district in Joshua's region that is intended to offer intensive behavioural support to elementary school children while keeping them enrolled in their mainstream school.

Step-up and Step-down Services: In this report, "step-up" refers to community-based treatment options for children and youth experiencing mental illness as an alternative to hospital placement. "Step-down" refers to community-based residential treatment options for children and youth transitioning out of voluntary or involuntary hospital care prior to returning to their parent or guardian.

Wraparound Services: This refers to supports services that are individualized to meet the needs of each child and youth and their families. Wraparound services are community-based, culturally relevant and include a team of service providers working collaboratively to develop and implement plans of care.

Appendix A: *Representative for Children and Youth Act*

Part 4 – Reviews and Investigations of Critical Injuries and Deaths

Section 11 – Reviews of critical injuries and deaths

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

Section 12 – Investigations of critical injuries and deaths

- (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that
 - a. a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
 - b. the critical injury or death
 - i. was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,
 - ii. occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
 - iii. was, or may have been, self-inflicted or inflicted by another person.
- (2) The standing committee may refer to the representative for investigation the critical injury or death of a child.
- (3) After receiving a referral under subsection (2), the representative
 - a. may investigate the critical injury or death of the child, and
 - b. if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.

Appendix B: Documents Reviewed for the Representative's Investigation

BC Coroners Service Records

- Kimble Report for Joshua
- Coroner's Report for Joshua

Legislation, Regulations, Standards and Policy

- British Columbia Children's Hospital policies and procedures regarding passes, nurse in charge handovers and missing patients
- British Columbia Ministry of Children and Family Development (2003). Child and Family Service Standards
- British Columbia Ministry of Children and Family Development (2012). Child Safety and Family Support Policies
- *Child, Family and Community Service Act* (1996). Victoria, B.C. Queen's Printer
- *Evidence Act* (1996). Victoria, B.C. Queen's Printer
- Memorandum of Understanding Between the Ministry of Children and Family Development, British Columbia Children's Hospital and Sunny Hill Health Centre for Children For Hospital Discharge Planning to the Community for Children and Youth in Care (2013)
- *Mental Health Act* (1996). Victoria, B.C. Queen's Printer
- Protocol Agreement Regarding Children's and Women's Health Centre of British Columbia and the Ministry of Children and Family Development: Roles and Responsibilities for Collaborative Practice (2011)
- *Representative for Children and Youth Act* (2006). Victoria, B.C. Queen's Printer
- *School Act* (1996). Victoria, B.C. Queen's Printer

Medical Records

- Health authority records
- Hospital records
- Family doctor records
- Medical Services Plan records for family

MCFD Records

- Computer records for service requests to MCFD regarding Joshua and his family
- Child and Youth Mental Health file for Joshua
- Family service file

Ministry of Education Records

- Joshua's school records
- Internal emails regarding Joshua

Police Records

- Records from four police departments regarding Joshua

Search and Rescue Records

- Records from Search and Rescue regarding Joshua

Appendix C: Interviews Conducted during the Representative's Investigation

- Family members (5)
- Community agency service providers (1)
- Health authority mental health staff members (4)
- Hospital staff members (14)
- MCFD staff members (10)
- School staff members (7)
- Search and rescue staff members (2)
- Total: 43 individuals interviewed

Appendix D: Multidisciplinary Team

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

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

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

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

Following is the list of members that comprised the team when the report was last reviewed:

Cory Heavener – Ms. Heavener is Assistant Deputy Minister and Provincial Director of Child Welfare for the Ministry of Children and Family Development. She is the former head of the Provincial Office of Domestic Violence. She was previously the Director of Critical Injury and Death Reviews and Investigations for the Representative for Children and Youth. Ms. Heavener has a lengthy career in child welfare in British Columbia and began her career as a child protection social worker 25 years ago.

Beverley Clifton Percival – Ms. Percival is from the Gitksan Nation and is a negotiator with the Gitksan Hereditary Chiefs' Office in Hazelton. She holds a degree in Anthropology and Sociology and is currently completing a masters degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a registered nurse at the BC Children's Hospital, is past president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

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

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

Dr. Christine Hall – Dr. Hall is the Medical Director of Trauma Services for the Vancouver Island Health Authority, an associate professor at the University of Calgary and a clinical assistant professor at the University of B.C. In addition to her training in emergency medicine, Dr. Hall has a masters degree in clinical epidemiology.

Deputy Chief Derren Lench – Derren Lench is currently with the Central Saanich Police Service where he is Chief Superintendent, Deputy Criminal Operations Officer in Core Policing. He recently joined the municipal service after 35 years with the RCMP. Deputy Chief Lench is the outgoing President of the BC Association of Chiefs of Police.

Dr. Margaret Colbourne – Dr. Colbourne is a clinical associate professor in the Department of Pediatrics at UBC and Director of the Child Protection Service Unit (CPSU) at BC Children’s Hospital. She has worked both as a Pediatric Emergency Physician and a CPSU pediatrician since joining the hospital staff at BC Children’s Hospital in 1994. She has served as a committee member of the Royal College of Physicians and Surgeons of Canada’s Pediatric Emergency Medicine Examination Board and holds a Founder designation in Pediatric Emergency Medicine. Dr. Colbourne is actively involved in many aspects of medical education and clinical research. Her areas of interest including topics in both pediatric emergency medicine as well as child maltreatment.

Dave Attfield – RCMP Chief Superintendent Attfield is the Deputy Criminal Operations Officer for Core Policing in B.C. This area includes oversight of our provincial programs relating to children and youth which are delivered through E-Division Crime Prevention Services. Chief Superintendent Attfield serves on several BC Association of Chiefs of Police committees including Violence Against Women; Mental Health and Addictions; and Crown-Police Liaison.

Deb Whitten – Deb Whitten is currently an Associate Superintendent of Schools in the Greater Victoria School District. Prior to this role, she was the District Principal of Student Services where she worked closely with students and families in supporting their educational goals. Ms. Whitten is an advocate for youth as they transition through schools and into adulthood. She has been working collaboratively with community stakeholder groups to address mental health concerns and continuity of support and services.

Dr. Rachelle Hole – Dr. Hole is an associate professor at UBC’s School of Social Work in the Okanagan and co-director of the Centre for Inclusion and Citizenship at UBC. Dr. Hole’s research includes a focus on human rights and social inclusion, supports and services for individuals with intellectual disabilities and their families, and transitioning youth with disabilities. Prior to pursuing her academic career, Dr. Hole was a community mental health worker and a family preservation worker.

Michael Egilson – Michael Egilson is the Chair of the Child Death Review Unit for the BC Coroners Service. Mr. Egilson has worked in the public sector for the past 30 years in various capacities related to the health and well-being of children and youth. Over the past three years, he has convened seven child death review panels culminating in public recommendations to improve public safety and prevent similar deaths in the future.

Kate Hodgson – Ms. Hodgson is the Coordinator at Ray-Cam Co-operative Centre, one of the key partners in Our Place – a collaboration of residents, community organizations, local business and community leaders in Vancouver’s inner city committed to ensuring that our children and youth have every opportunity for success. She has extensive experience working in Vancouver’s Downtown Eastside/Strathcona neighbourhood over the past 16 years, including as the Executive Director for the Network of Inner City Community Services Society. She has been a director on the board of the Federation of BC Youth in Care Networks and an advisor to the Vancouver Foundation’s youth homelessness initiative.

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Contacts

Phone

In Victoria: 250-356-6710

Elsewhere in B.C.: 1-800-476-3933

E-mail

rcy@rcybc.ca

Fax

Victoria: 250-356-0837

Prince George: 250-561-4624

Burnaby: 604-775-3205

Website

www.rcybc.ca

Mail

PO Box 9207, STN PROV GOVT

Victoria, B.C. V8W 9J1

Offices

Head office – Victoria

#400 – 1019 Wharf Street

Victoria, B.C. V8W 2Y9

Northern office – Prince George

1475 10th Avenue

Prince George, B.C. V2L 2L2

Lower Mainland office – Burnaby

#150 – 4664 Lougheed Hwy.

Burnaby, B.C. V5C 5T5



B.C.'s Representative
for Children and Youth
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