



REPRESENTATIVE FOR
CHILDREN AND YOUTH

**A Tragedy in Waiting:
*How B.C.'s mental health system
failed one First Nations youth***

Investigative Report

September 2016

Sept. 8, 2016

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

Dear Ms. Speaker,

I have the honour of submitting the report *A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,



Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Ms. Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth

Mr. Craig James
Clerk of the Legislative Assembly



REPRESENTATIVE FOR
CHILDREN AND YOUTH



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REPRESENTATIVE FOR
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Executive Summary

He was a 16-year-old First Nations boy, loved by his family and described by his teachers as “*sweet and easy to like*.” But on an early May day, when he should have been in class with his schoolmates and perhaps looking forward to the approaching summer holidays, Chester walked out into the woods near his suburban British Columbia high school and took his own life.

Any death of a young person is a tragedy, a tremendous loss of potential to the community and an ongoing heartbreak for family and friends. But the story of Chester (a pseudonym used to protect the privacy of his family and community) is particularly difficult for the Representative to tell because – for myriad reasons, none of them defensible – he simply did not receive the services that could have made a difference.

Chester was a bright and creative teenager who came from a close-knit family and lived on a reserve near a major B.C. city. Like so many other First Nations youth, he came from a family heavily impacted by the devastating and enduring effects of residential schools and profound intergenerational trauma.

But unlike children and youth profiled in previous Representative for Children and Youth (RCY) reports, Chester was not living in a rural or remote location that could have hindered access to services. In theory, he should have had easy access to every service this province, his community and the delegated Aboriginal Agency (DAA) that serves it can offer a young person with mental health challenges.

In reality, however, Chester did not receive appropriate services and only received a brief mental health assessment, despite exhibiting signs of serious mental health issues. During the final year of his life, both the Ministry of Children and Family Development (MCFD) and the DAA for his region were aware of his situation and had open files on him but ultimately, when he needed help, it wasn't there.

While this report centres on the experience of one youth, it also raises serious questions about health care services in B.C. – in particular, for Aboriginal children.

The Representative documented severe systemic issues in her report *Still Waiting: First Hand Experiences with Youth Mental Health Services in B.C.* (2013), which was released just one month before Chester's death. The findings of that report illustrated a system in disarray and families facing the frustration of extensive wait lists. This report, unfortunately, confirms those findings and offers a disturbing illustration of the problems faced by Aboriginal children and families in need of these services.

After a thorough investigation of the circumstances leading to Chester's death on May 7, 2013, the Representative has little confidence that the system has significantly improved in the three years since. Despite MCFD being well aware of unacceptably long wait lists for Aboriginal Child and Youth Mental Health (ACYMH) services in Chester's region,

there has been scant progress in addressing this issue. Lengthy wait lists remain the norm – the average wait time for services at that particular ACYMH office as of March 1, 2016 was 270 days. British Columbians have continually been told that, as the economy improves, the provincial government will make greater investments to address key issues that affect children and families. But the Representative believes that this reasoning makes no sense considering what is at stake here. This is a known cohort of children and youth who require support and seek a therapeutic system that understands and supports them, yet instead, they get a brick wall.

During the course of this review, the Representative's investigators interviewed Chester's family, staff at MCFD and the DAA, including social workers, Chester's support worker, ACYMH staff, school staff and officials, band members, health professionals and police. What they found was that, despite the good intentions of school staff and front-line workers, the systemic problems plaguing the MCFD, DAA and ACYMH support systems for First Nations families in the area, along with the patchwork nature of those systems, combined to produce a kind of illusionary support infrastructure – that is, a system that purported to support First Nations youth with mental health needs but that in reality was so uncertain and precarious that, in Chester's case, his needs went unmet.

This report details breakdowns in the child and youth support system for First Nations families that were so frequent that they formed the rule, rather than the exception. A Crisis Response Team (CRT) worker described the services in Chester's region as "*balkanized*," highlighting the fragmented system that so utterly failed this youth and his family. Interviews with workers in the field for this report confirmed that difficulties in accessing mental health supports were certainly not limited to Chester and, in fact, remain commonplace for Aboriginal children and youth.

The shortcomings in Chester's care comprise a litany of errors. The most glaring was the wait list issue for ACYMH services. Chester's MCFD social worker was told he would have to wait up to two years to be seen – unacceptable for any youth – while a CRT worker was told the delay may be up to one year. These contacts with ACYMH reinforced the perception of extremely lengthy wait lists for Aboriginal youth.

ACYMH services are designed to provide specialized mental health services to Aboriginal children and youth, whose families, like Chester's, struggle with issues such as intergenerational trauma related to residential schools and histories of colonization. These families require a culturally appropriate approach to mental health treatment that differs from that offered to non-Indigenous children and youth. The intent of ACYMH is to offer an approach rooted in Aboriginal values by staff who comprehend Aboriginal world views and experiences. Although the concept is laudable, in practice, interviewees for this investigation reported that the lack of resources and staff for ACYMH has rendered the service difficult to access for many, and the Representative is concerned that delays remain a hallmark of ACYMH services in B.C.

Chronic under-staffing and administrative confusion at ACYMH meant that two calls made by service providers on behalf of Chester did not result in a referral and there were delays in even having *discussions* about the possibility of service for him.

Government has known for years that Aboriginal youth experiencing distress as Chester was require immediate, urgent support. The kinds of mental health challenges that he faced need to be solved proactively with a system designed to meet the needs of children and families. Suicide prevention and intervention shows remarkable success when proper supports are present. But expecting children and youth and their families to wait 200-plus days for those supports is tantamount to the system abandoning children in crisis, even contributing to the isolation that envelopes young lives in need.

Seriously misplaced priorities by the entities responsible to help Chester also had an effect. When MCFD conducted a routine audit of the DAA's files in late 2012 – at the same time as the DAA was supposed to be delivering services to Chester and his family – the audit caused a panic at the DAA. As a result, the DAA focused almost all its efforts on getting its files in order in advance of ministry scrutiny, rather than prioritizing the children and youth it served. This loss of focus on children and families meant that First Nations youth such as Chester were largely left without support. A ministry “quality review” of the DAA, which followed the audit, extended the focus on files, rather than children and youth, into the final months of Chester's life. In addition, DAA front-line workers were inexperienced and insufficiently supported, so that they were unable to provide the level of care Chester needed.

Of particular concern to the Representative is the fact that the ministry was fully aware of the complete incapacity of the DAA to provide its mandated services to the community at the time the audit and subsequent review were taking place. This alarming lack of capacity was exacerbated by significant tensions between the ministry and the DAA. The DAA that served Chester's reserve had been performing poorly since 2006. In fact, over a number of years, audit after audit showed it had some of the lowest compliance to child welfare standards in the province. Ongoing efforts have resulted in recent improvements in performance by the DAA, which the Representative is pleased to note, yet it is troubling that the ministry allowed the situation to persist for as long as it did. The effect was that Chester did not receive needed support. The recent improvements, if sustainable, are welcome.

The medical system also missed key clues in Chester's case. Doctors, in large part, did not consider possible mental health causes for Chester's behaviours, and instead focused entirely on physical issues. Both a school administrator and a CRT worker, however, believed that Chester may have been dealing with mental health issues and suspected that he required services. This was discussed with Chester's family doctor, who was aware of a family history of mental health issues. And yet still, Chester was unable to access ACYMH services.

Breakdowns in communication between agencies and lack of coordination and collaboration were common. For example, the DAA social worker believed Chester was getting counselling at school – which was off-reserve – but never checked to ensure that was the case. Again, the result was a conspicuous gap in badly needed support for Chester. He received no counselling whatsoever, even though he clearly needed it and had agreed to it. Further, his needs would be beyond the current school-mandated model of “counselling.” There were also several instances in which staff at the various organizations Chester was involved with initiated actions and did not follow through. For example, the MCFD social worker planned to fill out a referral for Chester for ACYMH services but did not do so.

While it was technically the responsibility of the MCFD social worker to make the referral, the DAA social worker could have also made one and did not.

In addition, inaccurate information was being shared about Chester between organizations that affected the actions taken – or not taken – on his file. An example of this occurred when someone at the DAA told the CRT worker that Chester had a support worker whom he was seeing once a week. This vastly overstated the frequency and regularity of the support worker's visits with Chester which, in fact, totalled three over two months. The result was that the CRT worker closed Chester's file, based in part on erroneous information.

The ministry's own case review conducted in response to this tragedy acknowledged the shocking fragmentation and chaotic nature of the system and its disastrous effects, and recommended actions to be taken in response. Some of these have been implemented; others have not. Sadly, the ministry has not shown a full commitment to taking action and has become far too complacent on these well-known issues.

The Representative notes that the delivery of mental health and other child welfare services for Aboriginal children and their families, already wildly inconsistent and chronically under-funded in B.C., may be headed for even greater uncertainty and confusion. Recent confirmation by the Attorney General that the Province will be exploring the devolution of responsibility for delivering child welfare services to individual First Nations can only make the Representative wonder whether a fragmented group of nearly 200 First Nations will have the resources or the capacity to deliver these services effectively.

The Representative is deeply troubled by government's periodic practice of toying with the concept of devolving child welfare services without result. Typically when this takes place, no policy or infrastructure is developed and no practices are put into place. The outcome is predictable: scarce resources are drained from needed children's services and are redirected elsewhere. Given the lack of detail provided on government's latest exploration of this concept, the Representative believes there is a strong need for up-front clarity, lest youth such as Chester be ignored. For any such plan to have a realistic hope of being effective, it is crucial that a clearly articulated and documented infrastructure plan be implemented. Such a plan would also require funding that is both appropriate and separate from the current, already-struggling child welfare system. And it would need solid administrative leadership that is entirely independent of and exempt from political influences of any sort. These are basic and essential pre-conditions without which there can be no hope of success. The inefficiency of government spending on past Aboriginal governance issues regarding child welfare – highlighted in the RCY report *When Talk Trumped Service* (November 2013) – does not engender confidence in future such initiatives unless proper groundwork is done and sufficient resources dedicated.

The Representative acknowledges First Nations' right to self-government and respects their desire for change in the way services are delivered. However, the test of any such change should be the actual services delivered and ensuring that they are accessible and responsive to First Nations children and youth. The efforts of the First Nations Health Authority in

taking an approach to improve actual services appears to be a better short-term remedy to the failings that Chester experienced.

Perhaps the most obvious finding of this report is the glaring lack of leadership in B.C. when it comes to organizing and delivering mental health services. Strong leadership is required to identify and stay focused on the difficult problems that need to be addressed. Which children and youth are we not reaching or serving or, more importantly, not serving well? What do we need to do differently to make sure we have collaborative, respectful and accessible supports for Aboriginal mental health, including emergencies and expected patterns of emotional disturbance and distress that children and their families experience?

This report recommends that in the immediate term, in order to resolve the current urgent issues it faces, MCFD implement and appropriately resource mental health services for Aboriginal children and youth so that wait lists and wait times are reduced in keeping with recommendations by the Select Standing Committee on Children and Youth in its report *Concrete Actions for Systemic Change* (2016). As the legislative committee wrote, action to address mental health service deficiencies in B.C. is “*especially critical in regard to vulnerable populations, including children in care and Aboriginal children.*”

In the longer term, as a more realistic and comprehensive solution, the Representative recommends the creation of a proactive lead agency for the provision of mental health services for Aboriginal children and youth. This agency should be formed through a partnership with the British Columbia government, the First Nations Health Authority, delegated Aboriginal Agencies, other service providers and the federal government.

The report also recommends that the Ministries of Education, Health and Children and Family Development develop a plan to protect the rights of Aboriginal children and youth with mental health issues to learn, attend and participate fully in school.

Further, it recommends that before the B.C. government engages in an exploration of devolving child welfare services to individual First Nations, it should first establish a clearly articulated plan to ensure child safety, develop a workable and effective infrastructure, appropriately resource the plan, and ensure that competent, independent leadership is in place.

Finally, this report recommends that MCFD immediately develop a strategy to provide collaborative support for DAAs that are failing to meet performance standards. Clearly, resources, leadership and patient (youth) focus are essential – and all of these aspects are mostly absent for Aboriginal child and youth mental health.

This report is the story of one First Nations youth’s experience in what can only be described as a chaotic mental health system. Chester badly needed services and he didn’t get them. Instead, he waited and waited, until the level of his distress became too high. Given the details presented in this report, and other recent research completed by this Office, the Representative knows there are many more children waiting like Chester did. Mental health services must not be discretionary services for children and youth in B.C. As a society, we can and must do better.

Methodology

The *Representative for Children and Youth Act (RCY Act)* provides the Representative with the responsibility and power to review and investigate critical injuries and deaths of children in care of MCFD, as well as children and their families who have received a reviewable service in the year leading up to the incident.

The Representative received a report of Chester's death from MCFD shortly after it occurred. This report from MCFD prompted a broad review of Chester's life by the Representative. The review indicated that reviewable services and the policies or practices of a public body may have contributed to his death, and that an investigation by the Representative was necessary to further understand what happened in Chester's life and what could be learned from it. Under the *RCY Act*, the Representative must make a public report of her findings after an investigation into the death of a child. This public report examines the period from August 1996 (when the child was born) to December 2014 in order to fully understand the events leading up to and following Chester's death in May 2013.

Numerous files and documents were reviewed in the course of this investigation. Records were obtained from multiple sources including MCFD, the DAA, schools, health authorities and the BC Coroners Service.¹ Forty-two interviews were conducted under oath in accordance with s. 14 of the *RCY Act*. These interviews included ministry staff, DAA staff, band members, health professionals, family, school staff, the Royal Canadian Mounted Police (RCMP) and local police.

The Representative's Multidisciplinary Team² was briefed on the progress of the investigation, and provided its comments to inform the ongoing work.

Organizations and individuals who provided evidence to this investigation were given an opportunity to review and comment on the facts in the report for the purpose of administrative fairness.

A pseudonym has been used in order to protect the privacy of this young man and his family.

¹ See Appendix B for a detailed list.

² Section 15 of the *RCY Act* provides for the appointment of a Multidisciplinary Team (see Appendix D) to assist in this function, and a regulation outlines the terms of appointment of members of the team.

Chronology

Family Historical Context

First Nations reserves in B.C., and indeed across Canada, are often afflicted by extreme poverty, high unemployment, lack of services and substandard and overcrowded housing. Some are unable even to access clean water. Although each reserve is different, these situations are common and are legacies of colonialism, residential schools and more than a century of broken promises by governments – federal and provincial. It is not unusual for Aboriginal families suffering from intergenerational trauma to have ministry involvement. Poverty and neglect are two of the main reasons for contact with MCFD.

Chester's family is First Nations and lives on a reserve near a major city in B.C. At least three generations of his family have received services from MCFD or its predecessors for concerns including extreme poverty and abuse. In 1981 and 1982, protection reports were made to the ministry regarding the possible “*maltreatment*” of children in the family home. These children included Chester's mother, who was nine-years-old at the time. As a result of their investigation, the ministry and the band's leaders informed the family that two of the men who had been living in the family home, Chester's uncles, had to leave the reserve in order to protect the children from further abuse.

Despite being banned from the reserve, the uncles soon returned and the ministry opened investigations into further reports made by the school of the men's potential abuse of family members in 1984, 1985, 1986 and 1987. In each case, the family members interviewed by the ministry did not disclose any abuse and the files were closed with no actions taken.

Another child protection investigation in 1988 responded to a report about a possible inappropriate relationship between Chester's mother, who was then 15, and an adult relative. The social worker responsible for the file determined that the teen who would become Chester's mother was not in need of protection and sent a letter to the family placing the responsibility on the parents to ensure that their daughter was kept safe. At this time, ministry records indicate that 17 people were living in the family home – evidence of the ongoing challenges in securing adequate housing common on many reserves.

First Reports to Ministry Involving the Child

Chester was born in 1996 to First Nations parents – a 23-year-old mother and a 32-year-old father. He was the youngest of four siblings and grew up on the same reserve where his mother had been raised. His father had been born in the same territory as Chester's mother, but spent most of his childhood living on a reserve in the United States. People who knew the family described them as being very private, with little community involvement during the time Chester and his siblings were growing up. The family lived in their own home, with various members of the maternal extended family staying with them for long periods of time.

In February 1998, when Chester was almost two-years-old, a psychiatrist called the ministry to report that the children residing in the family home were at a high risk of experiencing abuse. The psychiatrist was treating an uncle who was living in the family home and who often babysat the children. In the course of treating the uncle for psychosis, the psychiatrist became aware of the uncle's interest in Chester's three-year-old sibling.

The ministry social worker who received the report contacted the RCMP for information on the uncle. The RCMP informed the social worker that the uncle had been a suspect in a number of sexual assaults, including some involving children. He had been charged in 1995 with sexual assault, receiving a conditional discharge and two years of probation.³ It does not appear that the RCMP had any further involvement with this first child protection report regarding Chester's family.

At the time of this investigation, a protocol agreement between the band and the ministry required that a band representative accompany any social worker coming onto the reserve. Ministry records reveal that during the attempted investigation of this child protection report, the reserve's band council was dealing with a significant inter-office crisis, which meant that no staff member was available to attend with a social worker. As a result, the social worker did not interview the children or any family members, even after the crisis had ended.

Ministry records indicate that the social worker considered obtaining a no-contact order for the uncle, but did not ultimately pursue this option.⁴ Instead, the file was closed after a band worker found housing for the uncle off-reserve. It is not clear where the uncle's primary residence was prior to the child protection report being made. A short notation on the social worker's file indicated that Chester's parents had agreed not to let the uncle babysit, although it was unclear who spoke to the parents about this or who was responsible for monitoring the parents' compliance.

Protocol Agreements

MCFD's protocol agreements are guiding documents made between the ministry and other organizations, such as an Aboriginal nation or a service provider. They are agreed to by all parties and spell out the practices, rules and customs that will be followed in the delivery of services to children and families in B.C. Protocol agreements are intended to be reflective of strong relationships that support respectful and effective practices. When these agreements are not developed and implemented appropriately and when strong relationships do not exist, there can be unintended negative impacts on child safety if workers are denied access to children.

³ According to s. 730(1) of the *Criminal Code of Canada*, the court may order a conditional discharge instead of a conviction if it is considered to be in the best interest of the accused, not contrary to the public interest, and if the accused pleads guilty or is found guilty of the offence. It is not considered a conviction, but the accused may be released on a probation order. If the accused fails to comply with the conditions of that probation order, the person may be charged, their discharge may be revoked, and they may be convicted of the original offence.

⁴ The term "no-contact order" likely refers to a protective intervention order under s. 28 of the *Child, Family and Community Service Act (CFCS Act)*. The ministry can apply to the courts for this order to legally prohibit a person from contacting a child if the ministry can demonstrate that contact with the child could reasonably be seen to cause the child to need protection.

In October 1998, a different ministry social worker was assigned to investigate a subsequent report by Chester's aunt. She had moved out of the family home, where Chester and his siblings also resided, to protect herself and her daughter from emotional and physical abuse. The aunt reported concerns for the remaining children in Chester's home because the same uncle who had been the subject of the February 1998 report had been returning to the reserve and staying with the family for weeks at a time. Neither the aunt nor her daughter was interviewed by MCFD about this disclosure.

The social worker went to the reserve, met with the parents, and recorded in his notes that the parents reported they did not leave the uncle alone with Chester and his siblings "*except for very short periods of time.*" The social worker determined that the children did not need protection or further services because the parents demonstrated a willingness to protect their children by forbidding the uncle to access the children without supervision, by agreeing to educate their children to never be alone with their uncle and by not permitting the uncle to live with them.

On Dec. 22, 1998, in his dual role as both the social worker and the acting team leader, the social worker signed off on and then closed the investigation. Fourteen years would elapse before Chester and his immediate family had contact with the ministry again. Although there was no further involvement with the ministry during this period, a report made to the ministry in 2013 suggested that abuse of another member of Chester's family had been ongoing during the time that the ministry was not involved.

Tribal School

Between 2001 and 2012, Chester attended his local tribal school. His Grade 1 teacher described Chester as shy and reserved, but very intelligent and funny once he opened up to people. He showed an enthusiasm for learning his First Nations language and for artwork. During those years, a member of the DAA that serves the reserve remembered the family as one that "*never bothered anybody.*" Community members recalled that Chester was extremely close to his family and only participated in activities that his parents or siblings also attended.

Despite his early success in school, Chester did not complete his Grade 10 year. In February 2012, at the age of 15, Chester stopped attending school. The reason for his absence from school remains unclear. His mother remembers the principal telling her that Chester

Delegated Aboriginal Agencies

Delegation agreements give the authority to Aboriginal agencies to administer all or part of the *Child, Family and Community Service Act (CFCS Act)*. This is intended to return the responsibilities for family support and child protection to Aboriginal communities. There are various levels of delegation, from providing voluntary services to Aboriginal populations to providing full child protection services. In the current model of child welfare in B.C., MCFD remains ultimately responsible for overseeing DAAs, ensuring that the *CFCS Act* is followed and that the children of this province remain safe. The DAA that served Chester and his family is delegated to a C-4 level, meaning that it is responsible for providing guardianship services, support services, voluntary care agreements, special needs agreements and foster services to a number of Aboriginal communities.

was suspended indefinitely and could never return because he had left during class hours to be with a girl he was interested in. When asked about Chester's absence, the principal did not acknowledge to the Representative's investigators that he had suspended Chester. He stated that he thought that the family had stopped sending their son to school for cultural reasons. He emphasized that he had no right to question cultural traditions and community practices, and that any intervention by the school would have been "*a colonial response.*" There was no documentation to confirm either interpretation of Chester's absence from school.

Chester did not attend classes again until his enrolment in the local public high school that September, six months later. This school was completely distinct from the tribal school and was not located on the reserve. Chester had still been interested in learning during his six-month school absence, so his sister brought home school work for him to ensure he did not fall behind. The tribal school did not keep written records of Chester leaving the school and did not assist Chester in transitioning to his new school.

On May 8, 2012, at 10:27 a.m., the RCMP found Chester unconscious on the side of a road outside the reserve and took him to the hospital. Chester told hospital staff that he had gone for a walk in the woods, but could not remember his name, where he lived or the date. When his family came to see him at the hospital, Chester told them that he felt like he "*wasn't himself,*" and that, when he was in the woods, he had "*seen everything in black and white.*"

Hospital records indicate that the doctors who examined Chester in the emergency room found no evidence that he had used drugs or alcohol. Chester's tests showed that he had low blood sugar, and he was released later that same day after his condition improved. His parents believed that he had been sleepwalking, and responded to this incident by ensuring that their home's doors were locked at night with chairs blocking them to keep Chester safe inside. As diabetes ran in his family, Chester's doctor suspected that Chester may have had chronic low blood sugar, but multiple blood tests failed to confirm this. It does not appear that any of the professionals attending to Chester explored the possibility of a psychological component to Chester's symptoms.

A New School

In September 2012, Chester began attending the public high school in his area, which was much larger than the tribal school he had attended previously. Approximately 10 per cent of the students who attend the school identify as Aboriginal and the school has an established Aboriginal support program. The public school did not receive any documentation from the tribal school alerting it to Chester's transfer, nor did it receive any transition information from the tribal school, such as records of Chester's academic performance. Chester was admitted during the summer and registered in person for Grade 11 on Sept. 4. Soon after arriving that fall, his learning level was assessed and Chester was placed primarily in Grade 10 classes. Chester's older sister was also enrolled at the same public high school.

School employees remembered Chester as social, with a core group of close friends described as having “*a lot of drama.*” They were often seen in a cluster in the school hallways, laughing, arguing or crying. Chester was passionate about music, poetry and dance and he exhibited extremely varied moods. Some days, he would be happy and excited; other days, he would be withdrawn and talk about feeling depressed. One school administrator said that Chester “*would have these days where he was really, really up and then really, really, really down.*”

School employees also noted that Chester was sweet and easy to like, but that he struggled with boundaries and with appropriate behaviour. He began a relationship with a female student and was caught with her in the school washroom. One administrator worried that Chester was overly affectionate with the females in his friend group, and that they did not always appear to reciprocate his feelings.

The school staff responded to Chester’s behaviours by discussing Chester during their weekly meetings about students who required counselling and by trying to build connections with him and his family. Chester’s older sister remained close to Chester and very protective of him in the school setting, taking care of him when he was feeling down.

Chester had received high grades in his tribal school, but he struggled with the academic transition to public school. He often skipped class and could be found wandering the halls, the school grounds, or the nearby forest. School staff said that although he frequently left his classes, he always came back before the end of the day. They attributed Chester’s tendency to leave the school as his method of “*self-regulation and his coping mechanism*” when he felt overwhelmed.

On Nov. 5, 2012, Chester was in his physical education class when, according to the school’s incident report, he “*seemed to trip and do a slow motion fall.*” The cause of Chester’s fall was unknown. When Chester tried to get up, he fell again and hit his head on the cement. An ambulance took him to hospital. The hospital doctor diagnosed Chester with a concussion and he was taken home to rest that day. One of the school’s Aboriginal support workers visited Chester at home the day after the incident occurred. He emailed other school staff members to let them know that Chester was doing better and that his sister would be staying home to help look after him until they both returned to school the following week.

Chester Talks About Suicide

The day after Chester’s fall, one of his siblings told a member of the school’s support staff that after a recent break-up with his girlfriend, Chester, now 16, had talked about taking his own life. The sibling was concerned as talking about suicide was unusual behaviour for Chester. The ex-girlfriend was the same person Chester had been caught with in the school bathroom. She was in Chester’s social group and, even after the relationship dissolved, they continued to spend a lot of time together. School employees working with Chester described this relationship as immature and “*off and on.*” Chester struggled with acceptance when the girlfriend wanted to end the relationship and kept pursuing

her despite her stated lack of interest in the relationship continuing. Various school employees tried to speak with Chester about respecting his ex-girlfriend's boundaries.

The support staff member spoke to the Aboriginal support teacher, who phoned MCFD's Aboriginal child protection team on Nov. 6, 2012, primarily to report the sibling's concerns that Chester may be suicidal. The teacher also reported that he felt Chester had not been eating properly, as on two occasions the teacher had spoken to Chester at school and found out that he had not eaten anything that day. The teacher believed that Chester may have been restricting his food as a means of self-harm.

The MCFD social worker who received the call asked whether Chester had a specific plan to commit suicide. When the teacher clarified that Chester's suicidal ideation did not seem immediate, the worker characterized it as "*historical*"; in other words, as not a current concern. The worker noted that the teacher mentioned that Chester had been self-harming by not eating, but that Chester's presentation at school was generally good, and he was well cared for by a protective family with restrictive parents. The family was unaware of the concerns about self-harming.

The MCFD social worker did a background check on the family. The worker reviewed the concerns documented in 1998 involving Chester's abusive uncle being in the home, but also noted that the 1998 report declared that the "*parents were found to be appropriate and willing to protect.*" The worker's assessment of the call was that there were no immediate child protection concerns and that a youth services response would be appropriate for Chester's needs. The file was then assigned to another social worker on an Aboriginal child protection team in an office closer to Chester's reserve. This social worker emailed the reporting teacher to confirm that she had received the call and was "*in the process of connecting with the band representatives to agree on a way forward.*"

On Nov. 20, 2012, the MCFD social worker and a local DAA social worker met with Chester and his teacher at the school in response to the child protection call made earlier that month. The MCFD social worker's main purpose for the meeting was to determine what support services would be most appropriate to help Chester with his suicidal ideation and the social concerns raised by his teacher. The MCFD social worker remembered Chester as

Youth Services Response

Standard 15 of *The Child and Family Development Service Standards* (2012) describes a youth services response to child protection reports, which may be appropriate when the child who is the subject of the report is older than 16. This response involves a social worker evaluating the youth's situation in order to help the youth in assessing and addressing his or her immediate needs, strengths and available resources. Youth services may include referrals to support programs offered by other agencies, such as a support worker, or direct services provided by MCFD, such as continued help from an MCFD social worker or a referral to Child and Youth Mental Health (CYMH). If needed, the social worker may engage in a long-term service plan with the youth.

nicely dressed, healthy looking and slightly overweight. When interviewed for this investigation, she told RCY investigators that Chester did not seem shy to her; rather, he *“was just kind of waiting to see what was going to happen before he spoke up or said anything.”*

The social workers were not there specifically to assess Chester’s possible suicidality as they believed that it was not a current concern, but they did speak to Chester about his mental health. The MCFD social worker felt that *“it wasn’t obvious in meeting with him that he had any kind of mental health problem whatsoever.”* The DAA social worker agreed that Chester did not seem to present as stressed or suicidal. She had been concerned about Chester’s possible suicidal ideations going into the interview and directly asked Chester if he had a suicide plan. Chester replied that he did not. The social workers provided Chester and his teacher with contact cards for Project Alive and explained those services.⁵

Chester’s experiences of other forms of psychological distress came up during this interview when he spoke about hearing footsteps in the school, distracting voices that he was not sure were real, the existence of ghosts and paranormal mysteries that he was interested in, but these comments were not explored further. This was the first time

ACYMH and CYMH

ACYMH and CYMH are voluntary mental health services provided by MCFD to youth and their families in collaboration with health and social service providers. ACYMH teams were implemented in Chester’s region by 2008 as part of a province-wide initiative to provide specifically designed services for Aboriginal children, youth and their families. Aboriginal children and youth are also served through general CYMH services. The similarities between the ACYMH and CYMH teams include a shared mandate to provide voluntary community-based services for children and youth from birth to 19 years of age (families can request service directly without need for a professional referral) and both CYMH and ACYMH teams report to their local community service managers and adhere to common MCFD and specific CYMH policies.

The main difference between ACYMH teams and CYMH teams is that ACYMH teams serve Aboriginal populations with an added emphasis on a) provision of outreach services in local communities and b) building relationships with children and youth, families and communities.

the child protection social worker had met with Chester and she felt that he was simply having fun with them and joking about his interests. It did not seem to her that Chester was scared about hearing voices. When asked if it worried him that he heard those things, Chester responded that it did not, but he would be willing to speak with a doctor or counsellor about his experiences. The MCFD social worker responded by telephoning Chester’s parents to inform them of their concerns for Chester’s mental health and by contacting Aboriginal Child and Youth Mental Health (ACYMH).

The social workers also spoke to Chester about his teacher’s description of Chester’s parents as restrictive and asked him what that meant. Chester explained that his parents did not want him to hang out with other youth on the reserve, which *“did bother him a bit, but he totally understood it because a lot of kids were around outside their house drinking, fighting, using drugs, getting into trouble and his parents just wanted the best for them and not to*

⁵ Project Alive is a program offered through CYMH. It provides assessments and short-term counselling to youth experiencing suicidal thoughts.

be involved in that stuff that was going on.” Nothing in his response suggested to the social workers that Chester needed protection from his family.

With no apparent child protection concerns, the MCFD social worker referred Chester to the DAA social worker for a support services follow-up.

This interview with Chester was the first time that the DAA social worker had met the Aboriginal support teacher at the high school and the first time that she had interviewed a youth at the school. Chester’s teacher warned the DAA social worker that, in his experience, the youth’s family was private and it would be a surprise if they agreed to work with anyone.

The ACYMH Wait List

Immediately following the interview with Chester, the MCFD social worker phoned ACYMH to ask about referring Chester for mental health services and left a voicemail. She called back a few days later and left another message. Soon after, she received a call from an ACYMH clinician who apologized and said that she did not know why the social worker’s messages were routed to her as she had been out of the office. In her interview with RCY investigators, the ACYMH clinician described the ACYMH office as chronically under-staffed, adding, *“We had a rotation of a number of different admin people the entire time I was there, and did not have consistent support.”*

The MCFD social worker and the ACYMH clinician discussed referring Chester to ACYMH. The MCFD social worker informed the ACYMH clinician of her concerns about Chester arising from her meeting with him and her conversation with his teacher. These concerns centred on his possible self-harm through food restriction and his poor boundaries with female peers at school. The social worker did not bring up Chester’s previous suicidal ideation, nor did she mention Chester’s possible auditory hallucinations. According to the social worker, the clinician *“said that the current wait list was 14 months, but that cases were taken based on urgency, and, based on the information [the social worker had] provided, it could be two years before [Chester] could be taken on.”* Regardless, the MCFD social worker requested the ACYMH referral form. The ACYMH clinician recommended that while Chester waited for ACYMH services, he should continue with school-based counselling and see his family doctor if concerns about his food restriction continued.

The MCFD social worker never filled out or submitted the two-page referral form that was required by ACYMH to place Chester on the wait list for services. She could not explain to the Representative’s investigators why she failed to do so.

DAA Voluntary Family Services and Chester's Support Worker

After the interview with Chester, the DAA social worker received the referral from MCFD in order to begin the DAA’s delegated role of providing Chester with voluntary support services. At that time in 2012, the DAA and MCFD used different information management systems, resulting in systemic gaps in the flow of information between the different service providers. What this meant for Chester’s file was that the DAA social

worker had no access to the records of the family's history and had to rely solely on the information provided to her by MCFD. The MCFD social worker did not share a copy of the original November 2012 intake with the DAA social worker, nor did the MCFD social worker include the family's known history with MCFD. This left the DAA social worker at a significant disadvantage in planning services for Chester.

Integrated Case Management System

The Integrated Case Management (ICM) system was proposed to replace outdated government computer information systems used to deliver critical social programs including child protection services. Implementation of the ICM system began at MCFD in April 2012 for child protection staff. Access to ICM was extended to DAAs; however, some chose not to initially sign on. The result was that DAA social workers did not have access to the most current information about their clients and were unable, in some cases, to take necessary action to keep them safe or respond to their needs. The Representative expressed concerns with the direction the ICM project was taking, and sought assurances that the system was being designed for child protection purposes directly with front-line staff who collect and keep secure information pertaining to child safety. ICM access has now been extended to include all DAAs.

On Nov. 29, 2012, the DAA social worker and the MCFD social worker met with Chester's parents at their home on the reserve. The DAA social worker was pleasantly surprised by how welcoming they were. Although the DAA social worker recalled that the parents seemed very concerned about having "*community involvement in their business*," they agreed to receive support for their son.

On Dec. 3, 2012, the DAA social worker completed a Family Support Worker Referral Form, writing that Chester needed "*support to look for employment to promote good mental health*" and that the goals of the service included helping Chester find part-time employment, researching music lessons to be funded by MCFD, and encouraging Chester "*to speak to a school counsellor and clinician around mental health*." The DAA social worker's team leader approved the referral. The support worker assigned to work with Chester had only been

hired the week prior to this referral and Chester was one of his first clients. The support worker described himself to RCY investigators as "*really green coming into this field*." He had started, but not completed, a local Aboriginal community's child and youth care course and had received limited training from the DAA for his new role.

Three days after the referral, the DAA social worker introduced the youth and his parents to the support worker and they all signed a support services agreement. The agreement's goals were for Chester to be helped with his education, his self-image and his employment search. The agreement did not mention a plan to provide Chester or his family with mental health services or counselling. It also did not set time frames, dates for a review

Support Services Agreements

Standard 6 of the AOPSI outlines support services agreements, which should be collaboratively written agreements that address the safety and best interests of the child, identify the type and duration of services to be provided, and define the period of the agreement. These agreements are voluntary. The worker should provide the family with a copy of the agreement and review it with the child and family at minimum every six months or if there is a change in family circumstances.

of the plan, or any mechanism to assess the effectiveness of the services.

The DAA social worker raised the issue of counselling during the discussion of the support services agreement. The parents said they preferred that Chester see a counsellor at his school because they were concerned for their privacy if they dealt with counselling resources offered by their band. The DAA social worker believed incorrectly that Chester was already receiving regular counselling from the school and did not press the matter further. The DAA social worker did not contact the school to ascertain the nature or frequency of Chester's involvement with school counsellors. The school has two qualified clinical counsellors and a third counsellor who acts as another layer of support for students by connecting with them and trying to discuss minor issues with them. Though the school counsellors were all aware of Chester, he was still a relatively new student and none of the counsellors was meeting with him on a regular, scheduled basis. The DAA social worker did not inform the school of the plan for Chester to receive counselling there.

Aboriginal Operational and Practice Standards and Indicators (AOPSI)

In 1999, DAAs developed their own comprehensive child welfare standards to guide their delivery of child welfare services in accordance with the *CFCS Act*. These standards were redrafted in 2012 to better reflect Aboriginal values, world views, beliefs and traditions.

Complicating the situation was a routine audit MCFD was conducting on the DAA. This audit had thrown the agency into what the DAA social worker described to RCY investigators as a “*state of panic*” and the focus on getting files in order so that the files met the standards of the audit meant that the DAA social worker was spending no time on Chester's case. She was entirely reliant on the support worker to provide services to Chester. The social worker's description of the situation is at odds with the DAA's assertion that caseloads remained significantly lower than the provincial average throughout this period.

On Dec. 11, 2012, the DAA support worker picked up Chester after school for their first one-on-one meeting. They went to a coffee shop and talked about the possibility of guitar lessons. The DAA support worker described Chester as quiet and offering short responses to questions. Chester and his support worker did not have any further in-person interactions in 2012.

Problems at School and Limited Supports

On Dec. 20, 2012, the school's Aboriginal support teacher called and left messages for the MCFD social worker and the DAA support worker to say that Chester had been displaying troubling behaviours and that the school was worried about him. There is no indication that the messages left by the Aboriginal support teacher elicited any response from those he contacted.

In the beginning of 2013, Chester's concerning school behaviours continued to escalate. In early January 2013, as the Aboriginal support teacher entered a classroom, Chester loudly asked him if he “*came here to rape little girls.*” The teacher had a discussion with Chester about the inappropriateness of his comment.

On Jan. 15, 2013, Chester wrote notes to his ex-girlfriend and another girl and put the notes in the girls' school lockers. The girls confronted Chester with the notes, which he tore up and threw at them. The content of these notes remains unknown. One of the school's three administrators questioned Chester about the incident. During the questioning, Chester vomited into a garbage can and said that he did not remember writing the notes. The administrator arranged a meeting with Chester's parents later that day. The administrator believed that Chester was either lying about his memory loss or that he was suffering from the long-term side effects of his November concussion.

After the arrival of his parents at school, Chester continued to insist that he had no memory of writing the notes. When the administrator confronted him, Chester threw up again. The administrator told his parents that Chester could not return to school without a doctor's note. The administrator explained to the Representative's investigators that he was trying to force the family to take Chester to the doctor, as he believed Chester had mental health problems that needed to be addressed. While the administrator never officially suspended Chester by completing the documentation necessary to support a suspension, the effect of his decision was that Chester did not attend school for approximately one month. Neither the school nor the family informed Chester's DAA social worker or support worker that he had been told not to come to school.

Chester's mother was angry about the family's interaction with the school administrator, believing that the administrator had behaved inappropriately and that he had called her son "*mental*." The family recalled this incident as one that had a very negative impact on their relationship with the school. Despite their anger, the parents remained focused on their son's well-being and took Chester to their family doctor that same day to examine possible causes for Chester's behaviours and memory loss. The doctor made an immediate referral to a pediatric neurologist. In his referral, the doctor did not mention possible mental health concerns; rather, it was focused on the symptoms he believed may have been long-term effects of a concussion.

On Jan. 16, 2013, the Aboriginal support teacher emailed the MCFD social worker and wrote that he was "*touching base*" because the school had ongoing concerns about Chester. The only specific concern mentioned in the email was the rape comment that Chester had made earlier in the month. The MCFD social worker responded that the teacher should contact the DAA social worker or the school's police liaison. She wrote that ACYMH had told her that there was a 14-month wait list for services, so the school could consider contacting Chester's family doctor to see if he could get Chester a quicker mental health assessment. The MCFD social worker added that she was "*not passing the buck*," but because there were no child protection concerns, she was no longer involved with the family.

On Jan. 21, 2013, the Aboriginal support teacher called the DAA social worker to let her know that Chester had not been at school since Jan. 15, and that there were still concerns about his behaviour. The DAA social worker later told the Representative's investigators that she recalled a brief conversation with the teacher being "*a little bit worried*" about Chester because Chester had been joking about the teacher raping somebody. The DAA social worker did not reassess her plan for Chester after the teacher called. She said that

the school never requested a formal meeting to talk with the DAA about concerns for Chester, and that she assumed that the teacher would have called MCFD if he had serious protection concerns. The teacher had not mentioned that it had been the MCFD social worker who had directed him to call the DAA social worker only days earlier.

The DAA social worker discussed Chester’s absence from school and the long wait list for ACYMH services with her team leader. She asked her team leader if there were any other resources for mental health support for Chester, but she did not follow up on finding supports after that discussion. It is unknown what resources were discussed, as neither the team leader nor the social worker could recall the exact content of this conversation and they did not take notes about it. The team leader then told the DAA support worker about the teacher’s phone call and asked the support worker to do a home visit and let the family know that he was there to help. The next day, the support worker picked up Chester at home and took him out for lunch. After lunch, they handed out his resumé to three prospective employers. They did not discuss Chester’s school attendance or any mental health concerns.

On Jan. 25, 2013, with Chester still absent from school, both of the school’s Aboriginal support workers visited the family. Chester’s parents remained upset about the meeting with the administrator and were considering withdrawing their son from the school altogether. A week later, the school’s Aboriginal support workers attempted to visit the family again, but only managed to leave a message with an older brother.

Dental Surgery and the Crisis Response Team

On Feb. 8, 2013, Chester had dental surgery to remove four impacted molars. He was given an intravenous anaesthetic as part of this procedure. Chester’s father and two brothers were with him in the recovery room after the surgery when Chester began hallucinating. He told them that he could see a little girl staring at him and he began shrieking and flailing when he perceived that she was walking away from him. His brothers and medical staff tried to restrain him as he struggled to get up out of his bed and tried to rip out his intravenous line. When his mother and sister arrived, Chester was screaming, “*You’re all gonna get it. You’re gonna get it now.*” His family and the staff were eventually able to calm him enough so that he could return home. On the recommendation of the anesthetist who had been assisting with Chester’s dental surgery, Chester’s family doctor requested a follow-up with the Crisis Response Team (CRT) on Feb. 12, 2013.

A CRT worker phoned Chester that same day to follow up. Chester said that everything was fine and that he had no memory of “*freaking out*” after his dental surgery. The CRT worker

Crisis Response Team

The Crisis Response Team (CRT) is a regional health authority team that includes mental health clinicians, social workers, nurses and plain-clothes police officers. The team can be accessed by individuals, physicians or mental health professionals to provide community-based, rapid responses to children, youth, adults and families in immediate mental health crises. Its services include crisis assessment, intervention and stabilization.

also phoned Chester's mother. The mother told the worker that they had decided to have Chester return to school on Feb. 18, 2013, and that the family had a support worker through the DAA with whom they could speak about any concerns.

The CRT worker then followed up with the family doctor, who shared both his concern that the family was reticent to provide information about Chester's health and his belief that Chester required mental health services. The doctor told the CRT worker that there was a history of mental health issues with the family, that the family told him that Chester had been acting strangely since his head injury, and that the doctor had already referred Chester to a pediatric neurologist for follow-up. The CRT worker then left a message for ACYMH requesting a consult. ACYMH did not return the call.

Three days after leaving the initial message, the CRT worker phoned ACYMH again and was told by a staff member that the organization had not been contacted about Chester, but that the ACYMH program would accept a referral. The staff member also told the CRT worker that ACYMH had a year-long wait list. In his interview with the Representative's investigators, the CRT worker stated that he wished that Chester could have accessed this service, but that ACYMH *"had the longest wait list of any of the CYMH offices in the area. [ACYMH] was definitely overloaded with demand."* He told RCY investigators, *"It's fucking ridiculous that a child has to wait a year to see a mental health professional."* The CRT worker ultimately did not refer Chester to ACYMH because the family would not provide consent for him to do so. The family has no recollection of consent being sought.

On Feb. 18, 2013, the CRT worker phoned the DAA office and was told that a support worker was involved and saw Chester once a week. The unidentified DAA worker he spoke to told the CRT worker to direct any concerns to the support worker's office, but did not inform Chester's own DAA social worker, support worker or team leader about the call. When the CRT worker tried to call the DAA support worker, he could not reach him. Based on the refusal of both Chester and his mother to consent to a mental health referral and the DAA's assurances that Chester had a support worker who was meeting with him regularly, the CRT worker faxed the information he had gathered to Chester's family doctor and closed his file.

When interviewed for this investigation, the CRT worker described service agencies in Chester's region as balkanized, with no centralized point of contact. He said, *"They're not all working together. It's all fragmented. It's really challenging that way."* He said that in a case such as Chester's, CRT's preference would have been the immediate involvement of ACYMH, *"but again, they weren't even involved."*

On Feb. 13, 2013, Chester's parents took him to the pediatric neurologist. The family mentioned the reaction to the dental anesthetic and that Chester was not allowed to go back to school, although they did not explain why. The family did not mention their contact with the CRT or the existence of possible mental health issues.

After assessing his MRI test, the neurologist found no physical reason for Chester to remain out of school. The neurologist had often received requests for notes indicating that children who had suffered a concussion should refrain from physical activities, but

she had never been asked for a note to allow a child to return to school. Nevertheless, she wrote a note saying, “*He has fully recovered from his concussion and is safe to return to school.*” Chester’s parents took the neurologist’s note to the school and demanded that the administrator and one of the Aboriginal support workers who had previously been involved with the family have no further dealings with them. Chester returned to school on Feb. 18, 2013, after a 35-day absence.

Loss of the DAA Support Worker

On Feb. 27, 2013, the executive director of the DAA announced at the end of a staff meeting that Chester’s support worker’s contract was coming to an end and that it was, in fact, his last day on the job. This occurred just nine days after the CRT worker had been told that Chester had a regular support worker who met with him weekly.

When the DAA support worker asked if he could inform his families that he would no longer be working with them, the executive director told him that he could not. Although the executive director claims that she had a transition plan for managing the loss of the support worker, there are no records to support this contention. Social workers and team leaders voiced their concerns to the executive director about the need for a transition plan or a new worker to replace the previous one to no apparent avail. The team leader asked for Chester’s support worker to remain on staff long enough to allow for an orderly transition, but the executive director refused.

Chester’s DAA social worker told her team leader that she still needed help supporting Chester. The team leader had a limited ability to address the request as the DAA now had only two active support workers, both of whom already had heavy workloads.

When the DAA terminated Chester’s support worker he had eight clients. On his final afternoon of employment with the DAA, the support worker wrote a report on his time spent with Chester working toward the goals of the support services agreement. He noted that he had helped Chester with his resumé, tried to find music lessons for Chester, and had tried to build a relationship with him. The support worker and his team leader both signed the report. Chester had only seen this support worker a total of three times over more than two months and no new support worker was ever assigned to his file.

Mental Health Concerns Escalate

While Chester did return to school on Feb. 18, 2013, he did not attend for most of March. Part of his absence was because the school’s two-week spring break fell in the middle of the month, and he missed the following week due to the death of his grandmother. Other than attending a four-day spring break camp hosted by the DAA, he had not received any services from the DAA during this time.

In April 2013, Chester’s family noticed that he had been sleeping an unusual amount, which they brought to the attention of their family doctor. Sleep testing at a local hospital showed no physical issues with Chester’s sleep or breathing patterns. The doctor did not consider mental illness as a possible cause for Chester’s continued exhaustion.

On April 19, 2013, Chester's math teacher reported to another of the school's administrators that Chester had skipped a number of classes and a test. This administrator had a counselling degree and had previously worked as a counsellor at the local middle school. She was familiar with Chester as the school counselling team had worked to engage with him since he had started at the public high school. The administrator responded that Chester was "*struggling with ongoing depression*" and that that day "*was a particularly bad day.*"

On April 23, 2013, one of Chester's school counsellors phoned the DAA social worker with concerns that Chester might be showing symptoms of the onset of psychosis. The counsellor had experienced a number of worrisome interactions with Chester during that year. In February 2013, Chester told him that voices of "*commanders from other planets*" were controlling him. Chester had not remembered that conversation after it happened,

Early Psychosis Intervention

EPI services for children and youth are offered by regional health authorities under the Ministry of Health. Through referrals, which can be made by anyone, these specialized collaborative services are meant to offer prompt support to children under the age of 17 who appear to be showing indications of early psychosis, which may include a decline in functioning, auditory or visual hallucinations, bizarre behaviour and/or delusions. EPI services may include initial assessments by an EPI clinician, psychiatrist assessments, medical and psychosocial treatments, outreach support and community education.

nor did he recall the incident in which he left notes in the girls' lockers. In mid-April, Chester gave his ex-girlfriend his iPod with a message saying he "*was done with [her] and life and everything was a lie.*" Chester ran away when the counsellor tried to talk to him about it and, when the counsellor located him, Chester claimed to not remember their previous conversations. Chester then showed the counsellor a piece of paper that indicated that he did not trust relationships and that he wanted the pain to stop. The paper also included a written conversation between Chester and the commander of a mission that Chester was supposed to be on. When the counsellor tried to discuss this note with him, Chester told him that things were getting harder but that he would not harm himself.

The DAA social worker and the school counsellor discussed making a referral to ACYMH, but neither of them did so. That day, the DAA social worker phoned to check in with Chester's mother who said that things were okay.

In late April 2013, during one of the school's regularly scheduled weekly meetings regarding students requiring extra mental health supports, the student counsellors, the Aboriginal support teacher and the administrator discussed their concerns about Chester. This included their observations of his behaviour, his apparent decline in functioning and the troubling interactions that Chester had been having with the staff. The school counsellor added that he had called the DAA social worker on April 23, 2013, and that the social worker said that she was "*going to look into things.*"

The administrator had not been aware of the extent of Chester's behavioural concerns. With the information and observations shared in the team meeting, the administrator realized that Chester needed immediate mental health support. The administrator phoned the local health authority's Early Psychosis Intervention (EPI) team and

requested an assessment. The health authority intake form shows the reason for the referral as “*hearing voices*” and “*bizarre behaviour*.”

On May 1, 2013, a nurse and a social worker from the EPI team came to the school to interview Chester. A school counsellor joined the interview. Chester had consented to the meeting ahead of time but, when the school counsellor took Chester out of his math class for the interview, Chester insisted that he wanted to return to class. Chester was very angry and uncooperative with the EPI team. During the course of the interview, Chester denied using any drugs or alcohol. When asked about suicidal ideation, he denied any mental health issues. The EPI team asked Chester for details about his home life and his family and he became defensive, repeatedly stating that his family was “*normal*.”

When asked by the Representative’s investigators whether she had observed any indicators of psychosis in Chester, the EPI nurse said that he “*appeared to be present in the discussion, he didn’t appear to be responding to anything else, but he clearly didn’t want to answer the questions*.” She confirmed that Chester denied hearing any voices or having any hallucinations. She further clarified that, when he was asked about writing a story about a commander from another planet, he “*brushed it off as, you know, It’s just my imagination, I’m just writing a story*.”

When it seemed clear to the EPI nurse that Chester was unwilling to answer questions, she attempted to shift the tone of the interview by offering him a mood questionnaire to fill out. Chester ripped it up and threw it on the ground. When he was offered a card for crisis services, he ripped up that as well. Despite this apparent hostility, he still waited to be excused before returning to class.

After returning to her office, the EPI nurse filled out a number of assessment forms based on the limited information that her team had gathered. These forms were meant to assist health professionals with their ongoing assessments and planning for clients. Most of the forms she filled out contained notations that the information needed for assessment was “*unknown fully*” or “*not clear*.” Using these assessment tools along with her professional experience, the nurse rated Chester as a moderate risk for suicide. In her interview with the Representative’s investigators, she said, “*Rather than putting him at low risk just because he denied everything, I put him at moderate risk. But there was nothing in that interview indicating he was at imminent high risk*.”

The nurse had previously served as a crisis nurse in a hospital, where she assessed suicidality on a daily basis. In her seven-page initial profile on Chester for EPI, the nurse wrote that Chester had expressed suicidal ideations to school employees, but that Chester himself “*denied any thoughts of self-harm or suicidal thinking*” when speaking with the EPI team. She mentioned the message that Chester had given to his ex-girlfriend that he was “*done with her and life*” and that Chester denied any recollection of the incident. The EPI nurse noted that the school counsellor reported that Chester had never directly stated that he wanted to kill himself and that the counsellor “*did not feel concerned at [that] time that [Chester] had a plan or intent*.”

On the final page of Chester's profile, the nurse wrote, "*It is unclear at this time if [Chester] meets the full criteria for psychosis. There was no obvious psychosis noted during the interview and [Chester] denied any concerns.*" She noted that Chester was clearly experiencing distress and unhappiness, and that he seemed to have been affected by his previous head injury.

On the following day, May 2, 2013, the EPI team – consisting of the social worker, the nurse and a psychiatrist – discussed Chester during a meeting. The nurse recalled that their plan was basically "*just connecting with people that knew him and seeing how best to proceed, given his obvious reluctance,*" to encourage him to consent to a mental health assessment and to offer support to the school. The EPI psychiatrist could have seen Chester promptly, but the team had to first find a way to gain Chester's trust and cooperation with the process. The EPI nurse also put in a formal alert to the crisis team and the local hospital to identify Chester as a high-risk youth if he were to seek treatment or services.

The EPI team did not contact Chester's parents because Chester had clearly stated during his interview that he did not want his parents involved. The EPI team was also concerned that his parents' reaction to having professionals involved would worsen matters for Chester. The EPI team did not have access to MCFD's files. In her initial profile for Chester, the EPI nurse wrote that he was well-supported at school and also had support through DAA family services. Her belief that this support was in place came from the EPI interview with Chester and from the CRT's inaccurate information that he was meeting his DAA support worker on a weekly basis. The EPI nurse spoke to the school counsellor about following up with support for Chester. The nurse also left messages for Chester's doctor and the DAA social worker, but didn't actually speak to either one until May 7, 2013.

On May 3, 2013, the school's administrator visited the band office and met with four members of the staff there to share her concerns about Chester. She requested help from the band staff in encouraging Chester and his family to cooperate with the EPI team and have Chester's mental health assessed. That same day, Chester and his family were invited to the band office for Chester's first piano lesson. The lesson went well and Chester appeared to enjoy himself. There is no indication that any of the band members present for the meeting with the school administrator addressed the concerns for Chester's mental health with his parents when they came for the lesson.

On Monday, May 6, 2013, Chester came to school. To school staff, he seemed to be having a good day. The school counsellor recalled that Chester had jokingly hidden in his office bathroom and when the counsellor entered the office, Chester popped out laughing.

On May 7, 2013, the EPI nurse spoke about Chester with his family doctor, a band employee who had called the nurse on the recommendation of the school administrator, and the DAA social worker. The EPI nurse also left a message with ACYMH asking about the status of any referral for the youth. Her goal was to try to find people who

could assist her in engaging with Chester and his parents. She did not recall specifically mentioning in her phone conversations that she had assessed the youth as a “*moderate risk*” for suicide. She told RCY investigators, “*If I had felt there was a high risk we would have notified the parents . . . If we had felt there was imminent risk we would have called [the CRT] and had him taken to the hospital, or called 9-1-1. That wasn’t the feeling we had in that meeting. And I say ‘we’ because we discussed it. So again, it was more: ‘How can we engage with him?’*”

That day, Chester left the school grounds after attending his morning class. He did not return after lunch. Although leaving school was a common behaviour for Chester, the administrator who had arranged Chester’s EPI assessment was concerned when she heard that he was gone. Chester had mentioned to his sister earlier that day that he was feeling suicidal. When she noticed he was missing, his sister immediately went to a trusted staff member and asked her to help look for him. The staff member told her supervisor and two members of the Aboriginal support team about Chester’s comments about suicide. More school staff heard that he was missing and joined the search. The family came to the school with other community members to help with the search. Police were called in to assist approximately four hours after Chester had last been seen at the school. Chester was found dead later that evening. He had hanged himself early that afternoon in a densely wooded portion of a nearby park.

At 4:30 p.m. that same day, not knowing that Chester was already dead, the DAA social worker phoned the family’s home and left a message with one of Chester’s older brothers saying that she wanted to set up an after-school meeting to arrange for a new DAA support worker for Chester.

After Chester's Death

On Aug. 5, 2014, more than a year after Chester’s death, MCFD completed a case review of the services received by Chester and his family. The review confirmed that the goals of the DAA’s service agreement with the family “*were not specific or measurable, nor did they support [the youth] with services appropriate to his level of need,*” and that the support service plan “*failed to provide a more comprehensive and coordinated approach to adequately identify, assess and support his risks.*” The review noted that the professionals involved with Chester collaborated to provide him with support, but that their “*approach was fragmented and opportunities to recognize the seriousness of [the youth’s] mental health crisis were missed.*”

The case review reported one action already taken by the ministry to respond to Chester’s death: the designation of one additional clinician and one additional mental health support worker to work with the local communities. This new ACYMH clinician now regularly meets with youth at the school, which has been a positive change. The clinician works with a number of students. School administrators and teachers can phone the clinician directly and he makes himself available within a very short time frame. According to the interviews conducted for this investigation, this clinician has been extremely beneficial for the school, greatly increasing its capacity to help students in

need. Unfortunately, the ACYMH team did not actually receive any new funding or staff to fill these positions. The clinician and support worker were not “additional”; they were simply moved from another area the ACYMH team covered, meaning that other areas lost essential supports.

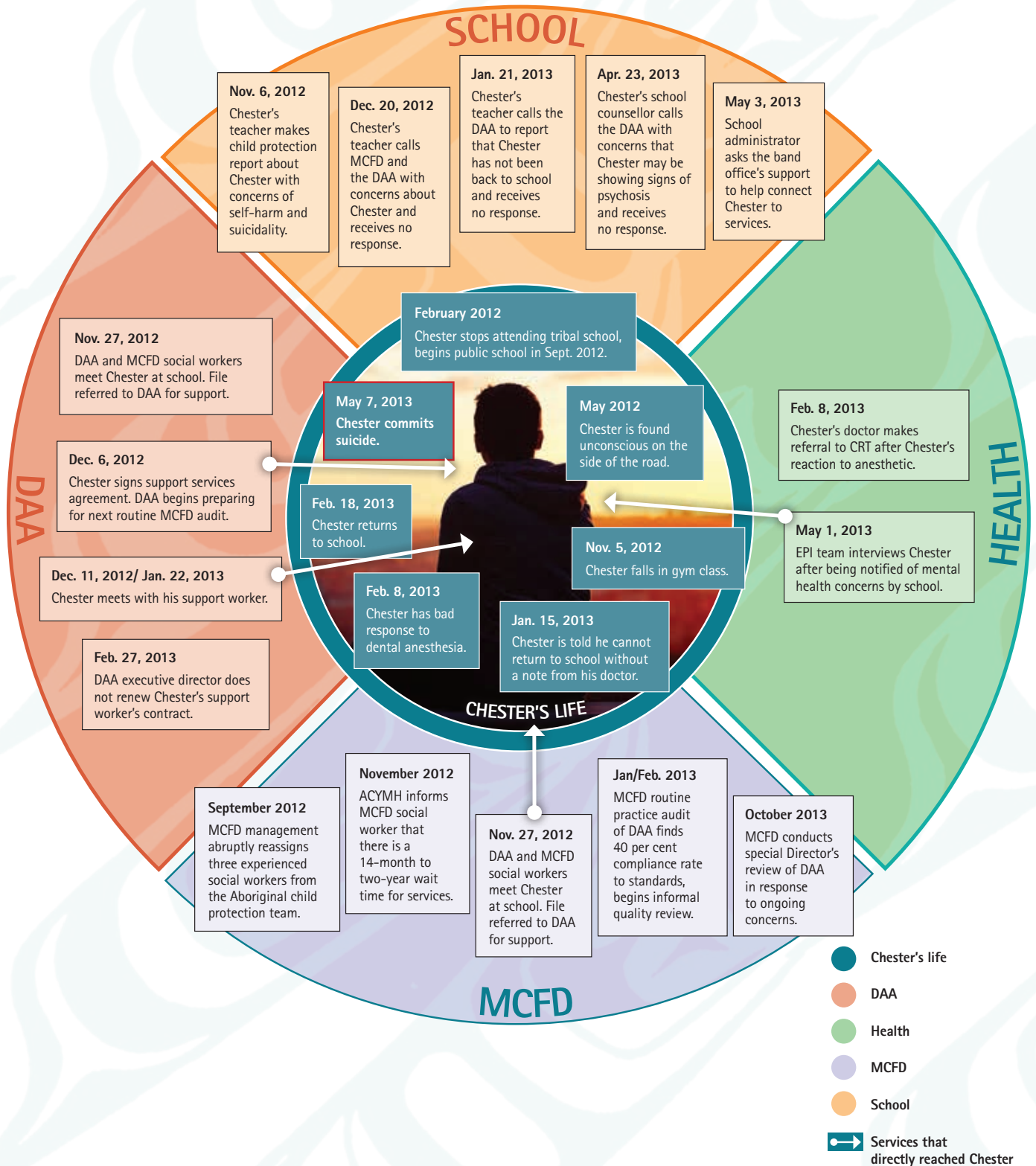
The case review included three further actions to be taken in response to this tragedy. The first action was for ACYMH clinicians, MCFD social workers, and DAA social workers to meet to discuss what information ACYMH requires when workers make referrals for their clients, and for the assigned ACYMH team leader to create written guidelines on the referral process to share with MCFD and DAA staff. Part of this first task occurred. The team leader met with social workers and provided them with policy packages, but he did not develop written guidelines for referrals.

The second action was for ACYMH staff to participate in monthly meetings with MCFD, the regional health authority, and the local First Nations communities to identify youth who may be at high risk and ensure that they receive appropriate services. The ACYMH team leader assigned to the second task explained to RCY investigators that these meetings had already basically “*disintegrated*” by June 2014. In some communities, different parties had completely taken over the meetings and, in others, attendance was poor. The monthly meetings now differ on every reserve, something the team leader saw as a potentially positive change as it allows for more specific and relevant conversations for each reserve’s particular needs.

The third action was for the DAA staff to receive training on suicide awareness, goal-setting and service provision for high-risk youth. Again, this third task was only partially completed. The executive director for the DAA was assigned the responsibility for this task. She confirmed that all of the DAA staff participated in a three-day suicide awareness training program, but could not recall arranging for any other specific staff training for goal-setting or for high-risk youth.

Timeline of Events

2012–2013



Analysis

After [his] death, when we all sat around the table, there was a very big realization that someone had a piece of information, someone had another piece, someone had another piece, and nobody knew it all . . . and that that could never happen again.”

– Band employee

Overall Finding: MCFD has full responsibility to resource and monitor DAAs to ensure that every DAA is able to carry out its mandated services. Such ministry support was glaringly absent in this case. The DAA’s lack of internal capacity, combined with the limited accessibility of ACYMH and CYMH services, resulted in an almost complete absence of external supports for Chester. The inexperienced DAA supervisors and front-line workers could not provide the level or type of services that would have been responsive to this youth’s needs. The ability of workers to assess and respond appropriately to Chester’s needs was negatively impacted by higher-level managerial decisions made by both MCFD and the DAA leadership, seemingly without concern for the effect those decisions would have on front-line staff.

The Delegated Aboriginal Agency's Capacity and the Ministry's Oversight

Finding: The DAA could not provide appropriate services for Chester and his family. MCFD was fully aware of the chronic systemic challenges within this particular DAA, yet the actions taken by MCFD management did not adequately address the lack of capacity of the DAA until long after Chester’s death and it remains unclear whether the DAA’s challenges have been resolved in a sustainable manner.

To comprehend the lack of DAA support for Chester in the year prior to his death, it is important to understand what was happening within the DAA. Analyzing the actions of individuals without attending to the larger context of their work environment removes the possibility for meaningful systemic change. The front-line service providers at the DAA faced significant challenges due to lack of capacity in leadership, lack of clinical supervision and support for front-line workers and continuous human resource issues.

In the case of the DAA responsible for serving Chester, MCFD was fully aware of the DAA’s lack of capacity to perform its mandated role. MCFD routinely checks the performance of DAAs through audits of their practice, which occur every three years. These audit reports showed that the DAA was achieving a very low level of compliance with the AOPSI standards that it was meant to be following, and these audit results were declining over time. Overall compliance with standards was 66.7 per cent in 2006 and that decreased to 54 per cent in 2009.

In the wake of the 2009 audit, the DAA’s board of directors hired a new executive director. The executive director immediately began trying to change what she described

MCFD's Role in Supervising DAAs

In *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.* (November 2013), the Representative concluded that MCFD's role is not merely to monitor any DAA to which the ministry has delegated authority, but to determine appropriate corrective actions when a lack of capacity is revealed. The Representative was clear that MCFD has spent millions of dollars on Aboriginal child welfare initiatives that have had no benefit for Aboriginal children and families because money was spent on "governance initiatives" instead of direct services.

Since 2013, MCFD has developed a partnership initiative called Aboriginal Service Innovations (ASI). MCFD partners with Aboriginal service providers, DAAs, First Nations, Métis and urban Aboriginal organizations to design and deliver services in local communities. ASI is meant to be entirely service driven and Aboriginal service providers now offer collaborative, direct services such as Family Finders, Kinship Care and culturally relevant support services. The initiative has resulted in contracts with 32 Aboriginal service providers located throughout B.C.

to RCY investigators as "a culture of work avoidance and poor performance." The executive director terminated nine employees in two years, and replaced them with new and often inexperienced staff. The executive director's background was in administration rather than child welfare and she hired a number of contractors to assist her with the child service aspects of her job. In another attempt to address concerns from the 2009 audit, the executive director of the DAA seconded an experienced and professionally accredited child protection team leader from MCFD to the DAA in November 2010.

Despite these changes, the next audit of the DAA, in January 2013, showed the lowest level of compliance to standards yet, a mere 40 per cent.

The 2013 Audit

The 2013 audit of the DAA by MCFD had the unintended and unfortunate consequence of focusing the DAA staff on trying to hastily update their files prior to the arrival of the auditors, rather than on providing service to their community. In the weeks prior to the audit in late 2012, DAA staff reviewed their existing files and retroactively tried to ensure that they contained all of the appropriate information. The executive director of the DAA described this situation to the Representative's investigators, saying that on some days, "they worked through lunch hour, or we locked down the boardrooms so no one could go in there and they really were going through the files, and the supervisors were having to review it."

Chester's DAA social worker described the DAA as in "full audit-mode" by December 2012, at the same time that she was meant to begin delivering support services to Chester and his family. In preparing for the audit, the DAA staff realized that much of the necessary file documentation for their work had not been done properly, if at all. The DAA social workers were told by their management that their primary focus was the audit. Meanwhile, Chester's DAA social worker recalled that she was also supposed to provide services to

the approximately 20 children on her caseload. As Chester's DAA social worker told the Representative's investigators, *"If you're focusing on the files, you can't get out. It's just logistics."*

The DAA staff felt that neither the MCFD auditors nor the executive director gave them sufficient support to continue providing services during this time. The executive director felt that her employees did not have enough work to warrant extra support, and did not see how the audit would have any effect on their day-to-day work. *"There's just not a big enough caseload . . . there's enough staff there to do the extra work or the family support work that's required, and on top of that there's the community services manager so I couldn't see how it would take away from their work."*

It was the DAA social worker's delegated duty to ensure that the services provided to Chester adequately met his needs. From the beginning, she failed to take a case management role and left the service provision to the inexperienced support worker. That being said, the DAA social worker was new to her position. She had graduated from university with a social work degree in 2011. She was hired by the DAA as a family support worker in February 2012, and had only begun her role as a delegated social worker approximately six weeks before meeting Chester. She was new to social work and she did not consider her on-the-job training support in this unfamiliar role to be adequate, stating to RCY investigators, *"I did not have a [worker] to shadow or any support in that context."*

The professionals interviewed by the Representative's investigators who have worked with Chester's DAA social worker describe her as competent, professional and passionate about her work. The DAA social worker was not adequately supported by her team leader or the upper management of the DAA in her new role, especially in consideration of the pressures of the audit and the ongoing instability in the office.

Communication within the DAA was also an issue during this audit process. The same team leader was meant to supervise Chester's DAA social worker and his DAA support worker. The DAA social worker assumed that Chester was meeting weekly with his support worker, as they had agreed upon, and then reporting to their shared team leader. Due to the pressures of her new role and the audit preparation, the DAA social worker did not have the capacity to ensure that this was taking place. She believed that if there were any problems with the support worker's performance, the team leader would let her know. However, the team leader did not have regular supervisory meetings with any of her staff. She incorrectly presumed that the DAA social worker was working directly with the support worker, and never clarified this expectation.

With the lack of internal accountability for service issues that DAA employees reported to the Representative in the process of this investigation, the 2013 audit determined that case supervision in the agency did not meet the level required for delegated work and that, when supervision occurred, it was irregular, unstructured, and *"at times, [DAA] staff [did] not know what [was] expected of them."* For a youth with a newly delegated social worker and a recently hired support worker, this lack of supervision, communication and guidance at the very outset of Chester's service agreement contributed to Chester receiving insufficient support in the final few months of his life.

Informal Quality Review

In January 2013, in response to concerns, including those identified by the audit, MCFD initiated an informal quality review of the DAA's child service files. This review took approximately three months and included interviews with children in care and their foster parents. Though the intention of the ministry was to identify and help correct ongoing performance issues in the DAA, neither the DAA nor MCFD put sufficient supports in place for the front-line workers to mitigate the strain that this review placed on their service provision.

Chester's social worker recalled that, during this time, foster parents were constantly phoning her worried about the process. She explained that for her, this review "*created a lot of stress and additional workload.*" Even though she was a newly delegated social worker, she carried all but one of the DAA's files for children in care. The informal quality review greatly affected the DAA social worker's ability to do her job supporting Chester because the majority of her time during this process was spent attending the review interviews to support the children and families.

At the end of February 2013, in the middle of this time-consuming review process, the executive director of the DAA ended Chester's support worker's contract. Though the support worker had not met the expectations of weekly meetings with Chester, he nevertheless had begun to form a connection, however tenuous, with Chester and his termination left Chester with no support at all from the DAA.

The DAA social worker immediately told her team leader that she needed a replacement support worker for Chester because she still did not have the time to work directly with him. The DAA social worker felt that all she could do was communicate to her team leader that she urgently needed Chester assigned to another support worker. The DAA team leader confirmed to the Representative's investigators that the DAA social worker was "*unrelenting*" about the need for Chester to have a support worker, and that the team leader continually raised these concerns with the executive director with no results.

The executive director felt that the loss of the support worker for Chester was not an issue. She had concerns about the support worker's poor performance and felt that Chester could easily be reassigned to another support worker because "*there are always other staff members and they don't have big workloads.*" In interviews, the Representative's investigators found that the front-line DAA workers believed that the other DAA support workers were already working at their maximum capacity.

It was the executive director's belief, as described to RCY investigators, that if a mental health concern had surfaced in Chester's case, a support worker would have immediately reported it to the delegated social worker, who would have met with a team leader and that "*would automatically trigger a response that they have to do something.*" Absent from the executive director's analysis was the fact that such reporting could not have occurred because Chester did not have a support worker during the last two months of his life.

Chester's DAA social worker was the only person at the DAA who took responsibility for failing to assist Chester during this time. When discussing her role in Chester's file with

RCY investigators, she said that what happened with Chester *“was such a tragedy and it impacted us all in such a big way . . . but it was also preceded by a number of months of the worst experience in my professional life.”*

The DAA social worker’s supervisors placed the blame for failing to assist Chester on other agencies that they felt should have been more involved. The DAA team leader said that if there were child protection or mental health concerns, then MCFD or ACYMH ought to have been involved, and that the school should have been counselling Chester. The executive director questioned why the school had not properly communicated its concerns to the DAA and asked, *“If someone’s not communicating what their real needs are, how are we supposed to support them?”* The Representative’s investigators found in this case, however, that the school did repeatedly communicate its concerns.

MCFD Director's Special Review

In October 2013, several months after Chester’s death, the ministry began a Director’s Special Review to respond to continuing systemic concerns about how the DAA functioned in coordination with MCFD. The review concluded that there was an urgent need for action because the ministry *“is not always able to effectively respond to child welfare matters when working with Aboriginal children, youth, and families served by [MCFD and the DAA].”*

The review found that both the MCFD and DAA staff members lacked a *“clear understanding of the roles and responsibilities of their partner agencies.”* An MCFD child protection social worker provided one example of how these misunderstandings could lead to open conflict between MCFD staff and workers from the DAA. In this instance, he had gone to a local hospital to apprehend a baby from a mother who lived on Chester’s reserve. This apprehension was based on significant child protection concerns. When he arrived at the hospital, he found a DAA team leader trying to give the child to one of the mother’s relatives without any consultation with MCFD. When the MCFD worker told the DAA team leader that the relative’s home was unsuitable, the DAA team leader accused the MCFD social worker of racism. The MCFD worker believed that this was symptomatic of the resistance presented by the DAA to MCFD’s child protection role. Fortunately, both MCFD and DAA workers expressed to RCY investigators that there has been a vast improvement in role clarity and collaboration between the DAA and MCFD since 2013.

In addition to confusion over role clarity, MCFD staff reported frustration with a *“lack of accountability and consistency with the contracted services delivered by [the DAA].”* Ministry staff did not trust the DAA staff to follow through on referrals for support services. One MCFD social worker interviewed by RCY investigators described the situation, saying that she would make a referral to the DAA for delegated family service work, but *“we had no clue that they were going to follow through, because they would just close the files down and then we would get them back . . . in like three to six months and then there’d be no evidence that they had actually taken the steps to address anything.”* Another MCFD social worker confirmed this, saying, *“You would check back with the clients. They hadn’t seen them.”*

Staff members from all agencies voiced concern about the capacity of the DAA's executive director to understand the complex issues involved in child protection work.

In an interview with RCY investigators, one social worker commented that upper-level MCFD management must start to recognize *“that there needs to be in place some guidelines around the executive director.”* She firmly believed that should MCFD continue to fund and contract service provision through DAAs, MCFD ought to ensure that the executive director running the DAA is capable and qualified. She described anything less as a *“huge disservice to the communities”* that MCFD is meant to be supporting to take back the responsibility for child welfare.

At this point in time, the DAA's executive director is appointed solely by a board of representatives from the reserves that it serves, with no input from MCFD. The result is that, although MCFD partially funds and is ultimately responsible for the performance of the DAA, the decision about who leads the DAA rests entirely with the board.

This Director's Special Review of the DAA demonstrated that the concerns from the previous audits remained unaddressed. In response to continuous findings of poor performance, the DAA restructured its programs and accepted MCFD's multiple recommendations. The executive director brought in experienced MCFD team leaders to support the front-line staff, clarified the roles of various staff members and reviewed the protocol agreement between MCFD, the DAA and the community.

Impact of Decision-Making by Senior Management at MCFD

Finding: Drastic and unexpected changes to the MCFD Aboriginal child protection team initiated by senior management meant that there was a significant loss of capacity in the MCFD team and loss of trust between MCFD and the DAA in the months prior to November 2012, when a protection report was made about Chester. This came about because, in the spring of 2012, certain First Nations community leaders in Chester's area and some of the staff of the DAA raised complaints with senior management at MCFD regarding difficulties in working with several MCFD child protection workers who worked on Chester's reserve.

In June 2012, senior officials at MCFD, the DAA, another local service provider and representatives of the local First Nations met. When one of the First Nations community leaders raised the possibility of banning all MCFD social workers from working on the local reserves, one of the options considered to prevent this from occurring was the removal of certain MCFD child protection social workers from the Aboriginal team. When this option was implemented later that same year, it had significant and long-lasting consequences on the functioning of the MCFD Aboriginal child protection team and its capacity to perform its key functions.

In September 2012, after continued pressure from certain members of the First Nations community, senior officials at MCFD *“reassigned”* three experienced MCFD social workers from the Aboriginal child protection team with no notice. They were told by local MCFD management that due to an *“executive level”* decision, they must remove themselves from all cases with any relation to the local reserves on short notice.

Combined, these workers had more than 50 years of experience serving Aboriginal communities. Rather than allowing for an orderly transition of the social workers' files after replacement workers had been found, management informed the three child protection social workers that they had two or three days to end all of their involvement with their Aboriginal files. These workers had to leave behind approximately 65 active case files. Budgetary constraints meant that those three MCFD Aboriginal child protection social workers were not replaced until mid-October 2012.

The three workers were not actually reassigned immediately; they had to compete for new positions. One of them described sitting at his desk, *"keeping a chair warm, getting paid, [and] maintaining conduct of cases that we couldn't touch . . . I'm counting paperclips for weeks here, watching children get hurt, which is kind of not why I got into this business."* This worker, who was Aboriginal, had hoped to stay on the Aboriginal team and eventually become a team leader there, and his entire career plan had been stymied by what he referred to as a *"year of chaos."* Another of the workers was so deeply affected by the transfer that she went on stress leave.

In reflecting on this incident to the Representative's investigators, one of the members of MCFD management for the region explained that the decision to remove these three workers had *"significant unintended consequences."* She admitted that the reassignment was not done well, and described a lengthy process after it occurred of trying to rebuild trust among the various service providers and the communities in the area.

The re-assigned social workers' team leader came back from vacation, unaware of what had transpired, to what he described as an *"atmosphere of fear"* in the remaining MCFD Aboriginal child protection team. This perception was echoed by the 2013 MCFD Director's Special Review, which found that *"following the staff reassignment several staff went on sick leave while others requested transfers to the non-Aboriginal team. Consequently, inexperienced workers were assigned to the Aboriginal team and found themselves with higher than average caseloads in a complex work environment."* Many on the Aboriginal team felt unable to do their jobs. They had lost faith in their management to support them in their work, and believed that senior management had allowed politics to trump the protection of children.

The removal of the three MCFD Aboriginal child protection social workers meant that many families on-reserve lost long-term relationships with social workers who knew and supported them. A DAA social worker told the Representative's investigators that this incident *"was very stressful for families and it was stressful for us as well because their social workers were just gone, and there [were] no notes, there wasn't anything."* With a complete lack of transition planning, all the knowledge and relationships that the three social workers had built in Chester's community were gone and the remaining members of the Aboriginal child protection team had to pick up the pieces.

By November 2012, when the school reported child protection concerns for Chester, the MCFD Aboriginal child protection office was still trying to navigate the fallout from the decision to remove the three workers. The MCFD social worker who interviewed Chester at the school had returned early from her maternity leave to help with the files that the

three had been forced to leave behind and the influx of new calls to an office that had an insufficient number of employees to handle them.

When the re-assigned Aboriginal child protection workers had needed mental health services for their clients on-reserve, they had directly called the team leader for ACYMH and sometimes managed to circumvent the lengthy wait list. The MCFD social worker assigned to Chester's case was not aware of this unofficial practice and thought that Chester would have to wait two years for a mental health assessment or counselling services. She described any attempts that she had made to get her clients access to ACYMH services at that time as futile.

The assigned MCFD social worker could not explain to the Representative's investigators why she did not fill out the ACYMH referral for Chester when it was sent to her in late November 2012, as it was her responsibility to do and as she had told the DAA social worker she would do. It is possible that the turbulent office environment, higher than usual workloads and the loss of the knowledge held by the three transferred workers, combined with the perception of an extremely long wait list, resulted in the failure to complete Chester's referral.

Meanwhile, other services available to youth at the local band office level in Chester's area were uneven and disconnected from the broader health care system. At the same time it was removing the three experienced social workers from the Aboriginal child protection team in this area, MCFD was providing a few band members with child welfare funding through a society to deliver family development and family preservation/unification services as well as services to strengthen families. It remains unclear how this funding or work aligned with child welfare services being provided by MCFD or the DAA.

A review by the Representative's investigators of service agreements and subsidiary component agreements with this society show that MCFD provided more than \$3.3 million to the society between 2009 and 2016 to fund meetings, reunifications, transitions and planning sessions between family members and other stakeholders. This included funding for the society to run "*practice circles*" within the community⁶ which, according to the society, were "*designed as a community structure from which vulnerable families, [the society] and other Aboriginal service providers can draw on to identify and/or inform services for families.*" No allocations to the society were budgeted for services or activities related to mental health or how to navigate mental health services for children, youth and families that need them. MCFD was responsible for this contract and was also responsible for mental health, child welfare and budgets and services for this service delivery area.

The ministry decision to allocate budget to community projects provided by this society was supported by leadership at MCFD, while budget decisions were at the same time being made to reduce capacity in ACYMH. This was occurring simultaneously with the

⁶ MCFD provided RCY investigators with a total of nine agreements (three service agreements and six subsidiary component agreements) spanning 2009 to 2016. The 2016 service agreement extends until March 2018.

debate around the removal of the three social workers. The same leadership officials dealt with budget and services allocation.

These dynamics are significant background factors to the service environment Chester experienced. Like other youth, he depended on the system to be professional, organized and able to build the bridges needed to obtain necessary mental health support.

Perceived Inaccessibility of Child and Youth Mental Health Services

Finding: The inaccessibility of ACYMH, based on the existence of lengthy wait lists, and poor management of this by MCFD, prevented Chester from receiving services that could have provided him with support in dealing with symptoms of emerging mental health concerns. There continues to be a lack of transparency about how to access services for children on-reserve. There also remains a lack of clarity on the difference between Aboriginal and non-Aboriginal CYMH services. Access to one door for services does not necessarily connect to health care or treatment plans that are available elsewhere for high-risk youth.

As part of its *5-year Child and Youth Mental Health Plan* (2003-2008), MCFD initiated a process to develop CYMH services dedicated to Aboriginal children and youth. In October 2005, a six-week regional consultation planning process was carried out that included 247 stakeholders from education, health, social services and Aboriginal community members including youth, family members and elders. The result was a reorganization of positions from existing CYMH teams to create two new ACYMH teams meant to provide specifically designed services to Aboriginal children, youth and their families.

Despite MCFD's positive intentions of creating and providing specialized, culturally appropriate services to the First Nations population in this area, the end result was described by multiple professionals interviewed by RCY investigators as a dedicated team of skilled professionals that suffered from a chronic lack of resources, a shortage of staff compared to what they needed to serve their assigned population and a lack of differentiation from CYMH.

Given the unique cultures, practices and traditions of Aboriginal youth, along with mental health challenges specific to colonial histories and intergenerational trauma, ACYMH services were intended to offer an approach grounded by Aboriginal values with staff who possess an understanding and ability to work within Aboriginal experiences and world views. ACYMH may have been an ideal resource for Chester as he began showing symptoms of emerging mental health concerns. Unfortunately, Chester never had the opportunity to connect with ACYMH due to a lack of clarity in how to access services and the perception of many of the professionals working with Chester of an insurmountable wait list to access these services.

Provincial Suicide Clinical Framework

In 2011, the Provincial Health Services Authority released its *Provincial Suicide Clinical Framework*, which clearly laid out the gold standard of assessment and treatment for young people at risk of suicide and established best practices for provincial organizations providing services to youth. The framework is designed to provide guidance in the development of protocols for suicide assessment, treatment and risk management, and includes a template that provides the steps program leaders need to take to develop appropriate clinical protocols for their specific populations.

The framework spells out the differences in risk management between youth and adults, and, with respect to youth, supports a comprehensive and integrative model of risk assessment that is responsive to children, youth and their families. Key to achieving the gold standard is that youth and their families are seen for a risk assessment as soon as possible following a referral. The framework goes on to state that *“at minimum, phone contact with the family within 24 hours of the referral should be made to discuss immediate issues and put a safety plan in place.”* In addition, because of the correlation between youth suicide rates and contextual family issues, the framework emphasizes the importance of relationship-building between the health professional and the at-risk youth, so that the health care provider understands what’s going on in the youth’s life and important relationships (Provincial Health Services Authority, 2011). The framework’s plainly stated best practices were clearly not adhered to in Chester’s case.

In working with adolescent mental health issues, the Representative has had long-standing concerns that timely access to appropriate services remains unavailable. The Representative’s report *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (April 2013) noted, *“Regardless of where they live in B.C., many youth seeking mental health services are put on wait lists because there are not enough services to meet demand. Those involved in the Representative’s review consistently identified wait times as a significant barrier to services.”* This finding holds true in Chester’s region, as was made clear in the interviews conducted for this investigation. The negative effect of long wait times was a continual theme across the entire youth mental health system, reflected in *Still Waiting*: *“Long wait times for mental health services can result in deterioration of mental health and daily functioning, as well as reduced motivation to seek services* (Brown, Parker, & Godding, 2002).”

The ACYMH team leader in Chester’s area confirmed in an interview with RCY investigators that the problem with the system is endemic and *“people don’t refer because they know there’s a wait list.”* Once a youth is referred and placed on that wait list, ACYMH staff typically check in and connect with the youth in an attempt to start building a relationship while the youth waits for services. Contact is usually via phone, and occasionally in-person in the community. So, in effect, though it may seem like one door is opening when a youth is placed on the wait list, another door – to actual services – remains closed and can stay closed for many months. In May 2013, the wait time for actual ACYMH services in Chester’s region averaged between 14 months and two years.

That translated to approximately 60 children waiting for support at any given time. One ACYMH counsellor described this wait list as a result of the lack of resources dedicated to what was intended to be a specialized team, explaining, *“We just didn’t have enough staff to support the population that we were trying to serve in any way.”* Despite the high wait list and workloads, ACYMH has not received any additional staff members since 2009.

Part of the difference between CYMH and ACYMH is that ACYMH focuses on outreach, which is highly time- and personnel-intensive. Without MCFD making a clear effort to adequately resource ACYMH, the team cannot meet the demands of the population it serves. To make matters worse, there is an inaccurate perception that Aboriginal children and youth cannot choose to access CYMH instead of ACYMH – that they must use ACYMH. Multiple mental health practitioners both inside and outside of MCFD told the Representative’s investigators that the ACYMH wait list was and remains longer than that of CYMH in Chester’s region.

The issue of wait lists is not unique to ACYMH. CYMH, in general, has faced a continuous shortage of funding from the provincial government. An upper level manager in MCFD told the Representative’s investigators that she could not recall any increase in CYMH workers in Chester’s region since 2003, and confirmed that they just try to reshuffle workers based on need.

In 2012 and 2013, when Chester needed mental health support, the wait list policy for ACYMH only required that a system of prioritizing clients be in place, that regular contact be maintained to monitor problem severity and that the wait list be reviewed at regular intervals. The policy did not dictate what that system looked like. This prioritization was done locally, involving clinical judgement and knowledge. The wait list was reassessed regularly to address changes in need and priority in order to try to serve the highest need clients soonest. The ACYMH team leader in Chester’s region told RCY investigators that, had a written referral been made, Chester would have been seen as soon as possible. In response to the general lack of access to services for youth on-reserve, the team at the time had an unwritten *“no wait list policy”* for reserves. The ACYMH team did not advertise this practice to prevent an inundation of referrals and the MCFD child protection social worker who initially called ACYMH did not mention that Chester lived on-reserve.

From the perspective of the Aboriginal child protection social workers interviewed for this investigation, despite this unwritten policy, the system was still not easily accessed. One child protection team leader told RCY investigators, *“Unless you got blood dripping, they’re not going to see you.”* This perception was echoed by other professionals interviewed by RCY investigators. When speaking about the mental health system in Chester’s region, the neurologist described it as *“totally opaque.”* She clarified that, for her, mental health seems to be *“the worst system we’ve got. Medicine at least is kind of straightforward, and mental health is all these little kingdoms and it’s all separate [with long wait lists].”*

Not only was there confusion amongst service providers with respect to how to access ACYMH services, but even those who were referred didn’t necessarily get accepted into the program. In 2012, only 33 per cent of referrals were accepted by the dedicated ACYMH team in Chester’s area. By 2015, the same team was accepting 87 per cent of referrals and, while this sounds promising, it does not mean that Aboriginal children and youth are now

able to immediately access ACYMH services. In fact, lengthy wait lists remain the norm. As of March 1, 2016, the average wait time at this ACYMH office was nine months (270 days). It is important to note that this is an average and, since some high-priority cases are seen very quickly, many children and their families on the wait list are left waiting for more than a year. Waiting to get in the door may lead to a second round of waiting for therapies that, given the wait list, are not available as staff does assessment rather than therapeutic treatment. Further, this wait list data provided to the Representative's Office by MCFD and confirmed by the team leader, does not capture the real need for services because it does not include those cases that were going to be referred but were not followed through on after hearing about the wait list – as occurred with Chester. Nor does it capture those who may drop off after being on the wait list for a lengthy period.

To address the confusion in how to access ACYMH services in Chester's region after his death, the ACYMH team leader visited the DAA and local MCFD office to clarify with staff that they must submit referral forms to ACYMH to access services for their clients. If a social worker calls the office, an appointment will be offered for that worker to fill out a full referral package, after which the child or youth will be placed on the wait list. Local CYMH offices now offer walk-in clinic times, and the outreach ACYMH worker who attends the schools now offers another point of access.

What has not been addressed since Chester's death is the need for more funding for CYMH and the need to re-assess how the ACYMH team can better serve the First Nations population in Chester's area. Staffing levels remain relatively static. According to staffing data provided by MCFD, there was an increase in staffing at that ACYMH office of only 0.38 full time employees – or less than five per cent – between 2013/14 and 2015/16. In addition, a member of MCFD senior management confirmed to RCY investigators that there is no specialized training or policy for ACYMH workers that differs from that used by CYMH. One of the consultants involved in the initial planning for ACYMH recalled they went in with positive intentions, but when it was rolled out, it was so under-resourced that *“anybody who had been involved in it was kind of shocked by this is it.”* Another clinician with ACYMH explained, *“Really what they've got right now is they've got Child and Youth Mental Health services just with Aboriginal in front of it. There ain't nothing Native about it.”* He said that ACYMH workers receive no specialized training and they are not given the tools they need to do the outreach that they are expected to do and that is so beneficial for connecting with the population they serve. For example, some ACYMH clinicians report that they cannot get funding approval for smartphones and their access to vehicles is so limited that they must be booked months in advance.

Essentially, ACYMH and CYMH employees at this time are making the most of the extremely limited funding dedicated to the vulnerable group of children and youth coping with mental health issues. Still, fewer than one-third of the children and youth in B.C. with mental health disorders are receiving the specialized services they need. A research report completed by the Children's Health Policy Centre at Simon Fraser University found that 12.6 per cent of children ages four to 17 years (or 84,000 British Columbians) are experiencing mental health disorders at any given time. However, only 31 per cent (26,000 in B.C.) of these children are receiving the specialized mental health services they require (2015). The chronic underfunding of CYMH and ACYMH

Preventing Suicide in Youth: MCFD 2005 and 2013 Reports

In the early 2000s, MCFD commissioned a report from UBC's Children's Mental Health Policy Research Program to identify the most effective prevention and treatment approaches for child and youth mental health issues. *Preventing Suicide in Youth: Taking Action with Imperfect Knowledge* was published in 2005 and highlights the importance and centrality of the school in managing suicide risk. Many of its points remain pertinent today.

The study points out that because youth spend a significant portion of their time at school, it is an ideal place for implementation of suicide prevention programs. It suggests that schools should have in place comprehensive suicide prevention strategies that are supported by clear policies and administrative guidelines, and further asserts that mental health assessment and treatment services, as well as links to crisis response programs, are essential elements of these strategies.

The study also identified best practices for school-based suicide prevention teams, including providing targeted school-based screening and prevention programs for high-risk youth, and establishing referral links with community-based youth mental health services (White, 2005).

MCFD commissioned a second report by the same author released in 2013 entitled *Preventing Youth Suicide: A Guide for Practitioners* which contained significant amounts of Aboriginal-specific information. This report supports the development of comprehensive, community-wide suicide prevention frameworks grounded in Aboriginal world views. It also suggests additional resources that advocate for recognizing the role of historical trauma in the emergence of suicidal behaviour and outline culturally informed traditional healing practices (White, 2013).

"There is no such thing as a singular 'one size-fits-all' approach to preventing youth suicide. Each youth, family and community is unique and close attention must be paid to the particular social, cultural, political and historical context when designing and implementing youth suicide prevention strategies," White wrote.

The 2013 report recommends the use of *"decolonizing practices,"* which create awareness of *"the systems and structures that perpetuate oppression and inequity, particularly among Indigenous youth, families and communities, invite practitioners to understand the social and historical embeddedness of problems like depression, despair, and suicide and highlight the need for individual, organizational, and social action."* Among the ingredients in its recommended comprehensive approach to the issue of Aboriginal youth suicide are: well-being and resilience promotion for youth; education about suicide and the early detection of it; working with individuals and groups at known risk; and assisting families and communities after a suicide occurs.

services contributes to the lack of services for youth experiencing mental health crises. This underfunding is a disservice by our province to young people requiring supports. In Chester's case, it led to a perception of an overwhelming wait list for services that might have been able to identify and address his emerging mental health problems during the final year of his life.

When asked by the Representative's investigators, one of the MCFD managers for Chester's region described the resourcing issues with ACYMH, saying:

"It's my personal belief that we missed an opportunity when we expanded Aboriginal Child and Youth Mental Health in the ministry . . . It potentially could have been provided by service providers that are Aboriginal themselves or that have an enhanced cultural background to provide the service. I think our staff do a pretty good job reaching out based on the resources we have. They've developed some pretty strong relationships with communities, and I hear that from the different communities and service providers. The demand outweighs what our resources are."

Lack of Response to the School's Calls for Help

Finding: For the most part, the public high school recognized Chester's need for mental health support and repeatedly reached out to other professionals to get help for Chester while attempting to connect him with counsellors at the school level. These calls were often met with inaction on the part of the professionals contacted. When the school successfully connected with Early Psychosis Intervention services, both the EPI team and the school worked quickly to engage with Chester six days prior to his death.

Given the centrality of schools in the lives of their students, the school system plays an important role in identifying challenges. Outside of family, school staff are often the first to see emerging mental health concerns in youth. This pattern held true in Chester's case.

Although Chester only began attending his local public high school in September 2012, school staff soon realized that he would need extra attention. Chester's Aboriginal support teacher and his school counsellors realized that Chester experienced huge variations in mood and socialized with a turbulent friend group. Beyond his moodiness, they grew concerned with the strange things he would say, his odd behaviours and his mentions of depression. Over a seven-month period, various staff members at Chester's school requested support for Chester from MCFD, the DAA, the family, a doctor and finally the EPI program, with varying levels of success.

The school had an Aboriginal support program and a dedicated group of counsellors who worked diligently to get to know Chester and his family well enough to establish a positive connection with them. Chester's older siblings had also attended the school, and teachers and support staff faced challenges in trying to work collaboratively with Chester's often insular family. The school did not have the capacity to provide long-term therapeutic mental health support to students, nor was that the school's role. School counsellors tried to offer consistent and proactive help to students in need, referring them to outside resources if necessary.

School programs are among the most common interventions to promote positive mental health in school and community settings (McCreary Centre Society, 2011). Rather than relying on reactive interventions, a better approach to address emerging mental health problems would be to ensure universal access to promotion, prevention and early intervention. As described in Clinton et al.'s report *Supporting Ontario's Youngest Minds* (2014), the ideal system would “*embrace a life-course approach to mental health for all children.*”

In Chester's case, the school's responses were not always appropriate or helpful. Four months after enrolling at the school, with his behaviours escalating, Chester was effectively suspended by one administrator and told not to return until he had a note from a doctor declaring him fit to attend school. The result was that this highly vulnerable youth missed a full month of school due to mental health issues. The Representative appreciates that these issues were beyond the school's capacity to deal with, but effectively suspending Chester was not a helpful or appropriate tactic and did not demonstrate understanding of how his family was left in crisis.

In most instances, the school responded quickly and appropriately to his behaviours, seeking help from both his family and the professionals serving the community while trying to support him at the school level. In their interviews with RCY investigators, school staff expressed frustration in the lack of response to their calls by the MCFD and DAA social workers. As one teacher said in his interview for this investigation, “*Once we make a call, we don't just do it without reason. The general expectation when we make a call is to get some kind of action, a response.*” He further described his experience with the ministry at the time, saying, “*You'd phone, and you'd expect something to happen . . . and nothing, I mean, not enough happened.*” The school assumed that once MCFD and the DAA were aware of the concerns with Chester, the social workers would take responsibility for getting him the extra help he needed. This response never occurred, and Chester was left with insufficient support during a time of crisis.

Additional Observations

DAA Performance Improvement

It is important to note that three years after Chester's death, the DAA's overall compliance rate for child welfare service standards has improved to 75 per cent in its most recent 2016 audit. That same 2016 audit showed a 70 per cent compliance rate for a total of 18 family service files, the category under which services to Chester would have fallen. This improvement is due to the ongoing efforts of the front-line workers, their supervisors, DAA management and the Aboriginal Services Branch of MCFD. This commendable increase should result in much better outcomes for children and families served by the DAA, and the Representative hopes that the DAA continues to perform to a high level in the future. However, the small number of files reviewed means no solid assessment of daily practice can be drawn from this recent audit.

The fact that it took a decade for MCFD to help ensure that this improvement took place is extremely concerning. The dysfunctional state that MCFD knew the DAA was at in 2012 and 2013 meant that Chester did not receive the support services he required. The Representative is concerned that, while one case has been examined in this report, other children and youth served by this DAA may not have received much-needed services and interventions over this period of dysfunction and, as a result, may still be experiencing unaddressed trauma as adolescents. And given the historical performance of this DAA and its relationship with the ministry, the Representative is left to reasonably wonder whether recent improvement will be sustained over time. The audits were not the only warning bells ringing and MCFD did not have the inclination to step back and assess or respond to a crisis over a decade. That speaks to a level of indifference that is troubling.

Potential Transfer of Jurisdiction for Child Welfare Services

In May 2016, B.C. Attorney General Suzanne Anton informed the Representative by letter that the provincial government is “committed to working collaboratively with First Nations in implementing new approaches to self-governance and delivery of child welfare services.”

Over the years, MCFD has gone through several cycles of contemplating and discussing the devolution of responsibility for such services to First Nations. In fact, as the Representative’s 2013 report *When Talk Trumped Service* revealed, these exercises have at times resulted in scarce resources for children’s services being redirected to fund what have typically been high-level discussions on governance with consistently fruitless results. In that 2013 report, the Representative conservatively estimated the total amount spent by MCFD on Aboriginal governance endeavours over the previous dozen years at \$66 million.

The recent signalling by the Attorney General of another cycle in this process – without any accompanying policy details – raises some serious concerns for the Representative. Without proper safeguards in place, it could result in First Nations taking responsibility without being properly prepared or resourced and an even further watering down of services available to help vulnerable First Nations children and youth such as Chester. There are clearly inadequate services and have been for some time, so why would a change in jurisdiction fix the problem? Or is this a possible distraction from the core issue – systemic under-funding and wait-listing?

First Nations have the right to self government and to design services they wish to deliver, but this should be a collaborative effort involving all levels of government and it should be transparent, clearly spelling out the services that First Nations children are to receive.

The Representative is cautiously hopeful that government will learn from past mistakes, and avoid diverting human and financial resources from what should always be the first and foremost priority – direct services to children and youth.

The transfer of jurisdiction for child welfare services to individual First Nations is something that will require a clearly articulated plan ensuring safety and well-being for all children both during and after this process. It is essential that this not be approached as a cost-savings or off-loading exercise for government. Whoever delivers the services will need sufficient resources – resources that have too often been lacking even with the provincial government itself at the helm.

It is also vital that government takes steps to ensure that any such devolution process be funded and administered separately from the current provincial child welfare system that is already under-funded and facing a litany of well-documented challenges.

Government must also ensure that any transfer of authority for child welfare features strong administrative leadership that is free from local political pressures and able to carefully evaluate whether a First Nation seeking jurisdiction – or its contracted service provider – has the capacity and expertise to deliver the type and quality of services

required. This is particularly problematic when MCFD executive and senior leadership increasingly includes fewer people with front-line experience who are clear and resolute that safety and wellness of children and youth must be a centrepiece of any innovation.

When considered along with details of this report, the potential devolution of responsibility for child welfare to individual First Nations is even more concerning. The DAA entrusted to serve Chester and his family was functioning far below acceptable standards for multiple years and the ministry was fully aware of this. The acceptance by senior MCFD staff that the DAA's failing performance would take years to fix amounted to a decision – explicitly or implicitly – that the well-being of the children for whom this DAA was responsible could also wait.

This report – which documents how three experienced child protection workers were removed without cause from the Aboriginal child protection team in Chester's region – also demonstrates the danger of political considerations working in opposition to child well-being. The system can be geared to satisfy the powerful adults and not necessarily serve the children and youth.

MCFD has begun engaging with the leadership in Aboriginal communities and this is a potentially hopeful development. However, any initiatives focused on transfer of jurisdiction, responsibility and resources will require strong accountability processes and an unrelenting focus on the services actually available for Aboriginal children and youth.

MCFD has provided more than \$3.3 million since 2009 to a society to deliver ill-defined child welfare services in Chester's community and yet no pressure for child and youth mental health services has been documented or addressed. That is frankly baffling given what families, school staff and knowledgeable support workers describe in this report as a dramatic, unmet need in the area.

There is a strong sentiment on the part of First Nations to rid themselves of MCFD involvement in the provision of child welfare. The Representative respects and appreciates that instinct, stemming from systemic failures of the past. But what is truly required here is a collaborative process involving First Nations as well as both the provincial and federal governments that will keep children at the centre.

Chester was not kept at the centre. And this report is a cautionary tale about the consequences of devolving responsibilities for child welfare to an agency that consistently failed to meet ministry standards and that was not adequately resourced and supported by the ministry to address these shortcomings in a timely way. Any attempt at widespread devolution in B.C. would do well to heed the lessons learned from this investigation. Children and youth need well-coordinated services that are accessible and effective. They don't need three separate and, at times, warring service providers who are captivated by their own turf.

Recommendations

Recommendation 1

That the Ministry of Children and Family Development immediately implement and appropriately resource mental health services for Aboriginal children and youth so that the wait list and wait times for services are reduced in line with recommendations from the 2016 report of the Select Standing Committee on Children and Youth (SSCCY) *Concrete Actions for Systemic Change*.

Details:

- As the SSCCY recommended, MCFD to: *"establish targets to ensure that children, youth and young adults identified as exhibiting signs of behavioural, emotional or mental health issues are assessed within 30 days and begin receiving treatment within the next 30 days."*
- Publicly report on compliance with these timelines on an annual basis.
- Take immediate steps to expand staff, including administrative and support staff to reduce ACYMH wait lists and offer a full range of therapeutic interventions and services geared to the child and youth population, especially for those at risk of self-harm.
- Clearly prioritize case-level work with Aboriginal children and youth waiting for service, featuring a proactive approach to working with communities and families, as well as serving the urban Aboriginal child and youth population.

The wait list and wait times for Aboriginal Child and Youth Mental Health clients should conform to targets (30 days or less) by April 1, 2017.

Recommendation 2

That as a longer-term measure, the British Columbia government, together with the First Nations Health Authority, delegated Aboriginal Agencies and other service-delivery providers, move to partner with the federal government to create a proactive lead agency for the provision of Aboriginal child and youth mental health services in the province, with a focus on service improvement, prevention and quality assurance.

Details:

This agency should:

- Monitor and publicly report on wait lists and wait times for mental health services to Aboriginal children and youth.
- Fund service improvement and negotiate greater service access and accountability for Aboriginal children, youth and families in all health regions and MCFD service-delivery areas.
- Absorb current ACYMH staff and expand staffing numbers to ensure that service times can be reduced and therapeutic services can be delivered in an ongoing fashion.
- Ensure a strong emphasis on supporting school-based initiatives, prevention and crisis intervention.

Progress report to be submitted to the Representative by April 1, 2017.

Recommendation 3

That the Ministry of Education, the Ministry of Children and Family Development and the Ministry of Health prepare an immediate plan to protect the right of Aboriginal children and youth with mental health issues and disorders to learn, attend and participate fully in school. This plan should be child- and youth-focused, identify and scale up existing best practices and, wherever possible, co-locate ACYMH/CYMH services in schools so that Aboriginal children and youth with mental health disorders are not excluded from the classroom or asked to leave school due to behavioural issues or lack of services at the school level.

Details:

This plan should:

- Identify a provincial expert lead for Aboriginal child and youth mental health with a focus on supporting the right of all Aboriginal children and youth to learn within a school environment of their peers. This position should also focus on flexible or personalized learning to accommodate Aboriginal children with mental health disorders who may have experienced school absences or periods of hospitalization or home care.
- Prepare and implement a province-wide proactive and positive approach to Aboriginal child and youth mental health and wellness which will include supports and training for teachers and school staff. This approach should ensure Aboriginal students experience appropriate transitions between home, schools and districts. The plan should also address a structured process with ACYMH and caregivers for student safety/wellness during school calendar breaks.
- Develop and implement a simple and accessible provincial complaint process for Aboriginal children, youth and their families experiencing school exclusion due to behavioural issues. This process should be culturally appropriate and enable parents and community to safely contact ministry staff to seek assistance with their concerns.
- Begin annual district and provincial reporting of outcomes for students with behavioural needs or mental illness special needs designations as part of the *Framework for Enhancing Student Learning*.

Ministry of Education, Ministry of Children and Family Development and Ministry of Health to present a joint draft plan to the Representative by April 1, 2017.

Recommendation 4

That the government of British Columbia first establish a clear plan to ensure child safety procedures and services are maintained before engaging in any process to transfer jurisdiction over Aboriginal child welfare. This plan would ensure such services are maintained during any future period of transition or transfer of responsibility.

Details:

This plan, developed in partnership with First Nations, should include:

- Acknowledgment that development of the plan is a necessary pre-condition to any further action relating to Aboriginal jurisdiction over child welfare or related services.
- Mechanisms to ensure that all parties maintain an uncompromising focus on the services required by Aboriginal children and youth and addressing the shortfalls in those services.
- A requirement that funding for any negotiation or related planning processes will not be drawn from any ministry or agency that is providing services to Aboriginal children and youth. Diverting resources from direct services to children and youth to fund transfers of governance and jurisdiction to be prohibited.
- The clear identification of responsibility for Aboriginal child welfare safety investigations and responses to Section 14 *CFCS Act* reports during any transition, with a strategy for ensuring that information identifying points of contact and accountability are disseminated to professionals and the community.
- Clear protocols that ensure appropriate sharing of information between professionals, agencies and levels of government and community during any transition to protect child safety.
- Ensuring all Aboriginal children and youth who are potentially impacted by a change of jurisdiction or responsibility are provided with the opportunity to provide comment on these changes and with advocacy support to ensure their civil and human rights are appropriately protected.
- Clarity with respect to the role of the Public Guardian and Trustee, as well as the potential impact of any transfer of jurisdiction on any existing civil, criminal or family law orders, particularly in those situations where domestic violence is a factor.
- A commitment by the Ministry of Children and Family Development, First Nations and the Ministry of Justice to robust monitoring of child and youth wellness and outcomes prior to, during and subsequent to any transfer of jurisdiction or responsibility as well as regular public reporting on these outcomes.

Plan to be developed and presented to the Representative by Dec. 1, 2016.

Recommendation 5

That the Ministry of Children and Family Development develop and implement a strategy to provide immediate collaborative support for delegated Aboriginal Agencies that are consistently failing to meet ministry performance standards.

Details:

This strategy should include:

- Identification of the performance deficiencies or audit results that will trigger an immediate response.
- Identification of experienced ministry personnel or other professionals who can be made immediately available to provide both in-person and remote support to DAA staff and executive.
- Public reporting on actions taken and any resulting changes to agency performance within 90 days of a ministry immediate response.
- Appropriate funding to support the activities necessary to bring a DAA to an acceptable level of performance.
- Enhanced monitoring of agency performance for at least a year following any immediate response to a performance deficiency or audit result, with accompanying public reporting on outcomes for youth.
- Removal of delegation when it is clear that standards cannot be met or that staff are not qualified or capable of performing after a remedial intervention of no more than one year.

Strategy to be developed and presented to the Representative by Dec. 1, 2016.

Conclusion

Aboriginal Child and Youth Mental Health services in B.C. are grossly under-supported and under-staffed, with wait times that effectively amount to a long gap in service leaving children, youth, families, schools and peers in crisis for unacceptable periods of time.

Children and youth living in the service-delivery area examined as part of this investigation experienced delays of as long as 18 months in order to merely engage with ACYMH staff. Since Chester's death, there seems to have been little to no movement made to change this situation, or to ensure appropriate services are available on a regular basis. ACYMH staff are still working in a system that cannot be described as proactive or reactive but, more accurately, inactive for the majority of children and youth requiring service.

This doesn't mean staff are not carrying caseloads and doing valuable work for children and youth. The Representative gives full credit to ACYMH staff and their dedication, but the miniscule capacity of ACYMH seems vastly out of proportion to the need presented, making the conditions for these workers too often untenable. Staff deserve support and recognition and the Representative sincerely hopes they will not be consequenced as a result of this investigation. They are not responsible for the delays and wait times in the system of care – that is clearly a failure of leadership.

Select Standing Committee on Child and Youth Mental Health Report

The Select Standing Committee on Children and Youth (SSCCY) is one of nine permanent all-party committees of the Legislative Assembly of B.C. In 2013, the SSCCY undertook a special project examining child and youth mental health in B.C. In the first phase of its work, the committee identified high-priority areas needing improvement. The second phase, launched in February 2015, focused on identifying concrete and practical initiatives to enhance Child and Youth Mental Health services and outcomes in B.C.

On Jan. 27, 2016, the SSCCY released its special report entitled *Concrete Actions for Systemic Change* with 23 unanimous recommendations to strengthen Child and Youth Mental Health services. The committee found that there are many services available, but they are not always easily accessible, nor are they well integrated into the overall system of care. As a result of gaps in services and barriers to service delivery, children, youth, young adults and their families are suffering and improvements are urgently needed.

The SSCCY's recommendations focused on a coordinated, integrated system that includes assessment time frames of 30 days and treatment within the next 30 days. The committee's top recommendation was the appointment of a new Minister for Mental Health, who would assume responsibility for the funding and coordination of mental health services for children and youth in the province. This recommendation echoes that of the Representative in her 2013 report, *Still Waiting: First Hand Experiences with Youth Mental Health Services in B.C.*

The SSCCY's report is available at: <https://www.leg.bc.ca/parliamentary-business/committees/40thParliament-4thSession-cay>

With no relief in sight, children and youth continue to wait. The message sent to these children and youth is that there is no urgency to their needs, and that the distress and difficulty they face is theirs to cope with on their own. While much talk is offered about reconciliation and placing children at the centre, this has clearly not been the case in Aboriginal Child and Youth Mental Health. These children are at the centre of a system failure in which referrals and passing of limited information occurs while children and youth are presumed to be fine, despite waiting for much-needed supports.

The ACYMH system is not coordinated with other parts of the health or education systems, and is unable to adequately respond to situations such as that experienced by Chester. First Nations are keen to support their children and youth and are often offered small amounts of resources to do work on mental health or wellness, but this work is not a substitute for appropriate clinical health care and services and, regrettably, has been used at times to drive further wedges between children and the services they require.

B.C. is not reporting on mental health service wait lists and wait times and deeper investigation reveals that those within these systems are well aware of the extent of service delay and lack of capacity to meet the needs of young people such as Chester who are in crisis.

Suicide-reduction strategies for Aboriginal children and youth can benefit from real services with proven therapeutic interventions and staff, led by those who want to deliver those services in a family- and community-centered fashion. However, the current system continues to be chaotic and under-funded, while displaying significant indifference and acceptance of delay and service gaps. MCFD has blended CYMH and child protection leadership and budgets and this does not permit adequate focus on mental health prevention and intervention work to be undertaken.

First Nations children and youth are likely missing out on services by virtue of how their services are being streamed by MCFD into these heavily wait-listed programs. This can only serve to turn children and youth away from positive supports based on the fact that they wait far too long and are expected to tolerate a level of distress and difficulty that may be compounded by other factors occurring in these families, outside of their control and as a result of a range of factors that can compromise the development and well-being of children. Young people waiting years for service may well seek out ways to self-medicate, self-harm or cope using the limited tools they have in their school, home or community.

The Representative reiterates recommendations previously offered in both her own report *Still Waiting* (2013) and *Concrete Actions for Systemic Change* (2016), the report of the B.C. Legislature's Select Standing Committee on Children and Youth. The Representative is grateful for the important work undertaken by the SSCCY on the matter of mental health. It is regrettable that the committee was unable to give sufficient attention to Aboriginal child and youth experiences, but the Representative believes the committee's recommendation to limit assessment time frames for children and youth presenting with mental health challenges to 30 days, with treatment to follow within the next 30 days, is one that should be immediately adopted.

The Canadian Human Rights Tribunal earlier this year confirmed that Aboriginal children in Canada have historically received vastly inferior services to those provided to non-Aboriginal children. Aboriginal children wait for service like other children, but there is no question they wait longer, have less likelihood of receiving well-planned and coordinated services, and are not involved in designing and delivering those services as their families are marginalized and at times fearful of the ministry and how child protection and mental health services continue to be blended and combined.

Chester was a young person in crisis who received no meaningful therapeutic supports. Limited relationships were built with him and his family to engage him in service, assessment or treatment. He struggled to explain his situation and find some positive way to connect to peers and services while handling what was happening in his life. Transitions in Chester's life were not managed well – his school files were not managed properly, his learning needs were never comprehensively assessed and he demonstrated all the characteristics of a young person experiencing severe mental health issues and high distress.

Chester and young people like him are not served by waiting for service for long periods of time. This amounts to a refusal of service to a cohort of our most vulnerable children and youth. It represents a choice we've made not to surface their concerns, coordinate care, or make a genuine effort to meet them where they are – at times in distress and crisis and requiring urgent help.

So little has been done to make service levels better in the period since Chester died that it is not possible to conclude that an "improvement" process of any kind is underway. These children and youth and their families are waiting, many of them desperately, and it is well past time that government took the action required to help.

Appendix A: Representative for Children and Youth Act

Representative for Children and Youth Act, SBC 2006, c. 29 [RCY Act]

Reviews of critical injuries and deaths

11 (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 a 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 following purposes:

- (a) to determine whether to investigate a critical injury or death under section 12;
- (b) to identify and analyze recurring circumstances or trends
 - (i) to improve the effectiveness and responsiveness of a reviewable service, or
 - (ii) to inform improvements to broader public policy initiatives.

(4) If, after completion of a review under subsection (3), the representative decides not to conduct an investigation under section 12, the representative may disclose the results of the review to the public body, or the director, responsible for the provision of the reviewable service that is the subject of the review.

Investigations of critical injuries and deaths

12 (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.

(4) If the representative decides to investigate the critical injury or death of a child under this section, the representative must notify

(a) the public body, or the director, responsible for the provision of the reviewable service, or for the policies or practices, that may have contributed to the critical injury or death, and

(b) any other person the representative considers appropriate to notify in the circumstances.

Power to compel persons to answer questions and order disclosure

14 (1) For the purposes of an investigation under this Part, the representative may make an order requiring a person to do either or both of the following:

(a) attend, in person or by electronic means, before the representative to answer questions on oath or affirmation, or in any other manner;

(b) produce for the representative a record or thing in the person's possession or control.

(2) The representative may apply to the Supreme Court for an order

(a) directing a person to comply with an order made under subsection (1), or

(b) directing any officers and governing members of a person to cause the person to comply with an order made under subsection (1).

Multidisciplinary team

15 In accordance with the regulations, the representative may establish and appoint the members of a multidisciplinary team to provide advice and guidance to the representative respecting the reviews and investigations of critical injuries and deaths of children conducted under this Part.

Appendix B: Documents Reviewed for the Representative's Investigation

Ministry of Children and Family Development Records

- Family service files (3)
- Audit and special review of DAA

Delegated Aboriginal Agency Records

- Delegation agreement
- Service contract agreement
- Case notes

RCMP and Police Records

- Records from police departments (4)

Medical Records

- Crisis response team records
- Early Psychosis Intervention team records
- Hospital records
- Health authority records
- MSP records
- Medical specialist records

BC Coroners Service Records

- Coroner's report for the child

Ministry of Education Records

- Child's school records (2)

Legislation, Regulations, Standards and Policy

- British Columbia Child, Family and Community Service Act (1996) Victoria, B.C. Queens Printer
- Mental Health Act (1996) Victoria, B.C. Queens Printer
- Child and Youth Mental Health-Policy, Standards and Guidelines
- Aboriginal Operational and Practice Standards and Indicators

Appendix C: Interviews Conducted During the Representative's Investigation

- Family Members (4)
- MCFD staff (10)
- Delegated Aboriginal Agency staff (7)
- Regional health authority staff (5)
- School staff(10)
- RCMP and local police staff (2)
- Community and band employees (4)

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. Members meet at least quarterly.

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

- Ministry of Children and Family Development, Child Protection
- Policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal 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. Cory 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 Master of Arts degree at

UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

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.

Margaret Colbourne, MD, FRCPC – Dr. Colbourne is a clinical associate professor in the Dept. of Pediatrics at UBC and Director of the Child Protection Service Unit [CPSU] at BC Children’s Hospital. Margaret 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. Margaret 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. Dave serves on several BCACP 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 (SD 61). 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. Deb is an advocate for youth as they transition through our schools and into adulthood. Deb 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 support worker.

Michael Egilson – Michael Egilson is the Chair of the Child Death Review Unit for the BC Coroners Service. Michael 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 – Kate 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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