

A Soft Place to Land: Lessons for Client-Centered Care



Office of the Child and Youth Advocate
Newfoundland and Labrador

October 2020

Published by:
The Office of the Child and Youth Advocate
Newfoundland and Labrador
193 LeMarchant Road
St. John's NL, A1C 2H5

Printed by:
The Queen's Printer
Government of Newfoundland and Labrador

Message From the Child and Youth Advocate

The Canadian Mental Health Association reported in 2015 that suicide was the second leading cause of death among youth and young adults between the ages of 15 and 24; and in 2017 it expanded the age range to between 10 to 24. This is frightening and shocking.



There are increasing public discussions about mental health and mental illness and the veil is being lifted on a subject that has long been taboo. There is also a growing recognition of the holistic nature of health, healing, and recovery. These discussions and this increasing openness must translate into concrete changes in the ways systems work, and work together for the benefit of young people in Newfoundland and Labrador.

This report looks at the struggles of a young person with a history of sexual abuse, and a host of complex mental health and addiction issues. Interwoven were issues involving housing, residential services, the criminal justice system, and education services. In some instances, resources and services were clearly unavailable. At other times, significant resources were involved, but were not always appropriately coordinated and integrated. So while many people worked hard for this young person, systemic barriers significantly limited their progress. When you read this report, you will see that young people do not always fit into neat program criteria or eligibility requirements. Their lives can be chaotic and their life stories can often tell us why. They are frequently rooted in histories of trauma. It is important to meet young people where they are. I strongly argue that while the participation of youth is a critical component in defining their own care plans, they are often excluded from this pivotal role, and may not be recognized as experts in their own lives.

We frequently hear terms such as client-directed, patient-focused, or youth-centered, but the reality is that this is often not the case. System-focused is often the reality where the needs and structure of the system prevail. This led to the title “A Soft Place to Land: Lessons for Client-Centered Care”.

I have made every effort to ensure this report does not identify this young person. You will not find reference to gender, locations, regions, or dates unless it involves a provincial service that is situated in a single location. I request that all readers respect this young person's privacy, and that of the family.

I offer my sincere condolences to this family. You have experienced a loss that is unimaginable. This young person's life was important.



Jacqueline Lake Kavanagh
Child and Youth Advocate

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I . Introduction

The Office of the Child and Youth Advocate

Newfoundland and Labrador's Child and Youth Advocate is an independent Statutory Officer reporting to the House of Assembly. She derives authority from the **Child and Youth Advocate Act**. The role of the Advocate is to represent the rights, interests, and viewpoints of children and youth in Newfoundland and Labrador.

Section 15(1)(a) of the **Child and Youth Advocate Act** provides the Advocate with authority to receive, review and investigate a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the Advocate. The Advocate may release a public report upon completion of an investigation. The purpose of the report is to present findings regarding the services provided to young people and to make recommendations that will help prevent similar incidents from occurring in the future.

An investigative report does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the **Criminal Code** of Canada. It is intended to identify and advocate for system improvements and meaningful changes that will enhance the overall safety and well-being of young people who are receiving designated services. It is not about finding fault with specific individuals.

The investigative process may include sworn interviews, review of documentation and reports, file reviews, policy and legislative analysis, consultation with experts, examination of critical issues, research, and other factors that may arise for consideration.

About this Investigation

This investigation was called after learning of the suicide of a young person who was living in a group home. The youth was receiving Youth Services from the Department of Children, Seniors and Social Development and had previously been In Care, had received child psychiatric emergency and outpatient services, mental health and addictions services, and was on a waitlist for adult psychiatry through a Regional Health Authority at the time of death.

This investigation involved sworn interviews, a review of relevant case file documents, an independent external medical consultant's review, and an examination of relevant policy and legislation.

The Office of the Child and Youth Advocate contracted the services of Dr. Sandra Fisman as it conducted this investigation. Dr. Fisman is a Child and Adolescent Psychiatrist, and Professor in the Division of Child and Adolescent Psychiatry, Department of Psychiatry at the University of Western Ontario. She is cross-appointed to the Departments of Pediatrics and Family Medicine. Dr. Fisman provided an independent external review of the clinical notes, including the health and medical documentation pertaining to this youth. However it should be noted this was not a peer review. Dr. Fisman was engaged due to the extensive medical record information in this investigation, and due to the challenges with identifying an independent medical consultant within the medical community in this province.

Dr. Fisman has generously offered to share and discuss specifics of the dialectical behaviour therapy model as well as the adolescent suicide screening tools used in her jurisdiction with health officials in Newfoundland and Labrador. It is hoped that health authorities will include Dr. Fisman in their plans to move forward in Newfoundland and Labrador.

2 . Case Summary

This case involved a young emerging adult who died by suicide while living in a group home. The Department of Children, Seniors and Social Development and health care services had been involved for years. This young person had a complex psychiatric history, and had disclosed familial sexual abuse. In the year before the youth's death, a child psychiatrist diagnosed multiple psychiatric disorders. This young person also struggled with addiction to multiple substances. There was regular self-harm. The youth visited the hospital Emergency Department on several occasions for emergency treatment of self-harm wounds, overdoses, and suicidal ideation. In the two years prior to death, the youth visited the hospital Emergency Department 26 times, and presented as suicidal on half of those visits. In the four months before death, there were seven Emergency Room visits, where the youth presented as suicidal three times. This young person also received child psychiatry services on an outpatient basis. There were multiple changes in housing arrangements, extensive absenteeism or lack of access to school, criminal justice system involvement, and no ability to access residential treatment services.

However it is important to note this young person had access to a variety of other services at different times as well as concurrently. These included addictions counselling, mental health treatment services, Youth Services, alternate schooling, residential services, equine therapy, and tutoring. In conducting this investigation, it became clear that there were professionals who worked hard for this young person, however systemic barriers significantly limited their progress.

The Office of the Child and Youth Advocate investigated the involvement and responses of the following departments and agencies:

- Department of Children, Seniors and Social Development
- Department of Health and Community Services
- Regional Health Authority
- Department of Justice and Public Safety
- Police Services
- Department of Education and Early Childhood Development
- Newfoundland and Labrador English School District
- Group Home Service Provider

The youth's first interaction with the Department of Children, Seniors and Social Development (CSSD) occurred at 14 years of age with the disclosure of sexual abuse by the father. CSSD assessed the concerns and directed that the father could no longer reside in the same home. The police concluded there was not enough evidence to lay charges. This was a very difficult decision for this young person to hear and it created significant distress. After subsequent assaults on the mother by the youth, which were borne out of anger and a belief that the mother had not been protective, CSSD took the young person into care involving a placement in a staffed residential arrangement. This young person was returned to the mother's care for a brief period but assaulted the mother again. A judge subsequently granted continuous custody to CSSD.

While involved with CSSD, the youth resided in nine staffed arrangements. The final placement before death was a group home with co-residents. Prior to this placement, several professionals including the CSSD social worker and clinical program supervisor, dialectical behavior therapist, child and adolescent psychiatrist, and youth corrections social worker advocated that a single bed placement should be maintained. All were concerned that the introduction of other residents would likely have a negative impact on this young person's well-being. This was a specific concern, given the trauma history of sexual abuse as well as multiple mental health diagnoses.

The CSSD social worker explored several residential treatment options for the youth including Hope Valley Centre, which is a provincial youth residential addictions treatment centre. The young person's social worker documented that it was critical for the youth to receive intensive treatment as soon as possible, and that a youth treatment centre would be a better fit than an adult centre, due to the level of emotional maturity. In discussions between Hope Valley and the addictions counsellor at the Regional Health Authority, the placement was deemed unsuitable due to the young person's lack of engagement and motivation to attend treatment. While placement breakdown was a concern for CSSD, Hope Valley indicated it could not accept a youth based on placement issues. The youth told the CSSD social worker on two occasions that agreement to residential treatment was contingent on being able to return to the group home. While not accepted for Hope Valley residential services, the youth was offered continued addictions counselling services with the understanding that an appointment must be made within 14 days or the file would close.

Tuckamore Youth Treatment Centre is a residential facility for youth with complex mental health needs. While there is no official referral on file, this option was

also explored and it was determined that the young person had aged out of their range of services. A self-admission for detox to the Recovery Centre resulted in a one-night stay, and the young person left early.

The CSSD social worker also explored supportive housing options for the youth through government and community organizations including the Department of Advanced Education, Skills and Labour (AESL), Stella's Circle, and Choices for Youth. The youth either did not meet eligibility requirements or was placed on a waitlist.

While living in the group home, the youth began misusing prescription drugs and smoking marijuana. More than 400 incident reports were placed in the youth's group home file, with various concerns including suicidal ideation, suicide attempts, self-harm, misuse of medications, missed curfews, bullying, and aggressive behavior. A letter in the medical records from the youth's child and adolescent psychiatrist stated that the youth did not need to go to the hospital every time there was self-harm, as the youth was capable of letting the group home workers and social worker know when in need of emergency assessment. The youth signed another Youth Services Agreement upon turning 18, and remained in the group home. The group home provider agreed to continue with the residency, knowing the complexity of the youth's needs.

The child and adolescent psychiatrist contacted the Regional Health Authority's intake system for transfer to adult psychiatry four months in advance of the young person's 18th birthday. When the youth turned 18, the child and adolescent psychiatrist advised the family doctor of the youth's status and the family doctor agreed to monitor medications. Dialectical behavior therapy remained in place, as well as anger management counseling, addictions counseling, and equine therapy. However the youth remained on a waitlist for adult psychiatry until death occurred nine months later.

A host of professionals were seriously concerned about the youth's well-being while awaiting the transfer to adult psychiatry services. The CSSD social worker and clinical program supervisor documented their concerns with the gap in service experienced by the youth while on a waitlist for adult psychiatry. The youth's family doctor contacted the Regional Health Authority's intake system a few months before the youth's death to stress the urgent need for services. Intake indicated the youth would likely be on the waitlist for another year. It is obvious that this young person did not suddenly turn 18. In fact, with the length of the young person's involvement in the system and the extensive number of

service providers involved, the opportunity for advance coordinated planning and transition presented itself for years. However when this young person turned 18, there was a significant gap. Planning must begin earlier and systems must be better structured to ensure continuity of care for emerging young adults.

Connections in the education system are critical because they offer opportunities for daily support, social and professional contacts, and access to other non-school services. The education system also failed to respond in a meaningful way to meet this young person's needs. This youth experienced sporadic school attendance while in the Youth Services Program. The CSSD social worker contacted several schools and alternative community programs so the youth could complete high school. A school with alternate academic programming assessed this youth and determined lack of readiness for their program and placed the youth on a waitlist to reassess at a future time. The regular school system was also not able to accommodate this young person's situation and needs. Therefore this young person did not attend school in the four months prior to death.

Four months prior to the youth's death, meetings occurred between CSSD and the group home service provider. They discussed concerns that the youth was a risk to self and other residents in the home due to misuse of prescription drugs and marijuana. CSSD assessed this young person as being at high risk for accidental death. Up to one month prior to death, the youth frequently talked about suicide and made one overdose attempt. Two weeks before death, the group home service provider advised CSSD that the youth was not within the intended scope of its service agreement with CSSD because of age. There were behavioral issues and the group home service provider indicated it would terminate services if they suspected drug abuse or that the youth was providing such substances to other youth in the home.

The CSSD social worker attempted to engage an external nursing service to ensure medications were taken properly, especially since there had been incidents where the young person hoarded medications and was under the influence of alcohol and other drugs. However the nursing service said it could not help with this situation. The group home indicated it would give 72 hours notice to CSSD if it intended to terminate the placement. The youth was upset about a possible move. CSSD staff actively pursued other options and requested to move the youth to a single bed placement but this did not happen before the young person died.

In the 48-hour period before death, the youth disclosed an attempted suicide to group home staff. Group home staff called CSSD and the on-call social worker directed that the youth receive a mental health assessment at the hospital, or call the Mental Health Crisis Line. The youth refused to go to the hospital or contact the crisis line. The group home worker called the Mental Health Crisis Line on the youth's behalf.

The next morning, the CSSD clinical program supervisor directed the group home to ensure the youth received a psychiatric assessment at the hospital, and also telephoned the triage nurse at the Emergency Department to communicate all necessary information. The youth went to hospital accompanied by a trusted group home worker as requested by the young person. The group home worker reported that the youth met with a doctor for approximately five minutes and refused to speak with a mental health nurse. After attempting to leave the hospital, security escorted the youth back. After leaving a second time, police located the youth in the community. When the police called the hospital, they were told there were no grounds to detain the youth, so they returned the young person to the group home.

That night the suicide occurred. The youth left the group home in the middle of the night advising staff of a plan to return soon. There was an absent/missing person's protocol in place in the group home. This required the group home to notify the police if the youth missed curfew. When away from the group home without staff supervision, the youth had to check in verbally every hour, and every half hour if visibly upset when leaving the group home. Forty minutes after the young person left the group home that night, staff tried calling and texting the youth, and filed a Missing Person's Report with the police. Police found the youth deceased the next day. Death was determined to be by suicide.

3 . Findings and Recommendations

In her review, Dr. Fisman identified strengths in this case that are worth noting. She found that the availability of child and adolescent psychiatric care with access to hospital-based child and youth psychiatric consults and follow up were positive. She noted that the Janeway’s dialectical behavior therapy (DBT) program was a therapeutic strength and an appropriate intervention in this case. In reviewing the clinical notes, she commented that the DBT program leaders were responsive and skillful. Her recommendations are incorporated in this section on overall findings and recommendations.

The Child and Youth Advocate has identified the following systemic areas for improvement as a result of this investigation:

- The right for youth to be heard in matters affecting them
- Supportive housing for youth with complex needs
- Trauma-informed practice and risk assessments
- Emergency Room responses to youth
- Transitioning from child to adult psychiatric and mental health services

a . Right to be Heard

Article 12 of the **United Nations Convention on the Rights of the Child** states that young people’s opinions should be heard and considered in all matters affecting them. For a young person facing significant struggles, this is extremely important and must be meaningful according to their age and developmental level. The unique experiences and perspectives of youth must be considered in order to ensure responses, services and interventions will improve their well-being. This approach also provides a valuable means of engaging young people, motivating their participation and making sure responses and services are meaningful for them. On various occasions throughout this investigation, we saw how this young person identified their needs and expectations for housing arrangements, and the conditions under which they would be prepared to undertake residential treatment services. However the subsequent decisions did not reflect these discussions. Dr. Fisman also commented that this young person perceived not being heard when discussing the history of abuse. She believed this was likely a contributing factor to the youth’s deteriorating mental state. This is a systemic issue and young people’s perspectives and views must be considered in a much more meaningful and consistent way.

b . Supportive Housing for Youth with Complex Needs

After violent incidents at home, this young person was placed in a series of Individual Living Arrangements (ILAs). While there were significant struggles and challenges in this young person's life, there was a noticeable decline in overall well-being after subsequently being transitioned from a single bed Individualized Living Arrangement (ILA) to a group home with co-residents. Several professionals involved with the youth formally recommended against co-residents due to the youth's complex psychiatric history and sexual abuse trauma. Authority for final placement decisions rested with CSSD. While CSSD staff attempted to transition the youth to a single bed ILA, the youth died before this could happen.

Various professionals indicated this youth did not have the necessary life skills to live independently as an adult. The CSSD social worker had sought other supportive housing options and residential treatment options, but these efforts resulted in responses of either ineligibility or waitlists. The prospect of having to move out of the group home was a source of stress for this young person. This lack of appropriate supportive housing services for an emerging young adult with clear mental health challenges and limited life skills is not acceptable.

In its **National Paper on Youth Suicide** (2019), the Canadian Council of Child and Youth Advocates speaks to the importance of stability for young people coming from child welfare histories. It is important to ensure that challenging behaviors which are often based in histories of trauma, and which frequently result in multiple moves, are not used to deny services to young people.

Recommendation 1:

The Department of Children, Seniors and Social Development develop policy to require staff to actively seek and incorporate the perspectives of youth/young emerging adults into decisions regarding their housing, and to do so in collaboration with contracted service providers and community organizations.

Recommendation 2:

The Department of Children, Seniors and Social Development work collaboratively with the Department of Immigration, Skills and Labour, the Newfoundland and Labrador Housing Corporation and community housing advocates to enhance access to and availability of supportive housing options for youth and emerging young adults with complex needs. Youth must also be included in this collaborative process.

c .Trauma-Informed Practice and Risk Assessments

In **Taking the Next Step Forward** (2015), the Mental Health Commission of Canada defines a youth or young adult aged 16 to 25 as an “emerging adult”, to highlight the significance of this growth period as a dynamic process, rather than a prescribed number. According to the Commission, 75% of adult mental health illnesses emerge at this time.

In reviewing this case, Dr. Fisman noted availability of emergency care and accessibility to outpatient child and adolescent psychiatric services. Despite this, she noted this young person had several predisposing risk factors that added to psychological vulnerability. There were experiences of childhood trauma and diagnoses of Depressive Mood Disorder, Borderline Personality Disorder, and Attention Deficit Hyperactivity Disorder. There had been a delay in language and speech development. This young person also struggled with polysubstance addiction beginning at age 12.

Trauma had a significant impact on this young person, as it does on all children and youth affected. If unaddressed, childhood trauma has negative life-long implications on physical, emotional, and cognitive development (National Child Traumatic Stress Network, 2008). Childhood trauma has strong links to an inability to manage intense emotions and feelings. As a result, emotions such as fear, sadness and anger can be emotionally, physically and behaviorally intense and difficult to deal with and navigate. The youth in this case expressed chronic suicidal ideation with multiple attempts, had long-standing substance abuse issues, and exhibited ongoing behavioral issues.

Dr. Fisman pointed to childhood trauma being significant in this case, and

that “a trauma-informed approach by therapists and care providers is much needed even when a youth is still too emotionally unstable to engage.” Lack of engagement and emotional instability were hallmarks in this case. While they created significant challenges in providing services for this young person, it is important to see these as symptoms, with childhood trauma being the underlying issue. These types of behaviors need to be understood in their trauma-based context.

The Canadian Council of Child and Youth Advocates reinforced this in its recent **National Paper on Youth Suicide** (2019). The report states that when trauma is not effectively addressed, negative health and behavioral outcomes can be expected, and that child serving systems can potentially mitigate the adverse experiences of trauma on children by using trauma-informed responses and practice.

Dr. Fisman noted that the Regional Health Authority’s dialectical behavior therapy (DBT) program was an appropriate intervention for this youth. DBT assists individuals to develop coping skills to help manage strong negative emotions. She further commented that young people in Newfoundland and Labrador would benefit from a refined and expanded program to ensure access to these interventions across the province and which are in keeping with an intensive, evidence-informed treatment model. For the benefit of health authorities, Dr. Fisman identified potential areas for DBT improvement including expansion of the number of group sessions, inclusion of caregivers, one-on-one therapy, 24-hour crisis services, peer support groups, team consultations, and access to psychiatric consultation for medication management and psychiatric care. Dr. Fisman further reflected on the benefit of additional DBT skills training in both the health care system and in the community to build capacity in this area, and in the importance of hospital and community collaboration to enhance the overall response to the tragedy of youth suicide.

Recommendation 3:

Regional Health Authorities, and the Department of Children, Seniors and Social Development ensure front line staff as well as service providers delivering front line services on behalf of the department receive appropriate professional development on trauma-informed care for children and youth.

d . Emergency Room Responses to Youth

Dr. Fisman stated “It can be challenging to differentiate chronic non-suicidal self-harm from suicidal ideation, gestures and attempts with high intent, particularly in the context of an individual who has so frequently presented to the emergency room and to crisis services.” However, she suggested that suicide screening tools and suicidal ideation assessment tools might further guide the triage and assessment process. In its investigative report **17 Year Old Catherine** (2015), Alberta’s Office of the Child and Youth Advocate addressed similar issues where a youth was assessed for suicide several times by different professionals. The Alberta Advocate cautioned about reliance on self-disclosure information. One of the recommendations called for a review of how young people attending hospitals are assessed for suicide, and to standardize responses provincially based on best practices.

The Office of the Child and Youth Advocate in Newfoundland and Labrador has found that when young people visit hospital Emergency Departments for suicidal ideation or attempts, their experiences and responses vary within and among individual Regional Health Authorities. Some hospitals seem to routinely admit, assess, ensure the young person is stabilized, and participate in a collaborative release treatment plan, which is frequently the following day or shortly thereafter. Other hospitals and Regional Health Authorities seem to focus more on Emergency services and varied follow up, but with fewer admissions. This report offers no judgment on individual medical clinical decisions. However it is timely for the four Regional Health Authorities to individually and collectively examine their practices for assessing and responding to suicidal young persons. This would provide an opportunity to review and share best practices, screening tools, policies, and outcomes to ensure the best interest of the child is always at the forefront of decision making throughout Newfoundland and Labrador.

Recommendation 4:

The Department of Children, Seniors and Social Development coordinate with the Regional Health Authorities to ensure that all youth receiving services from the Youth Services Program are referred to or seen by a registered hospital social worker when requiring emergency medical treatment for physical or mental illnesses.

Recommendation 5:

The Department of Health and Community Services engage the Regional Health Authorities to review their policies, practices, and training for assessing and responding to children and youth who present as suicidal and self-harming, in order to ensure the best possible health care services are grounded in best practice and guided by the principle of best interests for children and youth.

Recommendation 6:

As team lead, the Department of Children, Seniors and Social Development ensure full implementation of Recommendation 47 in Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador for a provincial implementation plan for suicide prevention and furthermore with specific attention to the needs of children and youth in this plan.

Recommendation 7:

Where a child or youth has had multiple Emergency Room visits for suicidal ideation or self-harming behaviors, all Regional Health Authorities establish and implement a mandatory records review process to ensure appropriate risk assessments and/or mental health assessments have been completed.

e .Transitioning from Child to Adult Psychiatric and Mental Health Services

The Canadian Council of Child and Youth Advocates (2019) point to gaps in mental health treatment and care during transition that can potentially exacerbate mental health problems for youth. Dr. Fisman noted that transfer to adult care often involves communication challenges, service gaps and a high risk of drop out from care. Careful transition planning is needed, she noted “with overlap of youth and adult services and a warm handoff including the youth in the planning process as they cross the service bridge.”

When this young person died, there was no direct route for young emerging adults to move to adult psychiatric services. This young person graduated from child psychiatry services to an adult psychiatry wait list, and was on the waitlist when death occurred by suicide. The child psychiatrist ensured the family doctor was updated on the youth’s status and medications. However there was no ability to move the youth directly to the adult system and under the conditions Dr. Fisman identified. The lengthy wait and the uncertainty of the timing of access to the adult system were sources of stress, considering this young person’s trauma history. While there was and is an expectation for continuity of care, this office has found the practice to be inconsistent.

Recommendation 8:

Regional Health Authorities immediately streamline services and policies to ensure a coordinated and uninterrupted transition from child/youth psychiatry to adult psychiatry and to other mental health services, and to consult with youth mental health consumers in this process.

In **Taking the Next Step Forward** (2015), the Mental Health Commission of Canada recognized that emerging adults from specific populations, such as the child welfare system, have a greater chance of experiencing poor outcomes during their transition to adulthood and that a systemic response is needed.

Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador (June 2017) identified gaps in how the system responds to youth and young adults moving from the children’s mental health system to the adult mental health system. Recommendations 13 and 46 in **Towards Recovery** propose to reduce wait lists and wait times for mental health and addictions services, and to improve responses to young people transitioning into adulthood so that programs and services are geared to young people’s needs wherever they are. The Office of the Child and Youth Advocate will continue to monitor the implementation of these recommendations and others in **Towards Recovery**. This work is critically important and must continue as a priority focus.

4 . Final Thoughts

This investigation examined the responses and services provided to a youth with a history of sexual trauma, complex mental health issues, multiple psychiatric diagnoses, and addictions. It explored the lack of supports and coordinated responses. While various services were sought, they were frequently met with eligibility restrictions such as age, waitlists, and suitability, which prevented the youth from receiving the care that was desperately needed. While there is much talk about client-centered services, they can be quite scarce in reality. Too frequently, services exist in distinct silos without appropriate coordination and transitional supports. Young people with complex lives and histories often don't subscribe to a "one size fits all" menu. They do not always present to the system as the perfect client. Services need to be flexible, able to meet the youth where they are, and able to adjust with the changing dynamics.

Throughout this investigation, there were missed opportunities for actively including and placing this young person at the centre of their own planning process. This investigation revealed situations where this young person's wishes and interests were known and were supported by professional recommendations and advice, yet alternate decisions were made. At other times, there is no record of the youth's participation being sought. This young person had a significant history of trauma and was obviously struggling.

In these types of cases particularly, every opportunity must be used to create emotional and physical safety, motivate participation, validate experiences and expertise in their own lives, build and nurture strength and resilience, and jointly map a plan together based on principles of empowerment. Thoughtfully incorporating the voices of young people into all planning processes involving them must be a priority for all service providers. If this does not happen, significant barriers will impede successful outcomes for the young people seeking help in Newfoundland and Labrador.

Appendix I: Resources and References

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Appendix II: Investigative Process

Documents Reviewed:

Department of Children, Seniors and Social Development

In Care file
Youth Services file
Youth Corrections file
Group Home Provider file

Department of Health and Community Services

Regional Health Authority files
Hospital records

Department of Justice and Public Safety

Police records

Court Services

Court documents

Department of Education and Early Childhood Development

School District file

Investigative Interviews

Office of the Child and Youth Advocate

**193 LeMarchant Road
St. John's, NL A1C 2H5**

Telephone: (709) 753-3888

Toll Free: 1-877-753-3888

Fax: (709) 753-3988

Email: office@ocya.nl.ca

Twitter: @OCYANL

