

# SIXTEEN

# SIXTEEN



CHILDREN YOUTH  
NEWFOUNDLAND & LABRADOR



## Published by:

Advocate for Children and Youth  
Province of Newfoundland and Labrador  
193 LeMarchant Road,  
St. John's, NL. Canada  
A1C 2H5

October 2013

### INVESTIGATIVE TEAM

#### Advocate for Children and Youth

Carol A. Chafe

#### Lead Investigators

Karen Gray, MSW, RSW  
Janice Mullins, MBA  
Samantha Emberley, MSW, RSW

#### Investigators & Reviewers

Heather Lannon, MSW, RSW  
Jennifer Forristall-Prim, MASP

#### Expert Consultants

Peter Collins, CD, MCA, MD, FRCP (C)  
Umesh Jain, MD, FRCP(C), DABPN, MSc, PhD, Med

#### Legal Counsel

Marina Whitten, QC

#### Administrative Support

Amanda Mercer  
Danielle Luby

#### Graphic Design

Nicole Rogers

"Young people should be at the forefront of global change and innovation. Empowered, they can be key agents for development and peace. If, however, they are left on society's margins, all of us will be impoverished. Let us ensure that all young people have every opportunity to participate fully in the lives of their societies."

- Kofi Annan



# Table of Contents

Confidentiality Caveat .....	iii
Foreword.....	iv
Executive Summary .....	v
Introduction .....	1
Methodology .....	2
Mandates of Pertinent Service Providers.....	3
Background of the Family .....	15
Summary of Facts.....	16
Findings and Analysis .....	50
Conclusion .....	107
Recommendations.....	109
Bibliography .....	117
Appendices .....	121



## Confidentiality Caveat

Section 13 of the *Child and Youth Advocate Act (SNL 2001)* states:

- (1) The advocate and every person employed under him or her shall keep confidential all matters that come to their knowledge in the exercise of their duties or functions under this *Act*.
- (2) Notwithstanding subsection (1), the advocate may disclose in a report made by him or her under this *Act* those matters which he or she considers it necessary to disclose in order to establish grounds for his or her conclusions and recommendations.
- (3) A report the advocate makes under this *Act* shall not disclose the name of or identifying information about a child or youth or a parent or guardian of the child or youth except and in conformity with the requirement of subsection 29(2).

Subsection 29(2) states: “The advocate shall not include the name of a child or youth in a report he or she makes under subsection (1) unless he or she has first obtained the consent of the child or youth and his or her parent or guardian.





## Foreword

In Canada, each province and territory individually defines the age of majority, which is when a person is considered by law to be an adult and anyone under that age of majority is considered to be a minor. In Newfoundland and Labrador the age of majority is defined as nineteen (19) years. The *United Nations Convention on the Rights of the Child (UNCRC)* defines a child as under the age of eighteen (18) years.

At the age of nineteen (19) a person can legally purchase and consume alcohol and tobacco yet the age of consent for medical treatment is generally recognized as sixteen (16) years and the right to opt out of care is recognized as sixteen (16) years. I will not attempt to rationalize these discrepancies in age definitions, but I will clearly say that we as a society are failing our most vulnerable children who require our assistance and guidance into adulthood. Professionals who work with vulnerable youth who are sixteen (16) years of age and older face the delicate balance of providing opportunities for youth to participate in decisions about their health, safety and wellbeing while at the same time determining whether or not they have the capacity to make such life altering decisions.

This investigation reveals the story of a child who was crying out for help. Due to deficiencies in the system, there were times when his voice was not heard, his rights were not respected and his right to services was not upheld. The incident which prompted this investigation was a fire which resulted in the tragic death of a man and I extend my deepest condolences to his family and friends.

The goal of any investigation is not to lay blame but to identify what went wrong and how to prevent it from happening again. This investigation clearly demonstrates themes of deficiencies in services being provided by various government departments and agencies. It highlights several recommendations to improve the system and reduce the risk of another child experiencing the same.

For reasons of confidentiality this child will be known as “John.” I would like to acknowledge John and his family for their commitment to this investigation in the hope that it will influence necessary changes. In John’s own words, he stated to me: “...I just hope this doesn’t happen to somebody else really, it sucks” (Transcript of ACY Interview, 2012, p.117).

Every child deserves the right to be seen and to be heard. We, as adults and professionals, have the responsibility of always ensuring their best interests are always considered.



**Carol A. Chafe**  
**Child and Youth Advocate**

## Executive Summary

In December 2011, the Advocate for Children and Youth (ACY) initiated this investigation following a fire that resulted in the arrest of a sixteen (16) year old male. At the time of the fire, this young person, John, was a client of the Youth Services Program and Community Youth Corrections Program under the Department of Child, Youth and Family Services (DCYFS). During 2010 and 2011 John had involvement with services from multiple provincial government departments and agencies. The purpose of this investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services; the Department of Justice; the Department of Health and Community Services (DHCS); and the Eastern Regional Integrated Health Authority (Eastern Health) met John's needs and whether his right to services was upheld.

This investigative report provides an in-depth overview of the case. The events outlined in this report focus on the years 2009 to 2011 during which the majority of service provision by various government departments and agencies was provided. In 2011, after having an active file with the DCYFS for eight (8) months, John was removed from his mother's care by the DCYFS several weeks before his 16<sup>th</sup> birthday. When John turned sixteen (16) he signed a Youth Services Agreement (YSA); he left a supervised residential setting and moved to a shelter. After residing in two (2) different shelters he moved to a bedsitting room where he resided for seven (7) months until the date of the fire.

During this investigation, the ACY gathered pertinent facts, analyzed the information and recommended the changes necessary to prevent the occurrence of a similar situation. Some issues identified are specific to certain departments and agencies involved, while others permeate multiple departments and agencies. The prominent theme throughout this investigation was the lack of collaboration among all departments and agencies.

Primary deficiencies that were identified throughout the delivery of services from the Department of Child, Youth and Family Services to John include:

- lack of collaboration with other departments and agencies;
- lack of opportunities for the voice of the child to be heard;
- nonadherence to documentation policies;
- lack of documentation policies at the management level;
- lack of a comprehensive assessment;
- inefficient on-call services;
- delayed transfer of files within DCYFS programs;
- lack of appropriate training for social workers assigned to work in areas beyond their everyday assignment;
- misinterpretation of policy at the front line and management level;
- lack of planning for transitioning out of temporary custody;

- lack of incorporation of informed consent in Youth Services Agreements;
- inadequate and inappropriate Supportive and Residential Services available through the Youth Services Program;
- disjointed service delivery relationship with Choices for Youth;
- inappropriate dual case assignment of one social worker to fulfill the role of both the Youth Services Worker and the Youth Corrections Worker; and
- incorrect use of the YLS-CMI assessment tool.

Primary deficiencies that were identified throughout the delivery of services from the Department of Justice and the Royal Newfoundland Constabulary (RNC) to John include:

- lack of collaboration with other departments and agencies;
- nonadherence to RNC documentation policies; and
- nonadherence to RNC record keeping policies.

Primary deficiencies that were identified throughout the delivery of services from the Department of Health and Community Services and the Eastern Regional Integrated Health Authority include:

- lack of collaboration with other departments and agencies;
- lack of opportunities for the voice of the child to be heard;
- lack of proactive engagement with the client;
- inadequate assessment; and
- inadequate access to mental health services.

Overall, there are thirty (30) recommendations stemming from the completion of this investigation which are identified to the applicable departments and agencies.

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their views are heard and considered. The Office also provides information to stakeholders involved about the availability, effectiveness, responsiveness, and relevance of services to children and youth. The goal of this investigative report is to help significantly diminish the likelihood of any similar situation in the future.



## Introduction

On December 12, 2011, the Advocate for Children and Youth (ACY) served notice to the Deputy Ministers of the Department of Justice; the Department of Child, Youth and Family Services (DCYFS); the Department of Health and Community Services (DHCS); and to the Chief Executive Officer of the Eastern Regional Integrated Health Authority (Eastern Health) that she would be “conducting an investigation into the circumstances surrounding [John],” who was in receipt of services from these government departments and agencies. Details of initiating the investigation were outlined in written correspondence to all parties on the aforementioned date (see Appendix A). The investigation was conducted in accordance with the provisions of Section 15 (1)(a) of the *Child and Youth Advocate Act*, Statutes of Newfoundland and Labrador 2001. The investigation by the ACY was completed on May 3, 2013 following a careful examination of the services and interventions provided to John.

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their views are heard and considered. In doing so, the ACY may be required to review or investigate matters affecting those rights and interests. It is in keeping with this legislative duty that the ACY reports on the investigation and makes recommendations based on its findings. The goal is to prevent any reoccurrence of a similar matter. The purpose of this investigation was to determine whether or not the services provided by the DCYFS, the Department of Justice, the DHCS, and Eastern Health met John’s needs and whether his right to services was upheld.

The ACY is legislated under Section 13(1) of the *Child and Youth Advocate Act (SNL 2001)* to protect the identity of the parties involved in the investigation. To meet the rigorous requirements of confidentiality under the legislation, this report will identify the parents as Mom and Dad; the child will be known as John. This investigation focuses on the timeframe of 2009 to 2011 during which the majority of service provision by various government departments and agencies was provided to the family involved. This investigation contains various acronyms in use throughout the system, both before and after legislative changes occurred; official agency names and terminology are detailed in Appendix B.

## Methodology

Information was obtained from a variety of sources during the investigation in accordance with Section 21(1) of the *Child and Youth Advocate Act (SNL 2001)*. Case files and documents were provided by the Department of Child, Youth and Family Services (DCYFS); the Eastern Regional Integrated Health Authority (Eastern Health); the Department of Justice; the Royal Newfoundland Constabulary (RNC); and the Department of Education. This included documentation from Choices for Youth and Caregivers Inc. (Blue Sky). The information spanned a sixteen (16) year period. All written correspondence and records were thoroughly reviewed by the ACY. In addition, the Office reviewed policies, protocols and legislation that corresponded with the relevant time frames.

In accordance with Section 21 (1.2) of the *Child and Youth Advocate Act (SNL 2001)*, witnesses were summoned to appear before the Advocate and answer questions under oath in recorded interviews. The Advocate interviewed employees of the DCYFS, Eastern Health, the Department of Justice, the RNC, Caregivers Inc. (Blue Sky), and Choices for Youth. Several family members and caregivers were also interviewed. John was interviewed in April 2012 and again in January 2013.

Appendix C provides a complete list of investigative documents reviewed and interviews conducted. The bibliography contains all literature, websites, policies, standards and legislation reviewed by the ACY for this investigation. Prior to the final completion of the investigative report, to ensure administrative fairness, departments and agencies involved were provided with the opportunity to review and provide feedback on the factual sections of the report. Departments and agencies included in this process were the DCYFS, the DHCS, Eastern Health, the Department of Justice, the RNC, the Department of Education, Choices for Youth, and Caregivers Inc. (Blue Sky). John was provided with the opportunity to review and provide feedback on the full investigative report.

Two (2) psychiatrists practicing in Ontario, Dr. Umesh Jain and Dr. Peter Collins, were retained to provide opinions in the field of child and adolescent complex mental health. This process involved their review and analysis of information gathered by the ACY, as well as their review of documents and transcripts of interviews. They completed a written report of their conclusions on the case that was provided to the Advocate. Refer to Appendix D for the qualifications of the two (2) expert consultants, their statement of disclosure and the bibliography for their report to the Advocate.

# Mandates of Pertinent Service Providers

## Department of Child, Youth and Family Services

In 1990, the *Child Welfare Act* was revised from its original version of 1972 to better address the welfare of children. The 1990 *Act* governed child protection services in the province until 2000 when a new *Act* was implemented. It is evident that the provision of child protection services in Newfoundland and Labrador has undergone significant changes since that time. Up until 1997, the responsibility for child protection services was under the purview of the Department of Social Services (DSS). In 1997, DSS was renamed the Department of Human Resources and Employment (DHRE). On April 1, 1998, the Department of Health and Community Services (DHCS) assumed responsibility for the policy direction of child protection services. The responsibility for the administration, management and service delivery of child protection services in Newfoundland and Labrador was devolved from the DHRE to a number of Health and Community Services (HCS) Boards.

This change coincided with the development and implementation of the *Child, Youth and Family Services (CYFS) Act (SNL 1998)*, an Act that was not proclaimed until January 5, 2000. The policy that was developed under this legislation, *Child, Youth and Family Services Policy and Standards Manual* (in draft from 1999 until 2007), governed the changes from the previous DSS *Child Welfare Act (SNL 1972)*. All other policy direction was guided by the DSS *Child Welfare Policy and Procedures Manual (1993)*. The DHCS committed to ensuring this new policy manual would be consistent with the new legislation; it would acknowledge the new service delivery system through the various HCS Boards, and would incorporate current best practice knowledge.

Added to this commitment was the provincial focus on the need for improved risk management in child protection services. The DSS *Child Welfare Policies and Procedures Manual (1993)* included a risk assessment instrument. Reference No. 02-04-04 of the manual outlined the purpose of the tool: "The risk assessment instrument attempts to standardize the questions asked by child protection social workers to assure that the decision making process is more objective, more consistent and therefore more accurate" (1993, p.1). In 2003, the *Risk Management System (RMS, 2003)* was revised; it provided a "standardized framework that would increase consistency and objectivity in the decision-making process" (p.5). While the RMS was developed and disseminated to the regions in 2003, it was not fully implemented until April 1, 2005. The Risk Assessment tool was only available for use by social workers who had received training in RMS.

In 2005, further restructuring of the HCS Boards resulted in Child, Youth and Family Services coming under the four (4) Regional Integrated Health Authorities: Eastern, Central, Western and Labrador-Grenfell. Following implementation of the health authorities, the DHCS still did not have a direct reporting line from these



agencies; however, the DHCS did develop, monitor and maintain responsibility for the policies and standards of practice within CYFS programs.

In 2009, the Government of Newfoundland and Labrador established the Department of Child, Youth and Family Services (DCYFS). The creation of the Department required a transfer of services from the DHCS and the four (4) health authorities to the DCYFS. In 2011, new child protection legislation was proclaimed. The *Children and Youth Care and Protection (CYCP) Act (SNL 2010)* replaced the *CYFS Act (SNL 1998)*. Section 8 of *CYCP Act* states the purpose of the *Act*: “to promote the safety and well-being of children and youth who are in need of protective intervention.”

The *CYCP Act* provides the legislative authority for the delivery of services to children, youth and families including: the Protective Intervention Program, services for children and youth in care, placement resources and the Youth Services Program. *The Protection and In Care Policy and Procedure Manual (2011)* contains policies guided by the *CYCP Act*. All interventions address children in need of protective intervention and a range of supports and services are provided to reduce risk to children and youth. In the region of the Province relevant to this investigation, social workers are assigned to specific DCYFS program areas, including Intake, Assessment, Long-Term Protection, Adoptions, Youth Services and Youth Corrections.

Documentation has been and continues to be an important tool for social workers working with CYFS programs. The Client Referral Management System (CRMS) is an electronic database used by social workers to record interactions with clients and other client information. Social workers enter service notes in CRMS and these notes document both the date that the note was entered in CRMS and the date on which the interaction or activity referenced in the note occurred. According to the *CYFS Best Practice Guidelines for Using CRMS (2002)* relevant to this investigation, all social workers were “required to document all service notes in CRMS” (p.5). In July 2012, the DCYFS updated documentation standards with the creation of the *CYFS Documentation Guide*.

All DCYFS interventions from 2007 to 2011 for the child in this investigation provided under the Protective Intervention Program and the In Care Program were subject to the *CYFS Act*, the *CYFS Standards and Policy Manual (2007)* and the *Risk Management System Manual (2003)*. Services provided under the Youth Services Program were subject to the *CYFS Act and CYFS Standards and Policy Manual (2007)* until the *CYCP Act* was proclaimed on June 30<sup>th</sup>, 2011. When the *CYCP Act* was proclaimed, services were subject to the *Protection and In Care Policy and Procedure Manual (2011)*.

### ***Protective Intervention Program***

The Protective Intervention Program provides social workers with the legal authority to intervene in order to protect children under the age of sixteen (16). The program is designed to help ensure the safety and well-being of children for whom there is a risk of maltreatment by omission or commission of a parent. Referrals can be made by any individual or professional who is concerned that a child is or may be in need of protective intervention. Once a referral is received, Risk Management processes (Risk Management System 2003 prior to the implementation of the Risk Management Decision-Making Model in 2013) are utilized to determine if a referral will be investigated in accordance with the definition of a child in need of protective intervention outlined in the *CYFS Act* (prior to June 30, 2011) or the *CYCP Act* (June 30, 2011 onward). Once an investigation is complete the social worker determines whether the child protection concerns are verified and if the child needs ongoing protective intervention. If it is determined that no child protection concerns are present, the case is closed. If protection concerns are present, the response can range from the provision of services to a child and his or her family, the development of a plan with the family, to the removal of a child from the parents' care, depending on the nature of the concern and the degree of risk to the child. Currently, under the *CYCP Act* the *Risk Management Decision-Making Model (2013)* is utilized to determine if a referral will be investigated in accordance with the definitions of a child in need of protective intervention outlined in Section 10(1) of the *CYCP Act*.

A Child Protection Report (CPR) received under the *CYFS Act* (prior to June 30, 2011) was required to be assessed by a social worker at the intake level to determine whether or not further investigation was warranted. The *Risk Management System (2003)* guided the assessment process for referrals received. When determining whether a CPR was accepted for investigation, jurisdiction and reasonable grounds to believe a child was in need of protective intervention as defined in Section 14 of the *CYFS Act* were required to be met. Section 16 of the *CYFS Act* provided the authority to investigate. Section 14 of the *CYFS Act* defined a child in need of protective intervention as follows:

14. A child is in need of protective intervention where the child
  - (a) is, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent;
  - (b) is, or is at risk of being, sexually abused or exploited by the child's parent;
  - (c) is emotionally harmed by the parent's conduct;
  - (d) is, or is at risk of being, physically harmed by a person and the child's parent does not protect the child;
  - (e) is, or is at risk of being, sexually abused or exploited by a person and the child's parent does not protect the child;
  - (f) is being emotionally harmed by a person and the child's parent does not protect the child;

- (g) is in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;
- (h) is abandoned;
- (i) has no living parent or a parent is unavailable to care for the child and has not made adequate provision for the child's care;
- (j) is living in a situation where there is violence; or
- (k) is actually or apparently under 12 years of age and has
  - (i) been left without adequate supervision,
  - (ii) allegedly killed or seriously injured another person or has caused serious damage to another person's property, or
  - (iii) on more than one occasion caused injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing, either with the parent's encouragement or because the parent does not respond adequately to the situation.

### ***In Care Program***

Both the *CYFS Act* and the current *CYCP Act* have provisions that allow the DCYFS to remove children from their parents' custody and place them in the care of the state. When children and youth are placed in care, the DCYFS must act in the best interests of the child in arranging care. Relatives and significant non-relatives of the child should be explored as possible placement options. If no relatives or significant others are able to care for the child, the child is placed in a foster home or other residential setting.

Planning for children in care is outlined in Section 3.21 of the *CYFS Standards and Policy Manual (2007)*: "Planning for a child must be comprehensive, action based and continuous throughout the social workers intervention with the child and/or family" (p. 1). The development of a Plan of Care for children in the care or custody of the director of DCYFS was a requirement under the *CYFS Act*. Within the plan, a social worker was required to identify goals for the child which could include independent living.

The *CYFS Act* indicates that when a child turned sixteen (16) he or she can no longer stay in the care of the DCYFS. In these circumstances, he or she had the option to: return home, live independently with support from the Youth Services Program or not avail of any CYFS services. It should be noted that under the *CYCP Act*, the DCYFS legislation proclaimed on June 30, 2011 and currently in force, a youth in continuous custody may remain in care until their 18<sup>th</sup> birthday. However, a youth who is sixteen (16) or seventeen (17) years of age can ask to have his or her continuous custody order set aside. The youth must make a written request to a DCYFS manager and the manager has the authority to deny the request if he or she has concerns with the youth's mental capacity or ability to understand the consequences of his or her request. *The Protection and In Care Policy and Procedure Manual (2011)* states that all youth

must be informed of all options available to them including: availing of Residential and Supportive Services, remaining in the current placement or returning home to live with their parents.

### ***Youth Services Program***

Under the *CYFS Act*, the primary focus of the Youth Services Program is stated in the *CYFS Standards and Policy Manual (2007)* Section 4: “the safety, health, and well-being of youth.” Further, the goal of the Youth Services Program under the *CYFS Act* was to assist young people to make successful transitions to adulthood. The Youth Services Program continues to operate under the new legislation, the *CYCP Act*. It is a voluntarily program for youth seeking support which can include financial assistance, housing stability, life skills, identity development, educational opportunities, and emotional well-being. Youth engagement is critical to maximizing the youth’s success. It is recommended by the DCYFS that youth take advantage of all supports available to them and set goals for the future (Department of Child, Youth and Family Services, Protection and In Care Policy and Procedure Manual, 2011).

Section 11 of the *CYFS Act* guided the use of Youth Service Agreements (YSA). To be eligible for the Youth Services Program under the *CYFS Act* a youth was required to sign a YSA when he or she turned sixteen (16) years of age. The YSA was required to be reviewed every six (6) months and signed by the youth, social worker and manager. A youth entering a YSA was required to have contact with his or her social worker at least once a month. Under the *CYFS Act* a YSA could not continue beyond a youth’s 18<sup>th</sup> birthday unless the youth had been in care or custody of a director prior to his or her 16<sup>th</sup> birthday, in which case the YSA could be extended until a youth’s 21<sup>st</sup> birthday if he or she were attending school.

Section 67 of the *CYCP Act* currently guides the use of YSAs. Youth ages sixteen (16) to eighteen (18) years may enter into an agreement. The *Protection and In Care Policy and Procedure Manual (2011)* identifies the criteria for the Youth Services Program:

The program assists youth who are:

- at risk of maltreatment and can no longer reside with their parents;
- at risk of being asked to leave the family home;
- transitioning to the [*Youth Services Program*] from the *In Care Program*;
- transitioning home from the *In Care Program* and requesting support to assist with the transition (Policy no.:5.1).

In accordance with Section 67 of the *CYCP Act*, services may be provided to a youth who was not in the care or custody of a manager on his or her 16<sup>th</sup> birthday up to age of nineteen (19) if the youth is attending high school or an equivalent program. Services may be extended to the age of twenty-one (21) if the youth is in an education or rehabilitative program and had been in care or custody of a manager prior to his or her 16<sup>th</sup> birthday.

The Youth Services Program can provide two (2) types of services to youth: Supportive Services and Residential Services. Supportive Services can be offered to youth and their families to assist with family preservation and to prevent a youth from leaving the family home. These supports address issues that affect the safety and development of youth such as neglect, maltreatment, addictions and mental health issues. Support available to youth can include facilitating referrals to community agencies, crisis intervention, and case management. Residential Services can be approved for youth who live outside the family home. This support is provided to youth who are at risk of being maltreated by a parent, or whose parent is unwilling or unable to provide care. Residential and Supportive Services such as financial assistance and rehabilitative services can be offered to youth under a YSA.

When the custodial relationship between a manager and a youth ends, a youth may continue to reside in his or her foster home or group home placement under a Residential Youth Services Program as outlined in policy 3.18 in the *Protection and In Care Policy and Procedure Manual (2011)*. In a foster home, foster parents provide care to children. A group home is a staffed residential placement.

Policy 5.5 in the *Protection and In Care Policy and Procedure Manual (2011)* outlines the types of accommodations available to youth seeking Residential Services: board and lodging arrangements, bedsitters, emergency shelters, and apartments. In a board and lodging arrangement, a youth resides with a family and meals are provided. A bedsitter is a self-contained room in a home with other tenants. Kitchen and bathroom facilities are shared and the landlord does not live on-site. Shelters are emergency placements for youth who have no other accommodations. Shelters are staffed and are available for a short period of time until more permanent arrangements can be made. An apartment is an unassisted living space and includes a bedroom, bathroom, kitchen and main living area. In most cases apartments are reserved for youth who are pregnant or have children. Youth are responsible for securing their own accommodations; however, a social worker may assist youth to find housing.

Youth receiving Residential Services are entitled to monthly housing, personal and grocery allowances as well as coverage for medical, dental and vision care needs. Youth may also receive a school supply and high school graduation allowance as well as an annual Christmas and clothing allowance. Appendix E outlines the allowances provided to youth receiving services through the Youth Services Program under the *CYFS Act* and current legislation, the *CYCP Act*.

### **Community Youth Corrections**

Community Youth Corrections is a program of the DCYFS that is mandated to provide youth corrections services in the Province. Community Youth Corrections provides services to youth ages twelve (12) to eighteen (18) years who have come into conflict with the law or are at risk of coming into conflict with the law.

As stated in Policy 2.3 of *the Community Youth Corrections Standards and Practices Manual (2002)*, “The Community Youth Corrections program endeavors to provide a service delivery system which meets the requirements of the law, and maximizes opportunities for rehabilitation of the young person” (p.1). Objectives of the Community Youth Corrections Program include providing the least intrusive measures when sentencing, ensuring youth are supervised when serving sentences, engaging the youth’s family in the process and ensuring youth and their families have access to services and supports.

Social workers supervise and support youth who are serving probation, community service orders, personal service orders, custody and supervision orders, and deferred custody and supervision orders. Social workers also supervise youth who have received open custody sentences and are placed in group homes or community custody homes. Youth who violate the *Youth Criminal Justice Act (YCJA) (SNL 2002)* are given a sentence from a Youth Court Judge.

### **External/Contracted Agencies**

To ensure that the DCYFS is able to meet its mandate and provide care to children and youth, outside agencies are often contracted to provide supervision, housing and other supports. Two (2) such agencies are Choices for Youth and Caregivers Inc. (Blue Sky).

#### **Choices for Youth**

Choices for Youth is a community-based non-profit organization that operates from an empowerment philosophy (Choices for Youth, 2013a). The mandate of Choices for Youth includes working with youth who have experienced a breakdown in family situations, homelessness, a lack of a safe and supportive environment, ongoing issues with the justice system, Fetal Alcohol Spectrum Disorder, learning disabilities, mental health issues, anger issues, violence, isolation from the community, a lack of stabilizing influences in their lives, academic difficulties, an inability to find employment, a lack of positive role models, drug and alcohol issues, prostitution and/or other high risk behaviours (Choices for Youth, 2013c)

Choices for Youth provides a continuum of programs and services, focusing on two (2) core areas: housing and support. Housing programs include: Transitional Housing, The Lilly Building, Young Men’s Emergency Shelter and the Supportive Housing Program. Support programs include Outreach and Youth Engagement, Train

for Trades Program, Moving Forward Program, Jumpstart, and Momma Moments (Choices for Youth, 2013b).

### ***Supportive Housing Program***

The Supportive Housing Program is one of Choices for Youth's core housing program areas. Block funding is provided from the DCYFS through a Memorandum of Understanding between the St. John's Regional Health and Community Services Board and Choices for Youth dated June, 30 2004. The agreement states in part that: "Choices agrees that the services will be provided in accordance with the policies and requirements of the Health and Community Services Board/Integrated Board and Department of Health and Community Services" (p.3).

All referrals for this program are received from the Youth Services Program within the DCYFS. The Supportive Housing Program assists youth ages sixteen (16) to eighteen (18) to access housing options. To be eligible for this program a youth must meet the qualifications required for the Youth Services Program of CYFS, have signed a YSA and be unable to live at home.

The Supportive Housing Program provides financial assistance to youth to support them in obtaining housing. In addition to an assigned social worker from the Youth Services Program, youth are assigned a community youth worker from the Supportive Housing Program who can assist youth with budgeting, resolving conflict, legal issues, educational support, addictions and health issues. Youth are required to "check in" with their community youth worker once a month. It is the responsibility of the youth to find his/her own housing. The community youth worker can support the youth by meeting with the youth and the landlord to explain the expectations and rules. Ultimately, any rental agreement is between the youth and the landlord.

### **CareGivers Inc. (Blue Sky)**

CareGivers Inc. is a private agency that operates Alternate Living Arrangements (ALA) through the Child and Family Supportive Care Program. ALAs are twenty-four (24) hour staffed out-of-home residential placements for children and youth who have been removed from their parents' care and require a placement that is not available, including foster homes, group homes, or Independent Living Arrangements. ALA services are contracted by the DCYFS from Caregivers Inc. In 2011, CareGivers Inc. rebranded their residential care division and became Blue Sky.

### **Department of Health and Community Services**

The Department of Health and Community Services provides a lead role in policy, planning, program development and support to the four (4) Regional Integrated Health Authorities and other health and community service agencies. The Department monitors the Regional Integrated Health Authorities and agencies in respect to program implementation, accountability and health and community outcomes. The DHCS is

involved in initiatives such as Wellness, Healthy Aging, Mental Health and Addictions, Violence Prevention, Immigration Strategy and Poverty Reduction. The department is accountable for forty-one (41) pieces of legislation and ensures budget controls are in place and adhered to by the Regional Integrated Health Authorities and other agencies (Department of Health and Community Services, 2013a).

### **Eastern Regional Integrated Health Authority (Eastern Health)**

Eastern Health is the largest Regional Integrated Health Authority in Newfoundland and Labrador and provides a full continuum of health services. The vision of Eastern Health is to focus on both a community and individual approach to health. Eastern Health extends from St. John's to Port Blandford and includes the Avalon, Burin and Bonavista Peninsulas (Eastern Health, 2011b). More than eighty (80) hospitals, health care centres, long-term care facilities and community care sites can be found in this region. Eastern Health operates seven (7) acute-care facilities, including the Janeway Children's Health and Rehabilitation Centre (Janeway), six (6) community health centres, twelve (12) long-term care facilities, the Dr. H. Bliss Murphy Cancer Centre and the L.A. Miller Rehabilitation Centre (Eastern Health, 2011a).

#### ***The Janeway Children's Health and Rehabilitation Centre (Janeway)***

The Janeway is the only children's hospital in Newfoundland and Labrador and provides inpatient and ambulatory care to children from infancy to eighteen (18) years of age. Inpatient and outpatient child and adolescent psychiatry services are provided at the Janeway.

#### ***Janeway Emergency Department***

The role of the Janeway Emergency Department is to provide pediatric emergency care to patients and their families twenty-four (24) hours a day (Dr. Charles A. Janeway Child Health Centre, 1993). When a patient arrives at the Emergency Department they are assessed, triaged and treated accordingly. The Department's function is to assess and triage patients for immediate emergency services. In the absence of immediate emergencies, patients are streamed through normal referral processes. Medical and nursing assessments are provided as well as emergency care and referrals for medical followup.

#### ***Child and Adolescent Mental Health and Addictions Central Intake Program***

The *Operational Manual (2008)* for the Child and Adolescent Mental Health and Addictions Central Intake Program ('Central Intake Program') describes the program as: "...a one-year pilot program designed to improve accessibility, standardize the process of referrals, monitor wait times, and improve efficiency among six Community Mental Health and Addictions programs and resources" (p.3). The program is no longer a pilot initiative as after one year it was fully implemented. The six (6) programs are listed in the *Operational Manual (2008)*: Janeway Family Centre, Family Services Program,



Bridges Program, Youth Services Program, Janeway Adolescent Psychiatry and Addictions: Adolescent Outpatient Services, and the Rowan Centre. Central Intake is the first point of contact for children and youth seeking mental health and addictions services. Referrals to Central Intake can be made by youth, their families or a professional.

The *Mental Health and Addictions Program Overview (2008)* lists the Bridges Program as a mental health service available to youth ages sixteen (16) to nineteen (19) who have acute mental illness or who are having a mental health crisis and would benefit from short-term intervention from an outpatient program. In January 2011 changes were made to the mandate and the program is now available to youth ages thirteen (13) to seventeen (17) (up to the end of their 17<sup>th</sup> year). The Bridges Program can assist youth who are dealing with family issues and mental illness, including depression, suicidal and self-harming behaviours, and eating disorders. Services available include individual and family counselling, education, information on inpatient services and referrals to other agencies.

The Rowan Centre is a day treatment program for youth ages twelve (12) to eighteen (18) who have addictions issues that are negatively impacting their lives. The Centre is located in St. John's but accepts referrals from across the Province. It can accommodate ten (10) full time youth and the average program length is twelve (12) to sixteen (16) weeks. Once youth complete the day treatment program, less intensive follow-up services are offered (Department of Health and Community Services, 2013b).

The wait time for service begins the day a referral is written by a referral source. Referrals are screened and assessed over the telephone and all youth are assigned to the programs that are most appropriate to meet their needs. Once a referral has been made, it is the responsibility of that program to address inquiries regarding waitlists. Youth on a waitlist are advised to contact Central Intake if their situations change and are offered other supports while waiting for a space in a program (Child and Adolescent Mental Health and Addictions Central Intake Program, Operational Manual, 2008).

*The Operational Manual (2008)* for the Child and Adolescent Mental Health and Addictions Central Intake Program indicates that for youth under the age of sixteen (16), Central Intake makes every effort to include the parent or guardian in the process. The age of consent is generally regarded as sixteen (16); however, there is some flexibility for fourteen (14) to sixteen (16) year olds, depending on their mental and intellectual ability to make decisions. The age of consent is assessed on a case-by-case basis. Children under fourteen (14) do not generally attend therapy without a parent's consent. Central Intake employs intake coordinators who speak directly to youth who are sixteen (16) years of age or older. The youth can decide if they would like their parents to be involved in the process. A youth who is (16) sixteen years or older has the right to decline or avail of services. If the youth declines the service he or she will not be placed on the waitlist, even at the parent's or guardian's request. Youth who present with life threatening or very serious issues may not necessarily be removed automatically from the waitlist if they decline services. In these situations, Central Intake will try to involve

the family and referral source in the final course of action (Child and Adolescent Mental Health and Addictions Central Intake Program, Operational Manual, 2008).

### **Department of Justice**

The Department of Justice is responsible for the administration of the province's legal system. This includes the administration of the courts, policing, adult corrections, secure youth justice services, and victims' services. The Department of Justice provides an oversight function to the Royal Newfoundland Constabulary (RNC) as well as the Royal Canadian Mounted Police (RCMP). The general public relies on the Department of Justice to protect their rights, liberties and freedoms. Civil services are provided to government through legal advice and representation in litigation. Those who are accused or convicted of criminal offences as well as victims of crimes receive services through the justice system such as police services, court services, prosecutions, legal aid, victim services and support enforcement (Department of Justice, 2013).

#### ***Pre-Trial Services***

According to the *Pre-Trial Services Program Standards and Procedures Manual (2006)*, Pre-Trial Services (PTS) is a program provided through the Department of Justice and serves as an alternative to the pre-trial detention of youth to a closed custody facility. PTS is available to youth ages twelve (12) to eighteen (18) who appear for a bail hearing or request a bail review. Youth can be referred to the program through the crown prosecutor or defence lawyer. The purpose of PTS is to decrease the number of youth remanded and awaiting trial. PTS provides community supervision to youth released on interim orders sanctioned by the Youth Justice Court. The Court sets a number of conditions that youth availing of PTS must follow. These conditions can include abiding by a curfew, abstaining from drugs and alcohol, and attending programs deemed necessary by the Court. PTS staff members monitor compliance with conditions and provide the court with information used to assist in making bail decisions. PTS staff members can provide supervision through making daily contact via home visits or telephone calls, completing curfew checks, making referrals to other services such as mental health and addictions counselling and connecting with supports such as family or other service providers.

Policy 4.05.07 of *The Pre-Trial Services Program Standards and Procedures Manual (2006)* sets forth the standard for file closure:

1. The young person is sentenced or acquitted for the charges which resulted in their participation in the Pre-Trial Services Program.
2. The young person receives new charges and bail is denied and the previous undertaking is revoked.
3. The young person is 18 years old and receives new adult charges and is detained at HMP.
4. The youth's undertaking is varied and the condition of supervision by Pre-Trial Services Program is removed (p.1).

### **St. John's Youth Detention Centre**

*The Operational Admission Policy of the Newfoundland and Labrador Youth Centre (2010)* sets the standards for practices at the St. John's Youth Detention Centre. The Centre is located in St. John's and is a short-term holding facility for youth awaiting court appearances or youth who have been arrested overnight in the St. John's area. When admitted to a closed custody facility, all youth must receive a number of services including showers, clothing, information regarding the facility and a suicide risk assessment. Youth are not held at the facility if they appear to be under the influence of drugs or alcohol or are in need of medical attention. In these cases they are transported to the Janeway for treatment and medical clearance and will return back to the Centre upon release.

Youth arrested overnight are brought to the facility by police. During their stay at the centre, youth are supervised by youth care counsellors from the Newfoundland and Labrador Youth Centre. Sheriff's Officers provide transportation of youth to and from court. The court determines if the youth will be released or held on bail.

### **Royal Newfoundland Constabulary (RNC)**

The RNC is Newfoundland and Labrador's provincial police service and operates under the authority of *the Royal Newfoundland Constabulary Act (SNL 1992)*, as well as *the Royal Newfoundland Constabulary Regulations (1992)* and *the Royal Newfoundland Constabulary Public Complaints Regulations (1992)*. The RNC is responsible for maintaining peaceful and safe communities through a range of policing responses. The organization has three (3) branches: Patrol Operations, Criminal Operations and Support Services. The RNC is comprised of detachments in the Avalon region, Corner Brook, Labrador City and Churchill Falls. The RNC responds to violations of municipal, provincial and federal laws including the *Highway Traffic Act (SNL 1990)*, the *Criminal Code (RSC 1985)*, the *Youth Criminal Justice Act (SC 2002)* and the *Mental Health Care and Treatment Act (SNL 2006)* (Department of Justice, 2013, Royal Newfoundland Constabulary, 2011-12).

## Background of the Family

John was born in 1995 and resided with his mother until he was fifteen (15) years of age when he was removed from her care by the Department of Child, Youth and Family Services (DCYFS) and placed in an Alternate Living Arrangement (ALA). Several weeks later, on John's 16<sup>th</sup> birthday, he signed a Youth Services Agreement (YSA) and moved from the ALA to a shelter. Following stays at two (2) different shelters, he moved to a bedsitting room where he remained for seven (7) months until the house was destroyed by a fire. A man who also lived in the house died in the fire. John pleaded guilty and was convicted of offences in relation to this fire, including *Arson* and *Manslaughter*.

## Summary of Facts

The *Summary of Facts* provides a synopsis of information obtained in the investigation that supports the Advocate for Children and Youth's (ACY) findings and recommendations. In investigating John's involvement with service providers, the ACY reviewed documentation. When documentation did not provide sufficient detail, the Advocate conducted interviews with John, significant family members and professionals to seek clarification. Due to the high volume of social workers involved in this case, where multiple social workers from the same Department of Child, Youth and Family Services (DCYFS) program area are referenced, numbers are assigned to those who had significant involvement with John to distinguish their role throughout the period of investigation. Additionally, given that the majority of social workers are female, to further minimize the identification of specific professionals involved in this case, all social workers are referred to as female.

### 2009

In June 2009, Mom called the Royal Newfoundland Constabulary (RNC) as John, who was fourteen (14) years old, had been reportedly beaten up. The RNC responded and as part of their investigation, the police officer documented the following comments: "[John] has been the victim of bullying at school for a while now. There have been incidents where other kids have spit in [John's] face and called him names" (RNC File). The investigative outcome produced no charges and the file was closed.

In September, the RNC received a second call regarding John after he had been caught with drugs at school (RNC File). The police spoke with Mom who advised the officers that John had never been in trouble before. Under the *Youth Criminal Justice Act (YCJA)*, it was deemed appropriate for a warning to be issued by the police given such circumstances; no further action was required.

John's school records prior to Grade 9 indicate he had been doing relatively well; however, during Grade 9 he missed a total of thirty-one (31) days. This was the same year when John's drug use first surfaced.

### 2010

In January, the police received another call relating to John having drugs at school. The RNC made a Child Protection Report (CPR) regarding this incident. It was noted that Mom "did not want to take [John] back into her custody when he was released from questioning" (Child Protection Report). In a telephone conversation the following day, Mom informed Intake Social Worker (#1) that she believed John needed to be held accountable for his behaviour. She stated she would be seeking help through her Employee Assistance Program (EAP) and that she would follow up with addiction services and a parenting group at the Janeway. Following this telephone call, the social

worker commented: "File recommended to be screened out" (Client Referral Management System [CRMS] note).

Later that month, Mom called the police to report her son had been missing since the previous evening. Mom was unsure of John's whereabouts and said he was refusing to return home. Mom reported to the police that John was upset because he was recently involved with selling drugs at his school. She also informed the police that John had been suspended from school and that she had grounded him. The police responded to Mom's call for service and later that day John was located by an officer at a local restaurant. The police officer spoke with John and the 14-year-old admitted that he was stressed out and having trouble getting along with his mom. He was adamant about not going home and told the officer he was staying at his friend's house. The officer contacted Mom to let her know that the police had located John and he had advised he was staying at a friend's house. The officer recommended the file be concluded. The following day, the police officer's supervisor reviewed the call for service and highlighted the need for a CPR. This was communicated to the officer and a referral was completed that day.

Two (2) days after Mom reported him missing, John returned home after a telephone conversation with a police officer. Mom spoke with Intake Social Worker (#1) by telephone about the referrals made by the RNC and provided details of what had occurred over the past few days. Mom spoke about issues regarding John including how he was not following rules and not keeping his room clean. Mom advised she had followed up with her EAP and an appointment had been made. Intake Social Worker (#1) suggested that Mom follow up with a parenting group and "pick which battles she is willing to fight" (CRMS note). Intake Social Worker (#1) documented that Mom advised she did not feel intervention was necessary at that time. She advised Mom that the referral would be screened out.

In February, a referral was made by Mom to the Child and Adolescent Mental Health and Addictions Central Intake Program (Central Intake Program) for mental health counselling for John. It was documented that John refused services and Mom was informed that if he changed his mind he could call back. Documentation indicates that Mom was referred to the Parents Reaching Substance Using Teens Group. After no further contact from Mom, a social worker documented in April her recommendation to "close file" (Handwritten Note). Also in February, Mom was advised by police that charges would not be laid in connection with John selling drugs at school in January.

In late May, a referral was made by Mom to the DCYFS Intake Program. She stated to Intake Social Worker (#1) that she wanted her son removed from her home. Mom reported that John had continued to use drugs and had other young people in her home using drugs. In addition, Mom informed Intake Social Worker (#1) that John had recently put his "knuckles prints in the walls." She said he was staying out overnight, coming and going through the windows and he often ended up sleeping in the nearby tunnels. Mom reported that she had accessed her EAP for an appointment to see a counsellor and the counsellor advised Mom that John needed more help than the

counsellor was able to provide. The counsellor recommended psychiatric intervention; however, John refused services. Mom stated that she believed she was no longer able to keep him safe and putting him in care was the only thing she could do. The next day, Mom called the CYFS Intake Program again and spoke with Intake Social Worker (#1). Mom advised that John was sleeping in tunnels, using drugs, and as a result she was seeking immediate action for John. On the CPR John was categorized as a homeless child; he was fifteen (15) years old. The CPR indicates that the referral information would be investigated to determine whether John was a “child in need of protective intervention” as defined in the *CYFS Act (SNL 1998)* subsections 14(a) (is, or is at risk of being, physically harmed by action or inaction of parent) and 14(h) (is abandoned). The child protection file was opened and remained an active case.

Assessment Social Worker (#1) became involved in John’s case in May 2010; however, she did not record any notes in CRMS. Handwritten jot notes are contained in the file and in an interview with the Advocate, Assessment Social Worker (#1) confirmed that she authored these notes. In her handwritten notes, the following statements were noted: “suicidal in Dec – on facebook...”; “not eating – very emotional... dying in front of me!” The social worker’s handwritten notes indicate that she completed a home visit; the notes do not include who was present and does not give a detailed account of this visit. In an interview with the Advocate, Assessment Social Worker (#1) stated that her handwritten notes were missing detailed information obtained in interviews with Mom and John. The social worker informed the Advocate that she had discussed John’s behaviours, mental health and even the possibility of out-of-province treatment with Mom (Transcript of ACY Interview, 2012).

Assessment Social Worker (#1) completed handwritten notes indicating that she attended a school visit with John in May. She also completed handwritten notes dated on the same day which indicated she had a telephone conversation with Mom. The handwritten notes from this telephone call include: “feels story [*sic*] are delusional”; “Psychatrice [*sic*] Problem”; “Father used to do it – stories” (Handwritten notes). In an interview with the Advocate, John recalled being visited by a social worker at school when he was in Grade 9. He stated: “She came to my school, yeah. She said she was going to come back to see me after that one visit she had when I was in Grade 9... she never came back” (Transcript of ACY Interview, 2013, p.57).

A letter dated for June, was addressed to an RNC constable from Assessment Social Worker (#1) regarding information she had obtained. In the letter she referenced a conversation she had with the constable in May. The letter provided details regarding gang activity in the community. Assessment Social Worker (#1) stated in the letter: “It should be noted that there are concerns regarding [John’s] mental health which are being explored at this time due to drug use and a strong family history of Schizophrenia.” This information was forwarded to the Criminal Investigation Unit of the RNC. There is no further documented involvement by Assessment Social Worker (#1) in John’s file. In an interview with the Advocate, Assessment Social Worker (#1) confirmed that she stopped working in her position in June 2010 and had no further involvement with John (Transcript of ACY Interview, 2012).

A Safety Assessment form in the file identifies a date in May 2010 as the *Date of Assessment and Date Completed*. In contrast, the CRMS notes on file indicate the Safety Assessment form was actually completed a year and a half later in December 2011 by a different social worker (Assessment Social Worker #2) who was not the social worker involved in the actual referral (Assessment Social Worker #1). Assessment Social Worker (#2) noted: “[John] is deemed safe based on the previous workers *[sic]* hand written notes.” The program manager signed off on the Safety Assessment form in January 2012.

Assessment Social Worker (#2) documented in CRMS that she actually took over the file in August 2010. Her CRMS entry read: “This worker now responsible for this file as of this date as transferred to this caseload. No involvement with this file until the referral dated December...2010 was received” (CRMS note). With the exception of this CRMS note dated for August 2010, there were no other notes indicating activity on the case from May 2010 until December 2010 when a referral about John was received. The supervisor signed off on this referral at 4:00 p.m. and at 4:10 p.m. the referral was assigned to Assessment Social Worker (#2). As this was a Friday, the referral was then given to On-Call Social Worker (#1) to action.

The Referral Source (RS) indicated that John had been kicked out of his home the previous evening. John had what appeared to be a broken nose and two (2) black eyes. He told the RS that he had been involved in a fight the day before. The RS further stated that John was not planning on returning home but was wearing heavy clothing to “...spend the night outside.” The intake social worker was given information indicating that John was concerned about repercussions if a social worker went to his home and that John would be at his part-time job that afternoon. The RS went on to say, “[John] appears to be a youth reaching out for help.” On-Call Social Worker (#1) received this information as an after-hours report at 6:40 p.m.; three (3) hours after the referral was received by the Intake Program. The CPR indicated that the information would be investigated based on subsections 14(a) (is, or is at risk of being, physically harmed by action or inaction of parent) and 14(c) (is emotionally harmed by the parent’s conduct) of the *CYFS Act (SNL 1998)*.

At 11:53 p.m., On-Call Social Worker (#1) informed her program manager that she had been unable to action this referral because she had been involved in a case that had taken higher priority. The program manager directed On-Call Social Worker (#2) to contact Mom via telephone. The manager directed that if John did not return home, On-Call Social Worker (#2) should advise Mom to file a missing persons report with the police. According to CRMS notes, On-Call Social Worker (#2) attempted to contact Mom twice that night via telephone but there was no answer. The on-call program manager was informed that On-Call Social Worker (#2) was unable to reach Mom and directed that the referral be actioned on the following day. Mom’s recollection of this date is that she did not receive any phone calls from the DCYFS.



On Saturday, On-Call Social Worker (#3) was assigned the case for followup and conducted a home visit with Mom on Saturday morning. On-Call Social Worker (#3) wrote the details of her intervention on an 'Out of Hours Call' form. Mom informed On-Call Social Worker (#3) that she was unsure of his whereabouts but called her own mother and learned that he was there. Apparently, John had spent the night outside and had called his grandmother at 7:00 a.m. that morning to pick him up at a local restaurant. He was soaking wet and his grandmother believed he was under the influence of drugs. Mom showed the social worker an exchange of text messages between her and John from the previous evening whereby she had encouraged John to go to his grandparents or come home. John had stated in a text message that he did not know what he was going to do. The social worker advised Mom that she had to know John's location and if she did not, then she should contact the RNC and report him missing. Mom asked the social worker if someone could follow up with her on Monday so she could get assistance with the issues regarding her son. On-Call Social Worker (#3) did not interview John in response to this referral and there is no indication in the documentation that Mom was questioned about the injuries noted in the referral.

The next evening, John was brought to the Janeway hospital via ambulance. While John was at the hospital, a call was made by an Emergency Room (ER) nurse to On-Call Social Worker (#4) with the DCYFS. This nurse reported John had a nose injury and she had been informed that he had been kicked out of his house for the past two (2) weeks. John had indicated to the nurse that he did not want to go home. In response to this, On-Call Social Worker (#4) informed the nurse that she had been directed by her program manager to contact Mom and request she pick John up. The social worker documented that the nurse did not agree with the direction given by the program manager for Mom to pick up John. It was documented that On-Call Social Worker (#4) requested contact information and it was not provided to her by the nurse. The ER doctor had noted on the 'Emergency Room Record' that John's injury was of "questionable mechanism." The nurse documented that upon contacting the social worker: "...request for intervention/placement made" (Patient Progress Notes). She also documented that On-Call Social Worker (#4) informed her that there was a file open for John and there was no indication of abuse in the home. The nurse then proceeded to contact the on-call program manager who advised that in order to have John placed in care he would need to be removed which would require a judge's approval. It was documented by the nurse that: "Not once did [Social Worker] ask to speak to this young man concerning his wishes" (Patient Progress Notes). After receiving medical treatment for his injuries that included a consult with an Ear, Nose and Throat Specialist, John was discharged at 12:25 a.m. and left with his grandfather.

While John was at the hospital, On-Call Social Worker (#4) visited Mom at 11:30 p.m. Mom confirmed that a friend and her children had been there for supper that evening. The friend hugged John tightly and his nose, just previously broken, had started to bleed. Mom advised On-Call Social Worker (#4) that her son had stormed out of the apartment. She further explained she had been trying to get John to go to the Janeway over the past two (2) days but he refused. Again, Mom showed the social worker text messages where she was encouraging him to come home but he was

refusing. Mom talked to the social worker about the long-standing behavioural issues with her son; she said she was at her “wits end.” Mom said she had contacted John’s grandfather who then picked him up from the hospital and brought him home. On-Call Social Worker (#4)’s documentation reflects that shortly thereafter John ran away again. She encouraged Mom to file a missing persons report with the RNC. Later in the evening On-Call Social Worker (#4) called and Mom informed her that John was at his friend’s house. The worker noted on the ‘Out Of Hours Call’ form: “[John] has not been interviewed in relation to referral and appears to be major mental health issues as per conversation with [Mom].”

The next activity entry in CRMS is dated for December 2010; the note was added to CRMS over eleven (11) months later in November 2011. In fact, there were twenty-two (22) entries altogether with an activity date for December 2010; most were added to the system in either November 2011 or December 2011.

In interviews conducted by the Advocate, it was revealed that Assessment Social Worker (#2) and her program manager were away from the office on the Monday following the referral. Assessment Social Worker (#3) was asked to follow up on John’s file in consultation with another program manager. The CRMS notes indicate that a telephone conversation took place with Mom, during which Mom informed Assessment Social Worker (#3) that CYFS needed to find John a place to stay. The social worker advised Mom that it was Mom’s responsibility to ensure John had a safe place to live and that that they would need to meet to discuss a plan for John as soon as possible. As far as Mom knew, John was presently staying at a friend’s house. Following a consultation with a program manager, Assessment Social Worker (#3) spoke with Mom once again to advise her it was her responsibility to find a place for John to live. Mom was adamant that she could not do any more for her son and she refused to ask her friends or family if they could take him. In subsequent conversations with Mom, the social worker explored John’s father and grandparents as options for living arrangements; Mom reported that these were not options. Assessment Social Worker (#3) then spoke directly to the grandfather who confirmed what Mom had said; they were unable to care for John.

Assessment Social Worker (#3) contacted the police and advised of the CPR received on Friday. A copy of the report was sent to the police department and an officer spoke with Assessment Social Worker (#3) who advised that while there was no criminal allegation, “...as per CYFS policy, it had to be faxed to the police.” The RNC documented that the file would be concluded.

According to Assessment Social Worker (#3)’s CRMS notes, later that same day, a decision was made in consultation with the program manager to visit the residence where John was supposedly staying and discuss living arrangements with John and the family. The program manager and Assessment Social Worker (#3) also consulted with a senior manager and confirmed this plan of action. In an interview with the Advocate, this program manager explained why she consulted a senior manager: “I remember going to [Senior Manager] because I always went to a senior manager if I thought I might need

to remove a child” (Transcript of ACY Interview, 2012, p.15). The program manager recalled the direction given by the senior manager:

... I remember the direction was that no we were not going to remove him at that time...That, you know, this was a youth who was almost 16, you know, its days before Christmas, you know, and mom needed to take some responsibility in trying to figure out a plan for him (Transcript of ACY Interview, 2012, p.15).

The program manager informed the Advocate that she was advised by the senior manager to seek more information from Mom regarding potential places John could stay, including his grandparents and friends (Transcript of ACY Interview, 2012).

Assessment Social Worker (#3) attempted a visit but the family and John were just about to leave so they made a plan to meet the following morning. The same social worker, along with a co-worker, went to see John at this friend's house the following day. This was the first documented face-to-face meeting social workers had with John since the May 2010 interview completed at his school by Assessment Social Worker (#1). Assessment Social Worker (#3) determined that John had left his mother's house after an argument on the previous Wednesday and that he had gone to his great-grandfather's house to stay that night. He had spent an additional one to two (2) nights with his grandparents and then his friend's mother said he could stay there. The explanation of John's broken nose was that a person hugged him and a previous break had been re-injured. It was explained that the initial break had happened while John had been standing on a mud-covered rock and slipped off. Conversely, the RS reported that John indicated it happened as a result of a fight. The notes and comments concerning the broken nose were conflicting and it does not appear Assessment Social Worker (#3) questioned John to ascertain which explanation was correct. The social worker spoke to John about attending group or individual counselling but learned he was not interested and he would consider it in the future. She also asked him a number of questions about his past and current drug use.

The friend's parents were interviewed during this visit and they agreed that John could stay with them for a short period of time. A program manager was contacted and she agreed to the temporary arrangement with an appropriate assessment to be completed. John was not interested in returning home and was relieved that he could stay at his friend's house.

A Safety Assessment form was completed for this referral by Assessment Social Worker (#2) and John was deemed *Unsafe*. Assessment Social Worker (#2) noted on the form: "Assessment completed based on [Assessment Social Worker's (#3)] notes and discussion with her on her involvement with the family in Dec 2010." The *Date of Assessment* and *Date Completed* were recorded as December 2010; the assessment was signed by the supervisor in January 2012 – over one year later.

Over a five (5) day period, starting when the referral was received by the DCYFS, a total of fifteen (15) professionals had involvement in the assessment of John and his circumstances. Professionals included: seven (7) social workers, four (4) program managers, one senior program manager, one ER nurse and two (2) physicians. John informed the Advocate that he also had contact with additional professionals during this time; the RNC (Transcript of ACY Interview, 2013, p.43).

In the CRMS note written by Assessment Social Worker (#3), outlining her visit to John's friend's parents' home, it was documented that John reported he was stopped by RNC officers on the previous weekend:

The writer asked [John] to describe the details of what had occurred on Saturday. [John] stated that the RNC stopped him and his two friends and checked their book bags. He stated that the RNC ended up taking his wallet. The writer questioned same. [John] stated he does not know why they stopped him and took his wallet but he advised that the officer told him that they would find a reason to arrest him (CRMS note).

The above comment is the only documented information pertaining to this alleged incident in all files received for this investigation.

In an interview with the Advocate, John was asked if he recalled this incident. John stated that the incident occurred approximately 2:00 a.m. to 3:00 a.m. near a friend's house. John stated he was with friends when he was stopped by the RNC, physically searched and had his wallet taken by an RNC officer. In an interview, John recalled interacting with the RNC:

They said they had a suspicion of break and enters in the area, and then he went through my wallet, and then looked around through my wallet and stuff like that, and I never got it back. The cop said if they seen me out roaming around again later that night, they're going to arrest me (Transcript of ACY Interview, 2013, p.43).

John said that he didn't realize his wallet was missing until later that night after the officers had left without further investigation. He said that his wallet had contained items including his bank card, social insurance number and hospital card. John said that he informed the RNC officers that he was sixteen (16) years of age even though he was actually fifteen (15) at the time. John further stated:

... they said they were going to arrest me if they seen me out roaming around the streets again, and I told them, man, I got nowhere to go, I'm out on my own, and they said, sure, you're 16, you should be at home (Transcript of ACY Interview, 2013, p.51).

When John went to stay at his friend's home a few days later, John said his friend's father assisted him in trying to locate the missing wallet. John informed the Advocate that they went to two (2) RNC locations and were told by RNC staff that his

wallet was lost. The Advocate also interviewed John's friend's father who confirmed that he accompanied John to these RNC offices in an effort to locate the wallet. When asked by the Advocate if the RNC gave John's friend's father a rationale for taking and keeping the wallet, John's friend's father stated:

I never got that answer. I never did get it, but I did go – we sat in a room and the Sergeant went out and called the officer at home... He called him at home... They'd lost it, and [John] said, this is my wallet somebody gave me, because [John] don't have much property. He was given a wallet. A matter of fact, he don't have much belonging of anything. So anything that he had, it was a possession and it meant a lot, you know what I mean, and his identification or there were some pictures in it and stuff like that, and he really wanted that back" (Transcripts of ACY Interviews, 2012, p.7)

John and his friend's father informed the Advocate in separate interviews that the wallet was never returned and John was not compensated for his belongings.

## 2011

In January 2011, two (2) weeks after the home visit to John's temporary accommodations, a CRMS note added by Assessment Social Worker (#2) indicated that John's friend's family, with whom he was then residing, had been the subject of concerns in the past. Despite this revealing information, there was no follow-up action documented. The information was added to CRMS in January 2012, over one year later and was the first recorded action on the file by Assessment Social Worker (#2).

A week later, the friend's mother with whom John was residing spoke by telephone with Assessment Social Worker (#2). The social worker was assigned this file since August 2010; however, this marked her first direct involvement in this case. This was also the first documented social work contact with the people who were caring for John since the home visit in December 2010. The mother was reporting that John needed a tutor for Math and she wondered about an allowance to help with expenses. Assessment Social Worker (#2) indicated she needed to review the file and speak with her manager before proceeding any further. She also wanted to speak with Mom.

The next day Assessment Social Worker (#2) spoke with Mom via telephone; the notes were added to CRMS almost eleven (11) months later in December 2011. Mom reiterated her belief that John needed a mental health assessment. He did not want to follow her rules which were that he should attend school, shower, brush his teeth and not allow garbage to build up in his room. Mom reported that John had not brushed his teeth regularly in three (3) years and that was "not normal". Mom also said he was working at a restaurant every night and was failing in school. She said John had threatened to kill himself and her. Assessment Social Worker (#2) documented in the CRMS note: "[Mom] reported that she has been told CYFS is waiting until [John] is 16 so we don't have to do anything with him. She stated that he needs to be helped right now or he won't be" (CRMS note). She refused to provide any money to the family

cares for John but said she would pay for tutoring if he was doing his school work. Again, Mom stated the need for John to have mental health services; Mom was advised by Assessment Social Worker (#2) that it was her responsibility to seek proper help for her son as she is the parent. The social worker further documented: "It is not the role of CYFS to provide or ensure [John] seeks mental health assistance..." (CRMS note).

The following day, Assessment Social Worker (#2) consulted with her program manager and noted the strategies she would now take. The plan included: to further research the family John was living with; find out how John was doing; advise his friend's mother that she could apply for the Child Tax Benefit; contact John's school to see if he was attending and if they offered tutoring; and call the Janeway Hospital to see if John could "get in to see someone." This note was added to CRMS almost eleven (11) months later in December 2011.

In subsequent CRMS notes outlining activity that occurred in mid-January, Assessment Social Worker (#2) detailed the conversations she had with the friend's mother and the school guidance counsellor. These discussions consisted of information sharing without any long-term planning. It was noted that the school was unable to provide tutoring services as John was in the basic program. A follow-up consultation between Assessment Social Worker (#2) and her program manager took place during this time and various strategies were to be discussed with John and Mom. John would be asked if he was open to addictions counselling and Mom would be asked if she wanted her son home. To the worker's knowledge, Mom had not been having contact with John.

The day following this consultation with her manager, Assessment Social Worker (#2) learned from Mom that John had returned home. Mom said her son was feeling guilty now and all she expected of him was that he would attend school and not have food left in his room (CRMS note). Mom reported that John believed there was something wrong with his brain and that the family doctor would not prescribe any medication until John had a psychiatric assessment.

Several days later, Assessment Social Worker (#2), who was assigned John's file since August 2010, conducted her first home visit; this was the first documented conversation any social worker had with John in one month. The social worker and John had a discussion about his broken nose; it did not happen at home and John did not want to discuss this further. The social worker learned that John did not feel happy and he had not been taking pills since last summer. John consented to the social worker sending a referral for counselling services.

Mom was also interviewed on this date and she talked about the difficulty of being a single parent. She admitted to raising her voice when John would not do what he was asked; mainly attend school and keep his room tidy. Mom was prepared to attend counselling; however, as she was working two (2) jobs her free time was limited. Mom stated she wanted John back with her but she needed help for him. Mom reported she had seen evidence of John's paranoia many times. She said she was sometimes

afraid of John as he looked like he could “rip her face off.” Mom went on to say, “My son needs psychiatric help” (CRMS note). On this date, Assessment Social Worker (#2) made a referral for John to the Central Intake Program.

Less than ten (10) days after this home visit, another referral was received by the DCYFS concerning John. Mom telephoned On-Call Social Worker (#1) at approximately 8:00 p.m. because she was fearful that John was going to harm himself. Her son had been threatening suicide on a regular basis, twice on this date. He had made threatening comments to her as well. Mom reported that John had punched holes in the wall and had broken her computer. She said that John told her he had been using drugs again but she believed this was his way of crying out for help. Even though she did not want John to work that day, he insisted on going and his grandparents drove him to his workplace to ensure he arrived at work. Mom was frustrated that nothing was being done about her son’s mental health issues. Mom reported that John would be turning sixteen (16) soon and stated: “CYFS is waiting for his birthday because then he will no longer be their problem and he can fall through the cracks of the system” (CRMS note). A plan was devised whereby Mom would pick John up after his shift at 11:00 p.m. and take him to the Janeway Hospital for a mental health assessment. If John refused to go voluntarily or was not at work, then the police would be notified for assistance. Mom believed the Janeway should admit John, not just assess him.

Later that evening, prior to getting John at work, Mom had called the police to advise them of the situation and the tentative plan. When she picked her son up, the police met Mom at her residence and John reported to them that he was experiencing suicidal ideation. The police asked John why he needed to go to the hospital. John advised them that he wanted to harm himself and felt his life did not have a purpose. He further told the police that he had a history of suicide attempts, depression and drug use. John was escorted to the Janeway by police and Mom followed in her own car. The police remained at the hospital during this time and sent a CPR to the DCYFS prior to closing their file.

The ER physician spoke with John and Mom at the Janeway. It was documented on the Pediatric Emergency Room Record form that Mom was frustrated with the lack of services and felt her son needed mental health support. John’s drug use was discussed and the physician documented that John had been unhappy for many years and had attempted suicide in the past. Examples were documented of the strained relationship between John and his mother. The ER doctor documented that John had no plan to harm himself on this date; however, she noted statements John had made related to self-harm (Pediatric Emergency Room Record). It was documented that John had school in the morning and he wanted to go home. John was discharged and the physician sent a referral the following day for Mental Health and Addictions Services, specifically the Bridges Program and Addictions Program.

When she returned home from the ER, Mom reported to On-Call Social Worker (#1) with the DCYFS that she and John were sent home from the Janeway. Mom expressed disappointment in the services received given that John had made

statements about harming himself both to the police and the ER nurse. Mom reported that John had not been seen by a psychiatrist but by an ER physician who told Mom that her son had no plan to harm himself. On-Call Social Worker (#1) documented that Mom reported she was told by the physician that John needs to stop using drugs and that, "...a psychiatrist will not see John until he has stopped using drugs" (CRMS note). Mom reported that the police on the scene had agreed with her assessment of her son. She continued to express frustration with the system saying she had five (5) different social workers since the previous month and many times they had not returned her calls. Mom and the social worker discussed the plan for the next morning and Mom made arrangements for John's grandparents to come and escort him to school in the morning as she would be working. Mom advised that she was disappointed with the entire hospital experience and that she would be contacting departments and agencies with these concerns.

The following day school was cancelled and Assessment Social Worker (#2) made arrangements to complete a home visit with John. Mom was at work but John's grandfather was present. Assessment Social Worker (#2) learned that John had been drinking the previous Friday and was using drugs. She also learned that John wanted to continuously bash his head off a wall when he gets mad. The social worker documented that there had been a past physical altercation and now John was having thoughts of doing serious harm to his mother. This information prompted the social worker to contact her program manager who, in turn, recommended that the police escort him back to the Janeway Hospital. John volunteered to go with the officers; his mother and aunt attended at the hospital.

An ER physician initially assessed John and determined that a psychiatric consult was required. The psychiatry resident who saw John during this visit did not believe he was a threat to himself. This resident noted the following impressions: Conduct Disorder (CD), Polysubstance Abuse, Antisocial Personality Disorder traits, parent/child relational issues, and drugs. She noted to rule out substance induced mood disorder. The psychiatry resident consulted with the supervising psychiatrist who approved her assessment. The psychiatry resident, as part of her duty to warn, advised John's mother that she should charge John for threats he made against her. The psychiatry resident explained the duty to warn in an interview with the Advocate:

... it's a duty to warn when you're – you know, when you're competent to make that decision and you are threatening someone, then the safety concern lies within we would warn the appropriate party. So warn the person who's being threatened, warn the police, and inform the person who's threatening to hurt someone else, that that has been put in place, so you've threatened to kill this person, I've told them, I've told the police, and, you know, you're being monitored... (Transcript of ACY Interview, 2012, p.25).



Assessment Social Worker (#2) documented that the psychiatry resident advised her that John had CD and was a “criminal” (CRMS note). The social worker documented that the resident suggested a bed at a detox centre for John and advised Mom that she should press charges against John. Mom informed the RNC that she did not want to press charges but she was unwilling to allow John to return to her home. The police informed Mom to call them if she changed her mind about pressing charges. John was discharged from the ER with a follow-up appointment for the next month. Upon John’s discharge from the hospital, a telewarrant to remove John from the care of his mother was obtained pursuant to subsection 25 of the *CYFS Act (SNL 1998)*. Assessment Social Worker (#2) took John to an Alternate Living Arrangement (ALA) early that morning. John got up the next day and went to school.

The next day, after consideration of the advice from police and the resident, Mom changed her mind about pressing charges against John and she called the police in order to do so. A Safety Assessment dated for February 2011, which deemed John as *Unsafe*, was signed off by the social work supervisor in January 2012, almost one year later. Assessment Social Worker (#2) noted the following on the form:

[John] was removed with a Telewarrant ... and placed in an emergency Caregivers Inc. ALA due to his mother refusing to allow him to be in home and [Mom] charging him with uttering threats to cause harm or death (Safety Assessment).

Based on CRMS notes, it appears that Mom was prompted to press charges by the psychiatry resident who had made three (3) telephone calls to Mom suggesting she call the police. The psychiatry resident informed the Advocate in an interview that she did not document such telephone calls; however, she did recall speaking with Mom in the ER where she explained that pressing charges could serve as a way to protect Mom and obtain support for John, such as mandated treatment. In an interview with the Advocate, the resident spoke about concerns for Mom: “... the major safety concern that I remember having that night was towards the mother especially after she had revealed that he had hurt her in the past and threatened her” (Transcript of ACY Interview, 2012, p.16).

The police arrested and charged John that evening; he spent the night in custody at the Youth Detention Centre. During his stay at this Centre, a standardized suicide assessment form was completed by a youth care counsellor. Based on his responses, John was deemed ‘*Not at Suicide Risk*’ (Suicide Assessment). The following day, John was interviewed by the coordinator of Pre-Trial Services (PTS) as part of the referral process to the program. It was deemed a partial interview as John’s level of anger was too high for completion. Following his initial Youth Court appearance, to which he was accompanied by Assessment Social Worker (#2), John was released back to the ALA with court-imposed conditions until the matter could be heard again in court. These conditions required John to keep the peace and be of good behaviour, to stay away from Mom, her home and her place of work and to honour the conditions of his contract with PTS. The contract with PTS required John to avoid substance use, reside at a

particular location, abide by a curfew, and participate in programs/counselling/meetings as outlined by PTS. No such counselling or programs were arranged. PTS conducted nightly telephone check-ins with John for the next five (5) weeks. Throughout the course of these five (5) weeks, John demonstrated cooperation with the program, he abided by his curfew and ALA staff noted he was a "pleasant" young man.

Three (3) days after seeing the psychiatry resident at the ER, John attended a follow-up appointment with the same psychiatry resident. The ALA staff person reported that John only stayed for ten (10) minutes before getting angry and leaving abruptly. In her handwritten notes, the psychiatry resident indicated that John was still having thoughts of suicide, especially with the possibility of jail looming over him. She noted he continued to have thoughts of harming his mother and he had a history of being verbally abused; however, there is no documentation to indicate that the doctor shared this information by way of a CPR or even apprised Assessment Social Worker (#2) of same. Again, the diagnosis for John was CD and the need to prescribe medication to lessen his aggression was considered but not explored due to the likelihood that he would misuse the medication. The resident indicated that John would benefit from treatment and followup if he was motivated to do so. He had been accompanied to the appointment by one of the ALA youth care workers. The ALA worker made notes and commented on John's agitation, particularly when the psychiatry resident spoke to John about his Mom. Also on this date, Assessment Social Worker (#2) sent a fax to the Central Intake Program for John to be seen; an ER doctor had already sent a similar referral several days before.

On this same day, John's grandmother left a voice message for Assessment Social Worker (#2). It was documented in the CRMS notes that she was upset and she stated that "[John] was a good boy..." and if the worker wanted to interview her, she was available (CRMS note). John's grandmother left a subsequent message for the same social worker of a similar nature and she offered assistance with the situation. There was no documentation indicating that the grandmother was ever contacted in response to these telephone calls. Assessment Social Worker (#2) indicated in her notes she did not have a telephone number for John's grandparents; however, social workers had contacted them in the past to see if they could care for John.

Also on this date, Mom called Assessment Social Worker (#2) and advised that she suspected John had returned to their house and had even gone into his room. She told the social worker that she wanted his house key returned to her. There is no documentation indicating this information was passed on to the police even though one of the conditions of John's release was for him to remain away from his mom and her house. Assessment Social Worker (#2) did call PTS to let them know of the occurrence but they said, without proof, there was nothing they could do. There is no documentation indicating whether John was asked if he had gone to his mother's house. Later that evening, staff at the ALA called and left a voicemail message for Assessment Social Worker (#2). The staff member indicated he was looking for direction regarding a suspicion that John was under the influence of drugs. Subsequently, the staff person contacted an on-call social worker who advised that if

John was under the influence of drugs, he should call the RNC and follow up with this on-call social worker again. Abstinence from drugs had been a condition of his release; however, the file does not reflect any followup nor a call to PTS to report suspicion.

Several days after John was placed in care he was moved to a different ALA where his first weekend passed without incident. Also on this date, Assessment Social Worker (#2) met with the ALA program manager. The social worker commented that she was unsure of what would happen to John when he turned sixteen (16) but she suspected that his supports would be outlined in a Youth Services Agreement (YSA). Assessment Social Worker (#2) documented a subsequent telephone call with a staff member at the ALA and noted that the on-call worker had not forwarded a report to her regarding drug use. Assessment Social Worker (#2) reiterated that if ALA staff suspected any drug use, they should call the on-call worker and possibly PTS. The on-call worker would then decide if the police should be informed.

Assessment Social Worker (#2) documented that she spoke with a staff member from the Central Intake Program in February. This person reported that John had declined every service that had been offered to him. She recommended that, as he had declined services, Choices for Youth would be a good option for him. The social worker provided the staff member with telephone numbers for John and his mother. The following day, the Central Intake Program staff person left a message at the ALA for John. The next day, John said he would avail of their program; however, four (4) days later he refused. John was given a telephone number to call in case he changed his mind about wanting to avail of mental health services.

A few weeks before John's birthday, Assessment Social Worker (#2) called Choices for Youth to inquire about available services. The social worker learned that Choices for Youth could provide help with employment, housing, meals, and support for addictions and mental health. The Choices for Youth worker advised Assessment Social Worker (#2) that John would need to call them and set up an appointment to speak with someone in their outreach program. The social worker commented that she was unsure whether John would have a Youth Services file when he turned sixteen (16).

Subsequent to that call, Assessment Social Worker (#2) visited the ALA to speak with John. He advised he was planning to go to Choices for Youth and he did not want the social worker to go with him. The social worker asked the staff at the ALA to inform her when John had met with Choices for Youth staff.

In a letter to Assessment Social Worker (#2) dated February, a senior manager with the DCYFS approved John's placement at the ALA until April. It was also noted on this day by Assessment Social Worker (#2) that there was no placement medical on file; a document that was supposed to be completed within 24 hours of John's removal and placement. The medical was completed later that day along with the required Plan of Care. A handwritten note on the Plan of Care indicates it was not filed with the court because a temporary custody order had already been granted and "he was shortly turning 16." In this document, Assessment Social Worker (#2) provided a synopsis of

the events that led to John's removal from his mother's care. It indicated that Mom was: "unable to make a plan to meet [John's] basic physical needs such as a living arrangement" (Plan of Care). It was documented that since John had come into care he was attending school and appointments. It was also noted that John was following his PTS conditions and the rules set in the ALA. There were six (6) recommendations in the Plan of Care:

1. It is recommended that [John] be placed in the Temporary Custody of the Director of Child, Youth, and Family Services for a period of 3 months.
2. [John] will reside in an approved caregiver home.
3. Individual counseling for [John] will occur upon his agreement.
4. Services from Choices For Youth will be sought after for [John] to ensure he is connected with services when he is 16 years old.
5. No visitation will occur at this time due to [John's] court ordered conditions to remain away from his mother's address and any building in which she resides.
6. [Mom] to continue to work cooperatively with Child, Youth, and Family Services in case planning (Plan of Care).

According to notes written by the psychiatry resident, a case conference took place in February. The purpose of the case conference was not clearly defined, nor was any list of attendees added to the notes. The resident presented John's case to the participants. Documented suggestions included: to consider potential diagnoses of Obsessive-Compulsive Disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD) and Psychosis; conceptualize where John's anger is coming from; and obtain collateral information. In an interview with the Advocate, the resident clarified that this case conference was for educational purposes: "... the purpose is for teaching, you present a case you found interesting without revealing personal information. And then everyone sort of discusses the case, whether they have any other suggestions or ideas..." (Transcript of ACY Interview, 2012, p.40). The resident said that participants would have been psychiatrists and other team members, including nurses and social workers. This was not a formal case conference. There is no documentation on file indicating any subsequent communication was made by the psychiatry resident to John, his mother or the DCYFS.

Assessment Social Worker (#2) completed an application dated for February, requesting services for John through the Youth Services Program. Information on the front of the application suggested it may have been completed at a later date as the writer documented John's address as the one he obtained in March 2011. It is not clear if John was advised of the referral that had been made to the Youth Services Program on his behalf.

According to this Assessment Social Worker (#2)'s notes, the ALA program manager advised via telephone that John would be able to stay at his present location

beyond his 16<sup>th</sup> birthday under a YSA. Assessment Social Worker (#2) conveyed that she would be speaking to John about Choices for Youth and would advise him to make an appointment. She further commented that John “needs to start to do certain things on his own” (CRMS note).

Assessment Social Worker (#2) documented that John was “stressed out” on the day of his family court proceeding (CRMS note). At court, both Mom and John consented to an order that John would remain in care until he turned sixteen (16) years of age. Following the court decision, Assessment Social Worker (#2) made a second visit to the ALA and learned that John did not want to go to addictions counselling as he felt he had stopped the habit on his own; he only used drugs now when he was upset. Assessment Social Worker (#2) spoke with him about calling Choices for Youth to make an appointment and John signed a release permitting the worker to contact Choices for Youth to ascertain information about John’s future plans. John advised that he would call Choices for Youth the following day. During a telephone conversation the next day, Assessment Social Worker (#2) learned that John had not yet called Choices for Youth and still did not know what he wanted to do when he turned sixteen (16).

Staff at the ALA questioned Assessment Social Worker (#2) about any potential issues she might have concerning another fifteen (15) year old youth who was moving into the facility with John. She documented her response: “I felt that [John] would be okay with another 15-year-old male and he would be moving from the ALA shortly due to him turning 16...” (CRMS note). On this same day, Assessment Social Worker (#2) called a youth services intake social worker with the Youth Services Program. This intake social worker advised that John could go ahead and complete the application process for housing under Choices for Youth but he could not sign the actual YSA until he was sixteen (16). Since the program was voluntary, John had to agree to participate. The youth services social worker suggested a meeting with John; he would need to be approved for Youth Services before Choices for Youth could help him. The youth services social worker advised that Choices for Youth staff would go with John to look at housing options. It is not clear from the file documentation if any meeting with Youth Services occurred before John’s birthday.

Following her conversation with the youth services social worker, Assessment Social Worker (#2) spoke with staff at the ALA who informed her John had not yet called Choices for Youth. They suggested that John should stay at their location for a longer period because “...he has no skills such as cooking and cleaning” (CRMS note). Assessment Social Worker (#2) documented that she provided the staff with the telephone number for the youth services social worker she had spoken with earlier. The ALA staff informed her that they would try to get John to call on this date.

The following day, John appeared in court concerning the charges of Uttering Threats against his mother. The matter was set over until March so John could meet with his lawyer to discuss his plea options. John’s uncle was in the courtroom and he offered to attend the meeting that John was supposed to have with Youth Services. The next day, John advised ALA staff he had tried calling Choices for Youth but did not

get an answer and he would not leave a message. The staff person encouraged him to leave a voicemail and someone would get back to him.

Two (2) days later, ALA staff noticed some unusual behaviour from John during the early evening. He had been frequenting the washroom with heightened regularity. After John and another resident went out, staff checked the washroom; they noticed a strong smell of marijuana and called the two (2) teenagers to come back. John admitted to rolling a joint but he did not appear to be high. Staff did not immediately report the incident to the DCYFS via a telephone call but the information was later faxed to Assessment Social Worker (#2). It is not known whether PTS were notified about the incident.

In late February, the ALA supervisor submitted a weekly summary of progress notes in the Home Supervisor Report. She commented on John's moods, behaviours and activities. It appeared as though John was making progress in completing chores and becoming more independent. His grandparents had been in touch with him and he had gone to their home on a number of occasions for dinner. His uncle was also staying in touch and he picked John up several times a week to give him rides to appointments and he attended court with him. John's anger about his mom seemed to have subsided and he was not talking about drugs or violence. Staff noted that his personal hygiene was still an area of concern. It was also mentioned in the report that John had attempted to call Choices for Youth but he refused to leave messages (Caregivers Inc. Home Supervisor Report).

A few days before John's birthday, Assessment Social Worker (#2) spoke with the Supportive Housing Program coordinator with Choices for Youth who advised that John and his uncle would be meeting with her later on this date. The Supportive Housing Program Referral Form was e-mailed to the Assessment Social Worker (#2) and completed by her on this date. It was noted on the form that John had not shown any sign of verbal or physical aggression to any staff person he had encountered; he only reacted negatively when his mother was mentioned. In response to a question on the form regarding the supports John would need, Assessment Social Worker (#2) documented: "I feel that [John] will need financial assistance to live independently, help with transportation such as a bus pass" (Supportive Housing Program Referral Form).

Following the meeting with Choices for Youth, John returned to the ALA where staff noted he was very quiet and wanted to be alone in his room. The next day, the ALA program manager left a voicemail message for Assessment Social Worker (#2). He advised that it appeared John did not understand the consequences of not contacting the Youth Services Program. He suggested that the social worker have a discussion with John to emphasize the consequences of not making these arrangements with Youth Services. The ALA program manager advised that he did not want John to turn sixteen (16) with "...no place to go" (CRMS note).

Two (2) days later, Assessment Social Worker (#2) called the ALA program manager back and was told by him that John could stay at their facility past his 16<sup>th</sup>

birthday as long as he signed the YSA. This was brought to the attention of a program manager within the DCYFS the same day and it was noted by Assessment Social Worker (#2) that the suggestion for John to stay in the ALA needed to be brought to the senior manager. It should be noted that there was already a letter on file from another senior manager that stated John could stay at the ALA until a date which was past his 16<sup>th</sup> birthday.

The program manager with the DCYFS and Assessment Social Worker (#2) discussed other options and the program manager suggested that the social worker contact the grandparents to see if John could stay with them and financial support would be provided. They planned to contact Mom to discuss any options she might have. They also discussed the possibility of placement with John's uncle and planned to explore funding for that option. After their meeting, Assessment Social Worker (#2) called Mom who advised that neither John's grandparents nor her sister would be able to care for him. She went on to say that her son needed a psychiatrist and there was no help for teenagers in this Province. The social worker advised: "I was calling today in relation to him having a supportive place to live and not a psychiatrist" (CRMS note).

Next, Assessment Social Worker (#2) called an intake worker with the Youth Services Program who advised John could not stay at the ALA after his 16<sup>th</sup> birthday. Despite this, the intake worker informed Assessment Social Worker (#2) that she could ask her program manager about the possibility of him remaining at the ALA. Assessment Social Worker (#2) also learned in this conversation that no personal allowance for John would be forthcoming under the Youth Services Program as he was employed and based on his net earnings he would not be entitled to an allowance. The youth services intake social worker told Assessment Social Worker (#2) to go ahead and transfer John's In Care file and to enter her notes after the transfer was made.

Assessment Social Worker (#2) again consulted with her program manager following her discussion with the youth services intake social worker. The social worker documented: "...discussed to talk to [John] to let him know he needs to find a place to stay as he is to move from the ALA..." (CRMS note). Again, the suggestion was made to Assessment Social Worker (#2) to call Mom and see if there was a family member who could take John – this despite a conversation fifty (50) minutes earlier with the exact same direction.

Less than one hour later, Assessment Social Worker (#2) contacted Choices for Youth and the supportive housing coordinator spoke about her meeting with John and his uncle earlier that day. The coordinator believed John was not a good candidate to live on his own because of his past drug usage and she recommended that a board and lodging arrangement might be more suitable. However, she went on to say there was nothing available at that time and she was dealing with three (3) other referrals prior to John's. The coordinator advised that John's uncle did not state he will have John stay with him but indicated he may be able to take John in the future. Later, in her CRMS notes, Assessment Social Worker (#2) stated she made a call to determine more information about John's uncle.

That afternoon, Assessment Social Worker (#2) visited John at the ALA. She discussed housing options with him and he stated he would be calling his grandparents and his aunt. John told the social worker that none of his friends had sufficient room for him and his uncle could not take him. The social worker asked if he was worried about what his birthday would bring and the decisions he would have to make as he turned sixteen (16); he indicated that he was unsure. The social worker completed the Youth Risk Screening Tool with John. Documented need/risk factors included in the tool were housing, financial support, and transportation. The social worker documented her recommendations on the tool: "Assist [John] with finding an appropriate living arrangement and help him understand the responsibilities he now has for himself" (Youth Risk Screening Tool). When the social worker left the ALA that afternoon, there was no definitive plan in place for John's upcoming birthday which was just one business day away.

As documented by Assessment Social Worker (#2), the program manager directed that consultation with senior management was required for John to stay in the ALA past his birthday. There is no further record in John's file regarding any consultation with senior management. When interviewed by the Advocate, the program manager indicated that she had at least two (2) undocumented discussions with the senior manager about John. The program manager stated:

... at that time what we talked about was the fact that we don't have the capacity in any way, shape, or form legally or otherwise to have this kid here in an ALA, which is a placement for children... that are care in of the Director, he wouldn't be in the care of the Director at that point in time because you cannot extend care to a child that's not in continuous custody (Transcript of ACY Interview, 2012, p.118).

When interviewed, the senior manager stated that keeping John in the ALA would have been outside the mandate and policy; however, she indicated that she had consulted with a senior official to determine whether John could remain in the ALA until further arrangements were made (Transcript of ACY Interview, 2012). She informed the Advocate that this request was not approved. She recalled the conversation with the senior official:

...but the answer was, no, and then I had more discussion with her about, you know, look, if there is nowhere – if we can't make suitable, you know, we'd need to keep him. So it was at that point I was directed to – and I think I subsequently told [Program Manager] that we needed to exhaust every option, which included shelters... (Transcript of ACY Interview, 2012, p.22).

When interviewed by the Advocate, the senior official stated that she did not recall the alleged consultation whereby she reportedly denied a request for John to stay in the ALA. The senior official stated:



... I still find it very difficult to believe, even comprehend, that I would have said that a child would have had to...leave an ALA on his 16<sup>th</sup> birthday and to move into a shelter that wasn't designed for youth. That is, you know, inconceivable that I would have done that... (Transcript of ACY Interview, 2012, p.25).

The weekly summary completed by the ALA home supervisor indicated John was of the strong belief that he was being "kicked out" of his current arrangement. The ALA home supervisor documented that it appeared John had a lack of understanding about what he would be doing regarding his involvement with Choices for Youth. John would not listen to staff members explain what was going to happen regarding his moving from the ALA.

On John's birthday, Assessment Social Worker (#2) called John's grandmother and documented that John's grandmother wished she could take John but she did not think she could handle it. She stated that John thought the Youth Services Program was going to place him in an apartment and that this was not realistic. The social worker then called the ALA to determine if John had come up with any ideas about accommodations and documented that staff questioned her about the possibility of John staying there longer. She advised the ALA staff that this was not an option. To the best of the staff's knowledge, John had not made any calls about a place to stay and he was still insisting that he was getting kicked out of the ALA. The staff advised the social worker they had a gathering planned later that day to celebrate John's birthday.

Assessment Social Worker (#2) then called John's uncle who advised her to call back later that day, as he wanted some time to think about having John come live with him. Mom had called the social worker and left a message asking what the plan was for her son. Assessment Social Worker (#2) called her back and advised she would be contacting shelters. She documented that Mom stated John did not follow rules and did not understand the reality of the situation. She also said that her son was telling people that the ALA had kicked him out and Choices for Youth turned him down. Assessment Social Worker (#2) informed Mom that John would have to sign a YSA soon and that she would speak to her manager about John staying at the ALA one more night. Next, Assessment Social Worker (#2) spoke to John's uncle who confirmed he was unable to take his nephew. Assessment Social Worker (#2) then consulted with her program manager. The CRMS note stated:

...there can be no extra night in the ALA for [John] and he will need to go to the shelter or find other living arrangements. [John] can go to court tomorrow in a cab. This writer to talk to [Youth Services Worker], YS worker, about how to get [John] to and from school and if it is a bus pass then [John] can use cabs until the bus pass arrives. This writer to move [John] to the shelter tonight and if someone is brought forward I would look into the address to determine if it is appropriate (CRMS note).

Starting at 10:25 a.m. on the morning of John's 16<sup>th</sup> birthday, Assessment Social Worker (#2) then made a number of calls to shelters in an effort to find a placement for John. She learned there was a bed available at a local shelter. The shelter staff was apprised of his pre-trial contract and its conditions, including his curfew. Assessment Social Worker (#2) advised that PTS would call nightly to ensure John was abiding by his conditions. After a discussion about his background and needs, Assessment Social Worker (#2) advised the shelter staff to set up a room for John for eighteen (18) days. If an extension was required, the social worker advised she would call back. Shelter staff outlined the rules to the social worker including no drugs or alcohol, no smoking inside the building, all residents must be in by midnight and a zero-tolerance policy with breaches of those rules. While the shelter did not have a youth counsellor on site, the shelter worker advised they had a youth group that John was welcome to participate in. A youth services social worker called later in the day and indicated the program would provide John with a monthly bus pass but only if he was attending school.

Assessment Social Worker (#2) spoke with John's uncle again who reported his niece (John's cousin) was prepared to take him into her home. She indicated in her notes that her intent was to visit the cousin's home and she would take John with her. She also noted that John would take taxis to school until his bus pass arrived. Assessment Social Worker (#2) called the uncle back to provide him with an update. She told him John would be staying at the shelter for the following two (2) nights. John's uncle reported he would be attending court with his nephew the next day regarding John's charges.

On the afternoon of John's birthday, Assessment Social Worker (#2) documented that she visited the ALA for his birthday and to move him to the shelter. She spoke to John about the possibility of staying with his cousin to which he was receptive. John was advised he would be staying at the shelter in the interim and documentation indicated he was "fine" with that. PTS were notified of the change of address and John was taken to the shelter where the rules were explained to him. It was documented that John wanted to return to the ALA for birthday cake and he had already made arrangements for his uncle to pick him up there as they were going out. A YSA signed by John, Assessment Social Worker (#2) and her program manager is contained in John's file dated for John's 16<sup>th</sup> birthday. In an interview with the Advocate, John spoke about signing his first YSA: "I might have read, like, the first page. I just more or less signed them to get them done" (Transcript of ACY Interview, 2013, p.15).

At 5:30 p.m., Assessment Social Worker (#2) dropped John off at the ALA where he was later picked up by his uncle. She told him to call her if he had anyone he wanted to stay with or if he had any questions. The ALA Home Supervisor Report indicated John had limited time to participate in his birthday celebration because of the move; the report noted, "[John] left the home with tears in his eye [*sic*], and was unable to say goodbye" (Home Supervisor Report).

While it is documented in CRMS that John was required to move from the ALA on his 16<sup>th</sup> birthday, an interview with John revealed that he had a different

understanding. When asked by the Advocate what his social worker explained to him regarding his 16<sup>th</sup> birthday, John stated:

She told me I could have stayed in the group home, I think, until I was 18, but I kind of wanted to get out on my own because in the group home, I couldn't stay out at friend's houses or go to family for a night (Transcript of ACY Interview, 2012, p.44).

On the day of his birthday, John said he "figured" he would be leaving the ALA. He further stated: "They told me [Assessment Social Worker (#2)] would be dropping by and then she said get your stuff ready, we're going" (Transcript of ACY Interview, 2012, p.55). Following this John said he was taken to a shelter. When asked why he had to go to the shelter, he stated: "Because once I was under Youth Services, I wouldn't have been allowed to live in the group home anymore" (Transcript of ACY Interview, 2012, p.55).

The closing statement on the ALA Home Supervisor Report reads: "[John] was a pleasure to work with. He is a very kind young man who has a lot of potential to be a successful young man" (Home Supervisor Report). It should be noted that during his time at the ALA, John attended school on a regular basis and continued to work his part time job.

The next day, John attended provincial court in relation to charges for threats against his mother; he was given a disposition of probation. As captured in CRMS notes authored by a youth corrections intake social worker, "The details of the offence sounded quite serious but despite the same, Judge [---] did not add a condition for counselling on his order." Following his conviction and sentencing, PTS was no longer involved with John as the service was not needed. This meant John did not have a court-imposed curfew. It also meant he was no longer restricted from his mother's place of residence or employment. There is no documentation indicating that this change was communicated to the shelter. Assessment Social Worker (#2) also learned that morning that John's cousin had changed her mind about having him live with her. It was documented that on the following day Assessment Social Worker (#2) made several unsuccessful attempts to contact Mom to inform her of the court disposition and where her son was now living. Mom's recollection was that she did not receive any phone calls from Assessment Social Worker (#2) that day.

An intake worker with the Community Youth Corrections Program met with John to outline the conditions of his probation order and what the expectations of him would be. At the meeting, John told the worker of his past drug use and anger management issues. The worker gathered additional information from John and used it two (2) days later to complete the *Youth Level of Service Case Management Inventory (YLS-CMI) - Initial Assessment Form*, in which John was rated 'high' risk. The required level of contact between a youth who is rated as 'high risk' and his or her youth corrections worker was noted as bi-weekly. It was also noted on this document that John stated he was not receptive to counselling. This intake worker then notified Assessment Social Worker (#2) that the Youth Corrections file would be transferred to a youth corrections

social worker. Additionally, it was advised that the newly assigned youth corrections social worker would likely also perform the functions of the youth services social worker. At that time, Assessment Social Worker (#2) continued to carry John's file despite the fact that she was not working in the Youth Services Program.

One week later, John submitted an application for housing to the Choices for Youth Young Men's Emergency Shelter. On this date, Mom left a voicemail message for Assessment Social Worker (#2) advising that John did not have any money nor did he have food for lunches and he had been unable to reach this worker. The social worker called Mom back and was told Mom's family had given John \$250.00. Mom inquired whether John was being supervised to ensure he was not using drugs. The social worker advised the shelter had a zero-tolerance policy relating to drugs and alcohol. Mom went on to say John had not washed in two (2) weeks and she questioned the ability of the DCYFS to properly care for his needs. Mom informed the social worker that she had requested file disclosure in order to file complaints. The social worker documented that she advised, "...at 16 [John] can't be forced to complete services, and when he was 15 he declined the services that were put in place. [John] could not be forced to enter services that he did not want." According to this note, Mom replied, "...someone has to force 'the hand' to have [John] complete services as he is mentally ill and no one is helping him" (CRMS note). Also on this day, Assessment Social Worker (#2) received a voicemail from her program manager indicating the need to meet and discuss the fact that Mom was having contact with John. There is no documentation indicating that this requested consult occurred.

There is e-mail documentation on file between Assessment Social Worker (#2) and the assigned youth services/youth corrections worker who would take over the file. It mainly centered on John's financial needs as Assessment Social Worker (#2) stated she was unaware of how to proceed. The youth services/youth corrections social worker provided information to Assessment Social Worker (#2) regarding financial assistance. The youth services/youth corrections social worker also advised Assessment Social Worker (#2) that she would be taking responsibility for John's youth services case management in the near future. She stated:

Prior to my taking on case management of this file it is required that this youths situation be stabilized with a long-term living arrangement and a financial assessment of his needs and eligibility. To date I know very little about this youth as I have not yet received an up to date file nor participated in a transfer meeting around this youth" (E-mail Correspondence).

She concluded by informing Assessment Social Worker (#2) that when the file was ready to be transferred she should contact her and they would get together as required for a "quick transfer meeting" (E-mail Correspondence).

Assessment Social Worker (#2) spent considerable time on this day attempting to locate John and advise him of a space available for him at the Choices for Youth shelter. Around mid-day, she contacted John's school, his grandparents, uncle and the

shelter. During the afternoon, John called this social worker to let her know he was presently at his grandmother's. The social worker told John he would be moving today and he was receptive to the proposed living arrangement.

A Youth Services File Transfer document was completed by Assessment Social Worker (#2); it contained a checklist of documents required for the official transfer. One item on the checklist entitled Individual Supports Services Plan (ISSP) indicated "N/A"; even though this specific document was referenced in the YSA signed on an earlier date as an attachment, no such form was ever located. It appears from the file documentation that the process of actually transferring the file took approximately two (2) months.

John went to the Choices for Youth Young Men's Emergency Shelter to complete the Intake Form. Following this, he left to get his belongings at the other shelter but failed to return. A telephone call was made the following morning to an on-call social worker by a staff member at the other shelter. The staff member indicated John had shown up at that location at 3:00 a.m. and he was intoxicated; they turned him away as per their policy. She also advised that John returned at 10:30 a.m. and told the shelter worker that he did not feel safe at the Choices for Youth shelter. The shelter worker told John to go to bed and they would figure out his accommodations later. The on-call worker provided authorization for John to stay an additional night at this shelter. Several days later, John informed Assessment Social Worker (#2) that he had moved to the Choices for Youth shelter.

In March, John's youth services/youth corrections social worker met with him for the first time as part of the worker's youth corrections role; the youth services file had not yet been transferred. It should be noted that the Choices for Youth shelter and the youth services/youth corrections social worker's office are located in the same building. The youth services/youth corrections worker documented that John presented as polite and talkative. This worker noted that John was still admitting he used drugs but would not disclose what particular type. John said he was not doing that well in school but would like to finish. He also indicated he had finished working about a week ago as he found it was too stressful. This worker noted there had been no counselling provision included in John's probation order and that John had declined those services in the past. The worker documented that John would report to her weekly while residing at the shelter and then bi-weekly when he acquired other living arrangements.

The following day, John's father called the shelter asking for information concerning his son. He was directed to call John's youth services/youth corrections worker, which he did. Dad, who had recently re-connected with John, expressed interest in beginning a relationship with him. He inquired whether he could or would be allowed to have John live with him. The youth services/youth corrections worker subsequently checked in with John; there were issues with a bus pass extension and lack of financial support thus far. John advised he had met with his father but did not speak of living with him. The youth services/youth corrections worker told John that she had not yet received John's file information so she was unsure of what arrangements

had been made; the worker would advise John when she received it. John's application for Supportive Housing through Choices for Youth was still being processed.

Several days later, a community youth worker from the Supportive Housing Program with Choices for Youth left a voicemail message for Assessment Social Worker (#2) who had not yet transferred John's file. The community youth worker advised that she and the youth services/youth corrections social worker had concerns about John's financial support and questioned if he had signed a YSA. Assessment Social Worker (#2) spoke to the community youth worker and advised that John was not eligible for financial assistance because of his employment earnings. It appeared she was not aware that John had already quit his job. She also advised that John had signed a YSA and the file was in the process of being transferred to the Youth Services Program. She noted that she had sent a copy of the YSA to the youth services/youth corrections social worker. She indicated that she had requested a bus pass for April and that John's mom had given him money. On this same day, Assessment Social Worker (#2) was faxed a copy of John's discharge summary from the ALA where John had resided until his birthday. The ALA program manager noted they had insufficient time to work on a service delivery plan or long-term goals for John.

The community youth worker documented that she visited the youth services/youth corrections social worker who expressed concern after a visit she had with John. The youth services/youth corrections worker indicated she had not yet received the Youth Services file and John had received no supports. The community youth worker also met with John and confirmed that he was no longer working and he had no funds. John was unsure about his future but was open to a board and lodging arrangement and expressed the need to be on a bus route for school. The community youth worker inquired into John's school attendance. The school forwarded a message the following day that indicated John's attendance was presently sixty percent (60%).

By the end of March, John was accepted into the Choices for Youth Supportive Housing Program. On the Admission Assessment form John indicated that he had telephone contact with his mother and had reconnected with his dad. John indicated that he smoked "weed" daily and drank alcohol on the weekends. He also stated that he wanted to finish school. John requested support related to housing and education. The Choices for Youth coordinator recommended assistance with appropriate housing, healthy lifestyle choices, continuing education and life skills.

One day, while still residing at the shelter, when John returned from a visit with his mother he spoke openly to the shelter worker about his addictions issues; he asked for assistance in getting a mental health assessment as soon as possible. He stated he was at high risk as there was mental illness was on both sides of his family. John was encouraged to see the shelter coordinator on dayshift the following day to get assistance with his request. It could not be ascertained from the file if such a meeting took place.

Assessment Social Worker (#2) noted in her CRMS documentation that as of early April, the file had yet to be transferred to the youth services/youth corrections social worker. Assessment Social Worker (#2) also documented a telephone call with John: “[John] asked this writer for his file as there was ‘no point’ for it to be with me ‘up there doing nothing’” (CRMS note). The social worker advised John she was in the process of transferring the file to his youth corrections worker, who would also become his youth services worker.

In April, John reported to a community youth worker at Choices for Youth that he was hearing voices. This worker suggested he should see his family doctor and get a referral for a mental health assessment. A few days later, a community youth worker helped John move from the shelter to a bedsitting room. John and his community youth worker viewed two (2) different bedsitting rooms owned by the same landlord. John chose to live at the bedsitting house where four (4) adults and one youth resided. In an interview with the Advocate, John stated that he chose to live at this location because it seemed quieter and he felt he would not have to worry about someone breaking into his room (Transcript of ACY Interview, 2012).

Also in April, a staff person from John’s school left a voicemail message for Assessment Social Worker (#2) outlining concerns about the number of days he was missing and questioning if he had somewhere to live. Assessment Social Worker (#2) was unable to reach anyone at the school due to the Easter holidays. Over a three (3) week period, CRMS notes and e-mails contained information about John’s school attendance deteriorating, his birth certificate being required and his bus pass being requested.

Later that month, Mom left a voicemail for Assessment Social Worker (#2) that indicated John had finally agreed to mental health assistance and she did not want to miss out on this opportunity. A portion of Mom’s message, according to the CRMS notes, stated: “...things can change and move on if he gets some help so she would appreciate it if I can do whatever I can for him.” Assessment Social Worker (#2) corresponded via e-mail with the youth services/youth corrections social worker; she questioned what action she should take. Assessment Social Worker (#2) then returned Mom’s call to advise Mom to call Janeway Psychiatry and make a referral. Almost one month after John had advised the shelter worker that he wanted assistance in getting a mental health assessment as soon as possible, it appeared as though a referral was made by Mom. In a follow-up e-mail that morning from Assessment Social Worker (#2) to the youth services/youth corrections social worker, she stated: “...his mom still wants me to ‘fix him’ sigh” (E-mail Correspondence).

In an office visit with the coordinator of the Supportive Housing Program at Choices for Youth, John acknowledged that he was struggling with alcohol abuse and he was feeling lonely. He talked of quitting school and seeking full time employment. John asked the coordinator to assist him with writing a resume but he did not show up for the scheduled appointment the following day.

Two (2) days after Mom contacted Assessment Social Worker (#2) regarding John's mental health, Mom contacted an intake social worker at the DCYFS and reported being concerned about John as she had not heard from him in a couple of days. During their last conversation, Mom said he was agitated and asked that she come and get his things; his hands were shaking and he felt like beating up stuff. Mom said she talked him out of it but she had not heard from him after that. The intake worker suggested Mom call the police, report John as missing and talk to Assessment Social Worker (#2). Mom also told the intake worker that John had an appointment with the psychiatrist in May.

The appointment with the psychiatrist did take place and an assessment was completed. Mom was also present at this appointment. The psychiatrist documented: "Not depressed now but if he continues drugs that is a possibility" (Patient Progress Notes). The psychiatrist noted that he told Mom that John did not have ADHD. He documented the diagnoses as CD and Antisocial Personality Traits. He documented that he told John he could help with his drug use and offered anger management, which John declined. There is no indication from the documentation that any other services were offered. The psychiatrist did offer to see both of them again and gave them his card before they ended the appointment.

In May, John met with his youth services/youth corrections social worker to review issues and concerns. According to this worker's notes, there had been three (3) previous meetings since his initial visit. This meant that the worker was now meeting with John on a bi-weekly basis as was stipulated in March. The CRMS notes summarized what had happened over the past month. The youth services/youth corrections social worker documented that John was showing less interest in developing a relationship with Dad. She also noted that she and "choices staff" had concerns with John's choice of friends and suspected drugs and alcohol issues.

A few days later, Assessment Social Worker (#2) documented: "[John's] file is ready for transfer to [youth services/youth corrections social worker] with Youth Services and will be sent on this date" (CRMS note). John had signed a YSA just over two (2) months prior to this. There is no file documentation to indicate the file was actually transferred or received nor is there any documentation to indicate a transfer meeting occurred. Assessment Social Worker (#2)'s name does not appear on any subsequent documentation.

Later that month, the school submitted a report for John to Janeway Psychiatry as requested by the Janeway. It should be noted that John had not attended school since April. The report outlined how his attendance, and subsequently his grades, were suffering and noted changes in John's mood. A school official documented that there had been repeated calls made by the school to Assessment Social Worker (#2) since before Easter that had not been returned. This school official was unsure of where John was living or if there was a plan for John to transfer schools. It was also noted that teachers were very concerned about John (School Report).



During the month of June, as reflected in file documents, John had regularly availed of weekend food bags which were supplied by the Choices for Youth shelter for emergency situations. A community youth worker documented that John's appearance was concerning as he appeared "haggard." He had told her he was struggling with drug use and she had recommended Narcotics Anonymous (NA). They discussed "the detox centre" and John advised he did not want to go and told her he would consider it in the future. A community youth worker had been meeting with John bi-weekly but it is not evident if these discussions were shared with his youth services/youth corrections social worker.

An office visit between John and the same community youth worker in July revealed John's relationship with his mother was deteriorating. The worker learned that John was still struggling with drugs and alcohol. He believed school might help him regain control over his life. While the file reflects that John and the community youth worker were speaking regularly, there are only three (3) documented conversations in July. It was noted in the Choices for Youth Monthly Update form that John attended the Choices for Youth Outreach Program regularly.

The next two (2) CRMS notes recorded by the youth services/youth corrections social worker are dated for the same day in July; she wrote a different note for the Youth Services and Youth Corrections files. The worker documented that she had been having face-to-face contact almost every two (2) weeks with John since April; however, there were no details regarding these meetings on file. It appears that the July documentation for the Youth Corrections file was a summary of three (3) visits since May. The youth services/youth corrections social worker documented that John was unsuccessful in school this year; however, he was considering returning in the fall. She also noted that "...other than living with alcoholics and druggies he says he is doing well and likes his place" (CRMS note).

While it was not documented in any CRMS notes, John signed a new YSA in August as his old one had a six (6) month validation period. It does not appear from documentation that there were any alternative living options discussed with John prior to him signing this new YSA. It was noted in CRMS that John was scheduled to report to his youth services/youth corrections social worker in August but because that worker was unavailable on the scheduled day, their meeting did not occur. The worker documented that John was given credit for his visit as he was reliable with his reporting.

In late August, John was charged with criminal offences related to the theft of a vehicle and possession of drugs. John was held overnight at the Youth Detention Centre. As was the case in February, another suicide assessment was completed by a youth care counsellor during his overnight stay. He was rated as *Not at Suicide Risk* (Suicide Assessment). John was released the following day on an undertaking; his next court appearance was scheduled for late September.

In September, the youth services/youth corrections social worker met with John. It was documented that they discussed his offences but John was not forthcoming with

information about the incident. A discussion followed about John's drug use and the social worker described this conversation as "good." It was documented that John would spend the next two (2) weeks thinking about where he would like to go with his life and report back to the worker. In the CRMS notes of this date, the youth services/youth corrections social worker commented, "He was also given a clear direction that if he is unwilling to make improvements in his lifestyle he will be required to attend certain services deemed appropriate by this worker to assist him in dealing with his issues" (CRMS note). It was noted by the youth services/youth corrections social worker in the Youth Services Program CRMS notes that John's aunt had recently expressed some interest in helping her nephew. It appeared from the notes as if the youth services/youth corrections worker had already pursued a discussion with the staff at Choices for Youth about this option.

According to notes written by a community youth worker, John's aunt was quite worried about John, especially since the auto theft. His aunt told the community youth worker that she was concerned about his living arrangement and she was thinking about taking him into her home. The worker paraphrased the aunt's comments in her notes: "He's crying out – stating he says he wants to get locked up to keep him off the drugs. States he's almost glad he got caught" (Supportive Housing File Notes).

John enrolled in a new school that was located closer to where he was living, making it easier for him to attend regularly. According to a community youth worker's notes, John advised her that things were going well. It was documented that John was finding the other tenants in the boarding house irritating; however, they were not bothering him and he still felt safe there. The monthly summary report for September from the Supportive Housing Program at Choices for Youth outlines how respectful, open and honest John had been and staff described him as a very intelligent young person. His attendance at school thus far was over eighty percent (80%). John continued to report he was using drugs and consuming alcohol.

A few weeks later, the Supportive Housing File indicates a community youth worker took John to the Recovery Centre after she learned that John was injecting drugs. John only stayed at the centre for three (3) days; he left voluntarily. While at the Recovery Centre, he was advised of a variety of programs that could assist him but he showed little interest in pursuing these services.

Several days later, as a result of charges in August, John was convicted of the drug possession offence and received a reprimand under the *YCJA*; court was postponed regarding charges related to the vehicle theft. A community youth worker noted that John was very upset and believed he would be "locked up for Christmas" (Supportive Housing File Notes). She noted that John presented as angry and was feeling hopeless about his situation.

In October, a school official contacted a community youth worker about John's recent attendance. Documentation from John's school indicated that his absences had increased. During a documented discussion with John, a school official suggested he

should speak with the guidance counsellor. The school official learned that one of John's relatives had been injured. A community youth worker also documented that John was quite upset about this incident and stated he was unable to focus on anything else as he was spending time at the hospital with his family.

A few weeks later, the youth services/youth corrections social worker met with John and again her CRMS notes reflect a summary of the events over a two (2) month period. The worker had attended court with John on two (2) occasions and conducted three (3) probation visits with him; the exact dates were not documented. The youth services/youth corrections social worker learned that John had done well at the Recovery Centre and that he was considering going back for another stay. It was documented that John had been considering going out of the Province for help at a treatment facility but he had not yet fully decided on that option. While it was reported he had a close relationship with his aunt, John had decided against a living arrangement with her. It was noted that he had been keeping contact with his mother to a minimum as he gets upset or angry after they talk. The youth services/youth corrections social worker noted that John was finding the court process stressful. The next court date was set for December.

Two (2) days following this meeting, the youth services/youth corrections social worker completed the *Youth Level of Service Case Management Inventory (YLS-SMI) – Re-Assessment Form*. Despite being rated as 'high risk' in the March assessment and suffering many setbacks since that time, John's overall risk was rated as 'moderate'. As a result of this assessment, John's required meeting frequency for the Community Youth Corrections Program decreased from bi-weekly to monthly.

Notes indicate that John had an appointment with a family physician and from this a referral was sent to Janeway Psychiatry for John. The referral, which indicated that John was an active patient and briefly outlined his past contacts at the hospital, was received by Janeway Psychiatry in December. John's next intervention with the Janeway was not a planned one; he was escorted to the Emergency Department a few days after his appointment with his family doctor. At 2:41 a.m., John's aunt called the police requesting they go to her nephew's residence. She expressed concern given a telephone conversation she had with John where she reported that he was "talking really crazy stuff." She informed the police that John had destroyed his bedroom and referenced, "...kicking in doors and burning down the house" (RNC file). Two (2) officers responded immediately and spoke with John. They observed that his refrigerator had been knocked over and mirrors were broken.

John agreed to go voluntarily to the Janeway Emergency Department at 3:15 a.m. with the police officers. The triage nurse recorded: "Anger issues. Caused extensive damage to apt. PT says he still feels ++ angry, feels he may hit someone if handcuffs are removed. He had a few drinks... drug use" (Hospital Records). In an interview with the Advocate the triage nurse spoke about her encounter with John:

There's not a lot to tell, actually. He was brought in by two RNC officers, apparently after – according to the officers, he had destroyed his room. It's not a residence he was living in, it was his room at the rooming house he was staying at. He didn't damage anybody else's property, he hadn't made any threats, hasn't threatened to hurt himself... but basically they had been contacted because he was very – he tells me he was very angry that night... (Transcript of ACY Interview, 2012, p.32).

After speaking with the triage nurse, John was directly questioned and assessed by the ER physician for a total of twelve (12) minutes. Under the category on the Pediatric Emergency Room Record entitled *Provisional Diagnosis*, she recorded: "Angry" and indicated that there was no suicidal ideation, homicidal ideation and no psychosis. The treatment prescribed was: "D/C to police custody. Back to ER if suicidal/homicidal or psychotic. F/U with GP" (Pediatric Emergency Room Record). The doctor noted the name of John's community youth worker with Choices for Youth as his social work contact; John's youth services/youth corrections worker was not identified in this documentation. Hospital documentation does not include the comments John allegedly had made earlier that night about wanting to burn down his residence. John was discharged from the hospital at 3:42 a.m.

In an interview with the Advocate, the ER physician was asked what was communicated to her by the police officers:

They spoke to the Triage Nurse initially and then the only information I was received was that he had done damages to the property that he was residing in, and that he was angry and that was all I knew (Transcript of ACY Interview, 2012, p.7).

When asked if she was advised by the police that John had threatened to harm himself or someone else, the physician informed the Advocate she was not advised of this information. When asked if the officers provided her with information that they received from John's aunt regarding him kicking in doors and burning down the house, she informed the Advocate that she was not advised of this information (Transcript of ACY Interview, 2012). When asked if John vocalized if he would hurt someone else or burn his house, she stated:

No, and I asked him directly – I asked him if he would hurt himself, and he said, no, and I asked him if he felt like he was going to harm anybody else, he said, no (Transcript of ACY Interview, 2012, p.9).

In a separate interview, the RNC constable who had escorted John to the Janeway was asked by the Advocate if he had provided information to the Janeway, specifically that John had stated he had thoughts about burning down his house and not knowing if he was going to harm himself or somebody else. He confirmed that he did. When asked by the Advocate if he had clearly explained that John had said he wanted

to hurt someone and burn down the house, the constable stated: “That he was thinking, yeah, yeah and [Aunt] relayed that same thing to me on the phone and I relayed it to them again so, twice” (Transcript of ACY Interview, 2012, p.33). When asked whom he told that John had reported having thoughts about burning down the house and not knowing if he was going to hurt himself or somebody else, the constable stated:

The two nurses that were there and also the doctor, in fact, in order to clarify what he had exactly said to his aunt, I called her up on the phone at the hospital and the nurses were seated in front of me and the doctor was standing probably about three and half, four feet away from me and I had the phone up to my ear and she was telling me what he had said and I was repeating it to them (Transcript of ACY Interview, 2012, p.15).

The other police officer involved that night informed the Advocate that she was speaking with John in another area when her colleague phoned John’s aunt in the presence of the ER physician and nurses therefore she did not witness this conversation. However, when the constable was asked if she was aware that her colleague passed information on to the hospital staff that John was going to hurt someone else and that he’d like to burn down the house, she stated:

Yes, when we first arrived that’s when [Constable] he had told the doctors that and yes I heard him tell the doctors... Yes, he told them he said, “He feels like he might burn the house down” and he did tell them that, yes (Transcript of ACY Interview, 2012, p.11).

It should also be noted that in an interview with the Advocate, John advised that he did inform the staff at the hospital that he wanted to harm himself and burn his house down. John further stated: “When I went to speak to the doctors and I said I was going to burn the house down or whatever, to be honest, I really think I should have been kept there overnight...” (Transcript of ACY Interview, 2012, p.115).

The police took John back to his bed sitting room and they completed a CPR. The report read:

Police escorted [John] to the Janeway Hospital... He told police that he didn’t know if he was going to hurt himself or someone else. He also said he wanted to burn down the house. [John] was assessed and released from the Janeway... (RNC file).

The report was faxed to the DCYFS at 6:05 a.m. that morning. The police also completed a *Mental Health Care and Treatment Act Template* form. The *Comments* section of the form contained a handwritten note stating: “[John] said he was angry and that he had thoughts about burning down the house. He also said he wasn’t sure if he would hurt himself or somebody else” (Mental Health Care and Treatment Act Template). The name of the officer who completed the form was indicated; however, the section identifying who received the form and at what facility was left blank.

John's youth services/youth corrections social worker received the referral information after 10:00 a.m. that same morning. She relayed the information to the community youth worker who documented that as a result, they had tried to reach John multiple times throughout the day to develop a safety plan. The community youth worker spoke to a resident at the bedsitting house and was told that John had left for a couple of days. The community youth worker documented: "Staff assessed that perhaps he was going to stay at his Aunt's..." (Supportive Housing File Notes). There was no documentation on file to suggest any further action was taken by the community youth worker or the youth services/youth corrections social worker on this day.

Two (2) days later, the next intervention with John occurred when in the early morning hours an emergency call was made concerning a fire at his bedsitting house. John was escorted to Hospital by the police for assessment of smoke exposure. The Emergency Room Record indicates that a Legal Aid lawyer was also present. It was documented that John presented as being very angry and stated that he was going to commit suicide. A doctor recommended John be admitted to the hospital for assessment of smoke exposure; however, John refused and left the hospital with the RNC that morning.

A community youth worker and the coordinator of the Supportive Housing Program documented that later in the morning, after they learned of the incident, they attempted to gather information and locate John. There is no documentation on file indicating that the youth services/youth corrections social worker had any involvement on this date. That afternoon a suicide assessment was completed by a youth care counsellor; John was rated as '*Not at Suicide Risk*' (Suicide Assessment). John went to court and was remanded to the Newfoundland and Labrador Youth Centre.

As a result of the house fire and the death of one resident, John was charged and pleaded guilty to criminal offences including *Manslaughter* and *Arson* related offences. John informed the Advocate that, since the fire, he received a mental health assessment and diagnosis while in custody and is receiving treatment. He informed the Advocate that his diagnosis is different from the one he received at the Janeway in 2011 (Transcript of ACY Interview, 2012 and 2013).

## Findings and Analysis

The *Findings and Analysis* identifies areas for improvement in connection with each relevant department or agency involved, thus informing the recommendations put forth by the Advocate for Children and Youth (ACY). Dr. Umesh Jain and Dr. Peter Collins, two (2) psychiatrists contracted by the Advocate, reviewed and analyzed John's case to provide their expert opinion in the field of child and adolescent complex mental health. Their confidential written report is referred to throughout this section as 'Jain and Collins (2012).'

### **DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES**

#### ***Documentation Deficiencies***

Documentation contained in all DCYFS program files significantly impacted the course of this investigation. Ascertaining the facts from the files was impeded by a multitude of deficiencies in documentation practices. These deficiencies included handwritten notes not entered in the Client Referral Management System (CRMS), late entry of documentation in CRMS, entries in CRMS that were dated incorrectly, missing documentation, incomplete accounts of events, and an absence of notes at the management level.

DCYFS standards required that all social workers document all service notes in CRMS (*CYFS Best Practice Guidelines for Using CRMS*, 2002). Jot notes completed by Assessment Social Worker (#1) for May 2010 were never entered in CRMS. As revealed in an interview with this social worker, these notes were lacking significant details of interviews with Mom and John (Transcript of ACY Interview, 2012). In reference to these notes, the program manager stated: "These are what we would call scratch notes, they're not even good handwritten notes" (Transcript of ACY Interview, 2012, p.22). When Assessment Social Worker (#1) left the position with the DCYFS, John's file was transferred to another assessment social worker without a transfer meeting. Due to the lack of detail contained in these handwritten notes, the file that was transferred did not adequately represent the involvement the DCYFS had with John in May 2010.

According to the *CYFS Best Practice Guidelines for using CRMS (2002)*, the standard for completion time was as follows:

Client documentation related to Protective Intervention Investigation must be completed within 24 hours of providing a service. All other documentation must be completed within 48 hours of providing a service. This is the standard practice of the organization and promoted as best practice by recognized Child Welfare Organizations (p.5).

Assessment Social Worker (#2), who was involved from August 2010 to May 2011, did not meet these standards as she entered a significant amount of service notes in the CRMS database up to twelve (12) months after the activities were completed. In addition, Assessment Social Worker (#3), involved in the response to a referral made in December 2010, entered documentation of her involvement and visitation with John in CRMS one year later. As a result, between May 2010 and November 2011, a significant amount of information was unavailable to any person searching John's name in the CRMS database for the Protective Intervention Program and the In Care Program. Such pertinent file information included past CYFS intervention and, in particular, details regarding John's drug use, behaviours, health, emotional wellbeing and family conflict. Without access to this information, a social worker's assessment of John and the continuity of service provision would have been considerably impacted.

In an interview, Assessment Social Worker (#2) explained that her late documentation entries were due to having "upwards of 80 to 100 files" (Transcript of ACY Interview, p.6); however, she informed the Advocate that she had completed detailed handwritten notes which were contained in the physical file. In an interview with the Advocate, Assessment Social Worker (#3) also attributed late entry of notes in CRMS to high caseload numbers and indicated her practice was to write detailed handwritten notes. The Advocate did not locate handwritten notes by either of these assessment workers in the review of file documentation.

On two (2) occasions Assessment Social Worker (#2) documented the details of a Safety Assessment form in CRMS based on the activity of other social workers. One Safety Assessment form was in response to a referral that was received prior to her being assigned the case (May 2010) and one was received when she was away from the office (December 2010). Both Safety Assessments were recorded in CRMS as having been completed by the program manager in January 2012. The late completion of these forms contravened *Policy 2.6* of the *CYFS Standards and Policy Manual (2007)*, which states: "The social worker must complete the *Safety Assessment Form 14-628*, as soon as possible and within 24 hours of seeing the child" (p.3). In addition, the social worker was required to consult with a supervisor following the completion of a Safety Assessment form and receive written approval of both a Safety Plan and Safety Assessment. Since the forms were completed by a social worker who did not respond directly to the referrals and written approval was received by the program manager over a year later, it appears that the documentation of these assessments served an administrative function only and did not contribute to the assessment of risk. Assessment Social Worker (#2) who completed these Safety Assessment forms confirmed that she documented the work of two (2) other social workers and agreed that it did not meet standards. In reference to this practice, she stated: "Unfortunately, like I said, I'm not the only one that does this" (Transcript of ACY Interview, 2012, p.16). It appears that this same social worker also incorrectly dated an application requesting Youth Services. The date recorded on the form was February 2011 but John did not move to the address noted on the form until March 2011.



In an interview with the Advocate, a senior official with the DCYFS acknowledged that late documentation was generally a concern. She informed the Advocate that initiatives were being made to reduce caseloads and allow social workers, particularly those on the Assessment Team, to complete their documentation in a timely manner. The senior official stated:

...there were steps taken to try and address it, but the Assessment Team was, you know, significantly understaffed for the volume of files coming into it, and that's well documented and presentations were made on that from Eastern Health to Government (Transcript of ACY Interview, 2012, p.7).

Incomplete accounts of events in recorded documentation were found in all program areas within the DCYFS. In many instances, it was only through interviews that the ACY was able to clarify details of the events recorded in CRMS by social workers. Many of the social workers interviewed indicated that while they were aware of documentation standards, they were just unable to meet the requirements. There appeared to be complacency with regards to meeting the standards on both the front line and management level. The youth services/youth corrections social worker's documentation practice was to compile notes regarding multiple meetings into a single summary without providing specific dates and content discussed in each meeting. When asked by the Advocate about this practice, the worker stated: "...is standard practice for me, I've been doing this for a long time... nobody has ever rapped me over the knuckles..." (Transcript of ACY Interview, 2012, p.31). In reference to this worker's documentation practice, the program manager stated: "Acceptable, probably not, you know, with [Youth Services/Youth Corrections Social Worker's] style [Youth Services/Youth Corrections Social Worker] is very general in... writing" (Transcript of ACY Interview, 2012, p.42).

The *CYFS Best Practice Guidelines for using CRMS (2002)* indicates that when a supervisor had contact with a client he or she was required to document this in CRMS; it did not indicate any documentation standards for supervisory consultations with social workers on a file. While this was not an expectation in policy, the importance of documenting decisions made at the management level was evident throughout this investigation. In particular, there were two (2) critical consultations at the senior management level that are alleged to have occurred, yet there are no records of any issues discussed and/or rationales for decisions made as a result of these consults.

In December 2010, Assessment Social Worker (#2) and her program manager were away from the office; other workers assumed responsibility for a referral regarding John. He was residing at his friend's parents' home and was reported to have a broken nose. In an interview with the Advocate, this program manager recalled she consulted with a senior manager about removing John; however, she could not remember detailed information as it was not documented and it had occurred eighteen (18) months prior to this interview (Transcript of ACY Interview, 2012). While the involvement of the program manager and senior manager was referenced in the documentation entered by

Assessment Social Worker (#3), there was no mention of whether consideration was given by management to remove John from his mother's care. In an interview, this program manager stated that her expectation was that Assessment Social Worker (#3) would update Assessment Social Worker (#2) on the case upon her return; however, there is no documentation indicating this occurred. Assessment Social Worker (#3) informed the Advocate that she did pass the information from her involvement in the case to Assessment Social Worker (#2) but she could not recall how she communicated the information. When asked by the Advocate how such information is passed along, Assessment Social Worker (#3) stated:

... it depends. She's in the same office as me, so – we were on the same team. So that usually would have been a – sometimes it's a sit down to go over all the information, all the notes. And sometimes it's providing the handwritten notes so that they can look at them for what they need to follow-up on (Transcript of ACY Interview, 2012, p.27).

In a separate interview with the Advocate, Assessment Social Worker (#2) did recall having a conversation with Assessment Social Worker (#3) about the case. However, due to the lack of documentation, there is no record of information sharing between the two (2) assessment social workers. As a result, the ACY cannot determine whether Assessment Social Worker (#2) and her program manager were aware of the severity and level of risk associated with the December 2010 referral as well as the consideration given by the program manager to remove John.

An undocumented second series of consultations at the senior management level made it impossible to resolve significant discrepancies in information provided by interviewees during the investigation. In the days preceding John's 16<sup>th</sup> birthday, the CRMS notes completed by Assessment Social Worker (#2) indicate that the program manager planned to consult with senior management regarding the possibility of John remaining at the Alternate Living Arrangement (ALA). While the subsequent notes completed by Assessment Social Worker (#2) indicate that John was unable to remain at the ALA, she did not provide a rationale for this decision or reference further consultations at the management level. When interviewed, the program manager indicated that she consulted with a senior manager regarding this matter and discussed options for John. The senior manager stated in a separate interview that she had consulted with a senior official to seek approval for John to remain in the ALA until the DCYFS was able to secure accommodations for him. She explained that this request was not approved. The senior official advised that she did not recall this consult. These alleged consultations were not contained in any of the documentation reviewed by the ACY.

A program manager informed the Advocate that she was unaware of any documentation standards for managers providing direction on a file. She confirmed that documentation is primarily completed by social workers and is not completed by management. A senior manager involved during the consultation preceding John's

birthday was also asked about documentation at the management level. Regarding her undocumented involvement, she stated:

...I should have documented that, but – that and probably a lot of other consultations about this and that and general files, but, no , and I guess the – and that’s not an excuse, but, I guess, the nature of the work is crisis oriented, it’s one from the other, and you just go on to the next one, which is the reality. It’s not the ideal, but it’s the reality (Transcript of ACY Interview, 2012, p.27)

A senior official was asked by the Advocate what her expectations were regarding documentation at the management level. She responded that documentation at the management level was not a common practice and it was her expectation that social workers consulting with management would complete the documentation.

Without detailed documentation completed in a timely manner by all professionals at all levels involved in the decision making process, details pertaining to important life events that were crucial for effective case management were not captured in the file. Documentation in social work practice serves as an important tool in assessment, planning and outcomes for clients. The Canadian Association of Social Workers (CASW) *Guidelines for Ethical Practice (2005)* provides guidelines on the *Maintenance and Handling of Client Records*:

Social workers maintain one written record of professional interventions and opinions, with due care to the obligations and standards of their employer and relevant regulatory body. Social workers document information impartially and accurately and with an appreciation that the record may be revealed to clients or disclosed during court proceedings.  
(p.9)

Further, the Newfoundland and Labrador Association of Social Workers (NLASW) recognizes record keeping as a vital component of social work practice in the *Standards for Social Work Recording (2005)*. This vital component of social work practice was not utilized to best meet John’s needs as evidenced by the contravention of documentation standards and the lack of accountability by management to uphold these standards.

There were two (2) prominent factors evident in interviews with DCYFS social workers and management as reasons for documentation deficiencies: workload issues and lack of standards at the management level. Many of the social workers and managers interviewed stated that workload issues impacted the completion of documentation in a timely manner. In addition, it is evident that managers were not required to follow similar standards for documentation on files. While these factors did impact the completion of documentation, social workers and managers remained professionally accountable for ensuring documentation was complete for John’s file. There was no evidence that documentation deficiencies found in John’s DCYFS files were addressed throughout the course of his involvement with this Department. This lack of accountability at both the front line and management levels prevented the deficiencies from being addressed and corrected.

**Recommendation 1**

***The Department of Child, Youth and Family Services develop and implement an auditing protocol to examine file documentation to ensure strict adherence to the documentation standards outlined in the Child, Youth and Family Services Documentation Guide (2012) and the Risk Management Decision-Making Model Manual (2013).***

**Recommendation 2**

***The Department of Child, Youth and Family Services develop and implement a policy that ensures all Managers document all consultations and any decisions made pertaining to a child or youth.***

***Lack of Comprehensive Assessment***

In May 2010, a referral was screened in and assessed based on Sections 14(a): *is or, is at risk of being physically harmed by action or inaction of parent* and 14(h): *is abandoned*. The file was assigned to Assessment Social Worker (#1) who subsequently attended separate visits with John and Mom and sent a letter to the RNC that referenced mental health concerns being explored with John. This social worker did not document a Safety Assessment or Safety Plan as per the Risk Management System (RMS) policy nor was any plan developed to address these concerns.

Assessment Social Worker (#1) left her position shortly after this involvement and the file was assigned to Assessment Social Worker (#2) in August 2010. No action was taken on this file by Assessment Social Worker (#2) until January 2011. It appeared that, as there were no new concerns brought forth to the DCYFS regarding John during those five (5) months, the assessment process was stopped and would not resume until an additional risk presented. In an interview with the Advocate, this social worker was asked if not making contact on active files was the standard practice. She responded: “Unfortunately, at the time unless they were calling us looking for help or needing services or there was, you know, referral information coming in, then unfortunately it did sit” (Transcript of ACY Interview, 2012, p.11).

The next referral was received by the Intake Program in December 2010. This time the referral source (RS) indicated that John had a broken nose, two (2) black eyes and had been kicked out of his home. Over the weekend this referral was assessed by multiple on-call social workers, yet no one interviewed John until four (4) days after the referral information was received. During the weekend, a second call was received by the On-Call Program after John was seen at the Janeway Emergency Room (ER) for his injuries. Rather than speaking with John, On-Call Social Worker (#4) visited Mom who confirmed later he was staying at a friend’s home.

When Assessment Social Worker (#3) finally met with John four (4) days after the referral was received, conflicting information concerning his broken nose was revealed. The social worker also learned that John and his mother argued and he previously had a drug problem. Once again RMS policy was not followed as no Safety Assessment or Plan was documented by the social worker who responded to the referral. John was left living with his friend's parents with no comprehensive assessment completed of their residence or John's circumstances.

Following the visit to his friend's parents' home, the next documented activity was completed two (2) weeks after this visit when Assessment Social Worker (#2) gathered information on the adults with whom John was residing. While the social worker found some concerns with this family, there was no indication in documentation that this was addressed by the DCYFS. Assessment Social Worker (#2) deemed John to be '*Unsafe*' based on information from an interview completed by another social worker in December 2010. Despite safety concerns, there was no documented contact with John by Assessment Social Worker (#2). She finally visited him at his mother's residence after he returned home from his friend's home where he had resided for one month.

Assessment Social Worker (#2) had multiple consultations with her program manager and had telephone contact with Mom, John's friend's mother, and his school guidance counsellor throughout early 2011. The content of these conversations appeared to focus mainly on administrative tasks (e.g. acquiring tutoring and applying for the child tax benefit) rather than assessment or long-term planning. Despite concerns presented regarding John's home and his temporary living arrangement with his friend's parents, Assessment Social Worker (#2) again did not complete a comprehensive assessment of John's circumstances in a timely manner.

There were multiple missed opportunities to fully assess John's circumstances prior to him coming into care. Over the course of one year, four (4) referrals had been received concerning John and multiple social workers documented significant issues, including: selling drugs, using drugs, mental health concerns, parent-child conflict, suicidal ideation, injuries, and homelessness. As a result of incomplete responses to two (2) referrals and lack of action on his file, John's concerns were not addressed and RMS standards were not met. Despite service providers having knowledge of 'red flags', John was left in potentially unsafe circumstances throughout the 2010 calendar year and into early 2011.

**Recommendation 3**

***The Department of Child, Youth and Family Services ensure that social workers working in the Protective Intervention Program complete comprehensive assessments in accordance with the Risk Management Decision-Making Model Manual (2013), ensuring that when a referral is screened in for a Protection Investigation:***

- (a) the social worker completes the Safety Assessment form within 24 hours of interviewing the child and parents as per Standard #3; and***
- (b) the social worker, in consultation with a supervisor, completes the Protective Investigation within thirty (30) days after the report is received as per Standard #4.***

***Inefficient On-Call Services***

When the Intake Program received the referral that John had a broken nose, two (2) black eyes, and had been kicked out of his home, the referral was signed off by the assigned program manager and then passed to on-call services. The involvement of on-call services in response to this referral illustrated an uncoordinated, inconsistent and under-resourced approach to service provision.

There were inconsistencies in the approaches taken by on-call social workers involved during this time. In an interview with the Advocate, On-Call Social Worker (#1) confirmed that she worked from the office where she had access to the CRMS database and likely the hardcopy referral. On-Call Social Worker (#3) informed the Advocate that typically she completed on-call shifts from her home and On-Call Social Worker (#4) informed the Advocate that she worked from home on the night she was involved with this case. Despite visiting Mom on Saturday, On-Call Social Worker (#3) did not document information about John's alleged injuries. When asked in an interview with the Advocate, this social worker could not recall that it was alleged John had a broken nose and two (2) black eyes (Transcript of ACY Interview, 2012).

A program manager described CRMS as unreliable when accessing it from home and stated it was not a "user friendly" system (Transcript of ACY Interview, 2012). One of the on-call social workers interviewed confirmed she could access CRMS from home while another on-call social worker claimed this was not the case. Given this discrepancy and the reported unreliability of the database system, it seems on-call social workers working from home were at a disadvantage as they may have had inadequate information when responding to referrals.

On-Call services proved to be under-resourced as social workers who were not regularly assigned to the program area often were assigned to fill vacant shifts.

Additionally, when a high volume of calls was received, reprioritization of referrals could occur. In this case, On-Call Social Worker (#1) enroute to visit Mom received a higher priority call and the referral was passed to the following shift. A program manager with the DCYFS stated:

...on-call is an emergency service. You only have one person available generally. Sometimes you have to do what you have to do. Sometimes things are – if somebody follows up tonight they may only put a Band-Aid on for the night for the regular worker to follow up afterwards, so while the best practice is probably to interview him he may not be interviewed it depends on what's going on with on-call because realistically one worker can only do so much... (Transcript of ACY Interview, 2012, p.50).

The program manager also indicated that at the time of this referral there was a 'stand by' social worker who was available to be called if needed; however, this social worker would also be on 'stand by' to cover potential staffing emergencies at ALAs.

Given that on-call social workers were permitted to operate away from the office and through telephone consultation with management, it would have been appropriate that these social workers were highly trained in the on-call practice. Two (2) social workers involved with this referral were not regularly assigned to on-call services. In an interview, one of these social workers explained that she did not regularly work on-call and this was her first on-call shift. When asked about her basic knowledge of the on-call role, she stated: "I believe there was orientation done for on-call when I was first hired in 2008, but prior to me actually doing the shift, there was nothing" (Transcript of ACY Interview, 2012, p.19). Another social worker who responded to this referral recalled having a one day orientation for on-call; however, she stated: "I think I did on-call shifts before the training" (Transcript of ACY Interview, 2012, p.6).

While these social workers should have had basic knowledge of all programs, they were assigned to other program areas. As a result, both social workers indicated they relied heavily on direction from the program managers with whom they consulted via telephone during their on-call shifts. On-Call Social Worker (#4) was asked multiple times by the Advocate if she agreed with direction given by a program manager not to visit John when he was at the hospital with an injury and refusing to return home. The social worker explained that she followed the direction given by the manager. When asked if she thought she should have visited John at the hospital, the social worker stated:

If it was my own case load I probably would have made, you know, decisions on my own basically and in consultation with my manager, but you know on-call is such is a very hectic and you do get a lot of calls when you're on-call...But on-call is really common – it's common practice for me to consult on everything because I'm not familiar with the files (Transcript of ACY Interview, 2012, p.25).

The response from on-call services resulted in John not receiving a proper assessment or quality services during a three (3) day period. Despite the involvement of four (4) social workers and three (3) program managers throughout this time period, John was not seen or spoken to by any of the seven (7) professionals working with the DCYFS who were involved. Risk Decision #2 stipulates that “The child alleged to have been maltreated shall be seen as soon as possible and no later than 72 hours after the receipt of the report” (RMS, 2003). While John was seen within the time frame of 72 hours by Assessment Social Worker (#3) following the weekend, given that this was an open file and the RS alleged John had injuries and was not living at home, it would have made sense for John and his mother to be interviewed by the DCYFS during the weekend. The same quality of service should be afforded to all children and youth regardless of the date and time a referral is received by the DCYFS.

#### **Recommendation 4**

***The Department of Child, Youth and Family Services review and revise current on-call services standards throughout the province to ensure that:***

- (a) there is sufficient human resources to meet the demand for these services;***
- (b) all social workers providing on-call services provide those services from a DCYFS location or have sufficient portable technology to ensure appropriate and timely access to information; and***
- (c) social workers who are not regularly assigned to on-call services only provide this service if they have completed on-call training within the previous twelve (12) months.***

#### ***Impact of Age ('Almost Sixteen')***

An additional factor that appeared to impact the quality of assessment services John received from the DCYFS was his age. In May 2010, when an Assessment file was opened for John, he was fifteen (15) years of age. The extent of his involvement with DCYFS programs from this point forward appeared to be defined by his impending 16<sup>th</sup> birthday. In August 2010, Assessment Social Worker (#2) was assigned his case but had no documented action on the file until January 2011. When asked by the Advocate if John's age had an impact on the priority of his case, the program manager stated:



He has a greater capacity to protect himself and inform people. I mean, a child that's pre-verbal or has no capacity to get out of isn't seen anywhere in the public eye is most certainly at greater risk sometimes than a child who is going to school, is able to say to somebody, look, you know, things are getting bad again or this sort of thing, who has some protective factors such as grandparents that have stepped in, and at the time he was spending time with friends at their houses and that sort of thing. So he has a greater level of capacity to protect himself, and not just [John], but most children that age unless they present with a cognitive – you know, a very serious cognitive delay or absolutely no supports at all, like, you know, aren't in school or aren't seen in the community anywhere, that would most certainly up the risk level. You know, so on a – you know, a continuum kind of basis, like, when you're looking at approximately 80 files, he would have been on the lower end, but most certainly not the lowest end... (Transcript of ACY Interview, 2012, p.41).

During the involvement of the DCYFS in December 2010, a program manager reportedly consulted with a senior manager regarding John's case. In an interview with the Advocate, the program manager recalled this undocumented consultation because she claimed she would always consult with a senior manager if she was considering the removal of a child. The program manager reported to the Advocate that the direction was not to remove John, "That, you know, this was a youth who was almost 16, you know, it's days before Christmas, you know, and the mom needed to take some responsibility in trying to help figure out a plan for him..." (Transcript of ACY Interview, 2012, p.16). When asked, the senior manager reported to the Advocate that John's age would have been a factor in the decision not to remove him. She stated: "...would it have been because he was close to 16; probably" (Transcript of ACY Interview, 2012, p.14).

Following the December 2010 activity, Assessment Social Worker (#2) commenced an active role on John's file in early January, yet she did not visit him for several weeks. When asked by the Advocate to explain the reason for the delay in speaking with John, she stated:

...it more than likely fell on the fact that he's a 15 year old boy who's able to self-protect. In other words, he can call the RNC himself, he can leave if he needs to, he can, you know, go back to the [friend's family] if need be to... for a teenager, it would be looked upon as a 15 year old, you can get up and leave the house if you are feeling like you need to or call the RNC yourself if you need to. It's different if it was a two year old (Transcript of ACY Interview, 2012, p.33).

On multiple occasions it appeared that John, at fifteen (15) years of age, became responsible for the management of his own circumstances due to the passive role of the DCYFS. In December 2010, despite there being a referral to the DCYFS that John was kicked out of his home, John had to make his own arrangements to stay at a friend's parents' home. This referral source also indicated that John had a broken nose; yet there was no immediate response by social workers involved. John went to the Janeway Emergency Department alone two (2) days later following a re-injury to his nose without the involvement of social workers. While the On-Call Program had information that John was not living at home and had a broken nose, they did not speak directly with him and John was left to take action on his own behalf.

Under the *CYFS Act (SNL 1998)* a child was defined as a person under the age of sixteen (16). At the age of sixteen (16) a person was considered a youth and could avail of voluntary services under the *CYFS Act*. There were no legislative or policy restrictions preventing service provision to children who are approaching their 16<sup>th</sup> birthday, yet it appears the DCYFS was reluctant to provide services to John due to his age. His age contributed to the low level of services he received during 2010 and early 2011; a time when it was critical he receive services and supports, especially considering the mental health concerns presented and his stressed relationship with his mother.

#### **Recommendation 5**

***The Department of Child, Youth and Family Services ensure the provision of complete and comprehensive assessments of all children and youth, regardless of age, to determine the need for protective intervention based on the Risk Management Decision-Making Model (2013).***

#### ***Lack of Transition Planning***

John was only to remain in care for a period of several weeks until his 16<sup>th</sup> birthday. Given that John's time in care would be relatively short, it was critical that intensive intervention and planning be implemented to facilitate the transition to the Youth Services Program. Furthermore, John's first involvement with the Pre-Trial Services (PTS) Program coincided with the time he came into the care of the DCYFS. These experiences were obviously significant stressors for a fifteen (15) year old child. Unfortunately, until the days immediately preceding his 16<sup>th</sup> birthday, little effort was made on the part of the DCYFS to assist John in intensive planning for his transition out of care.

It is documented that John was visited three (3) times at the ALA prior to his 16<sup>th</sup> birthday by Assessment Social Worker (#2); and a fourth time on his actual birthday when she facilitated his move to a shelter. When questioned as to why she did not visit

John at the ALA sooner after he entered care, Assessment Social Worker (#2) referenced her caseload and spoke about John's behaviour. She stated:

...Multiple reasons, caseload issues. I would have seen [John] in court before he moved to [the ALA] so it wouldn't have been the first time I had seen him... my relationship with [John] was very, like, quick to happen. Like, I'd just get involved with this kid and now I'm taking him into care, so there are times you'll not go over the next day because they may not – you know, you're getting the vibe that they don't want to talk to you and there have been times [John] has walked away from me... (Transcript of ACY Interview, 2012, p.47).

It did not appear that John's social worker was a support to him during his transition out of care. In reference to his birthday party, she stated to the Advocate:

I was willing to stay because I was invited to the event too, even though I knew [John] was – our relationship wasn't – it's not like he was asking for me to come. It wasn't like "my friend", he didn't look at me as support (Transcript of ACY Interview, 2012, p.85).

When asked about his conversations with Assessment Social Worker (#2) by the Advocate, John stated: "Every time I ever really talked to [Assessment Social Worker (#2)] it wasn't really for a long time. It was only ever short brief talks" (Transcript of ACY Interview, 2012, p.54). John further stated in an interview: "...if she was there, she wouldn't be there for too long... she never really got to get to know me or what exactly was on the go..." (Transcript of ACY Interview, 2013, p.40-41).

In the region where John lived, after the removal of a child the file is transferred from the Assessment Program to the In Care Program and a new social worker from this program is typically assigned. In John's case, he had the same assigned social worker for both the Assessment and In Care portion of his services. If Assessment Social Worker (#2) thought that her involvement with John's removal was having an impact on her ability to form a supportive relationship with John, it would have been appropriate to transfer his file to another social worker within the In Care Program.

As previously mentioned, during the several weeks John was in care there was minimal action taken by the DCYFS to address planning for his upcoming transition. In fact, the majority of planning action was not taken until days prior to his birthday. The CRMS notes for this time document a flurry of consults by Assessment Social Worker (#2) with professionals, including her program manager, the ALA program manager, a Youth Services social worker, a coordinator with Choices for Youth and the RNC. Through interviews, the Advocate was informed that consults with senior officials also occurred on this day.

Although Assessment Social Worker (#2) encouraged John to speak with Youth Services and Choices for Youth multiple times throughout the several weeks he was in care, it was not until the end of the business day preceding his 16<sup>th</sup> birthday that she met with him to strategize about where he was going to reside. Following this visit, John was left to contact his grandparents to inquire if he could reside with them. Despite not having a concrete plan in place for his impending birthday, no action was taken. Assessment Social Worker (#2) informed the Advocate in an interview that planning for John was on her mind prior to this but she was told by Youth Services that he was unable to sign the YSA until he turned sixteen (16). While policy does stipulate that the YSA could not be signed until John turned sixteen (16), there was nothing that would prohibit the social worker from preparing John for independent living prior to his 16<sup>th</sup> birthday.

Given that John was in care, planning should have been an ongoing process captured in a Plan of Care. Section 31(1) of the *CYFS Act (SNL 1998)*, states:

Not later than 10 days prior to a protective intervention hearing, a director or social worker shall file with the court a written plan for the child and provide a copy to those persons to whom notice of the hearing has been given.

The Plan of Care is a comprehensive, action-based tool that should be continuously used throughout the duration of a child's in care placement. According to Policy 3.21 of the *CYFS Standards and Policy Manual (2007)*, the Plan of Care should have been reviewed by the social worker each month and updated before John left care. Within the plan, the social worker typically would identify goals for the child which could include independent living.

Assessment Social Worker (#2) documented in CRMS that at the family court proceeding, the judge inquired into the completion of the Plan of Care and was advised that it would be filed with the court at a later date. Policy was not met as the Plan of Care for John was dated two (2) weeks after he came into care and was never actually filed with the court. The completed Plan of Care contained one recommendation relating to independent living but did not provide an action-oriented plan for John to become independent. Recommendation 4 of his Plan of Care stated: "Services from Choices for Youth will be sought after for [John] to ensure he is connected with services when he is 16 years old" (Plan of Care). There is no reference made by the social worker in this document regarding a comprehensive plan to address John's transitioning out of care into the Youth Services Program.

The extreme increase in activity in the days leading up to John's birthday illustrated that there was an inadequate and uncoordinated approach to planning for John's transition to the Youth Services Program. The last minute search for housing took a crisis-oriented approach which could have been mitigated by the commencement of planning for his transition from the day he entered into care.

**Recommendation 6**

***The Department of Child, Youth and Family Services ensure that all social workers comply with Policy no.: 2.16 Plan for the Child and Policy no.: 3.9 Planning: In Care Progress Report of the Protection and In Care Policy and Procedure Manual (2011) and utilize the Plan for the Child and In Care Progress Report to prepare for the transitioning of children who are in care and approaching the age of sixteen (16).***

**Recommendation 7**

***The Department of Child, Youth and Family Services develop and implement a policy to ensure that children in care who express their intention to receive Residential Services through the Youth Services Program to live independently:***

- (a) undergo a life skills assessment prior to any transition to independent living; and***
- (b) be provided with training to assist with the demands and responsibilities of independent living.***

***Misinterpretation of Policy at Multiple Levels***

Interviews with professionals at multiple levels involved in the decision to move John to a shelter on his 16<sup>th</sup> birthday revealed that there were discrepancies in policy interpretation and application pertaining to the *CYFS Act*. As previously discussed, these interviews also revealed discrepancies in the recollection of undocumented consultations during this time. Assessment Social Worker (#2) and her program manager understood that policy in March 2011 directed that children in care who turned sixteen (16) years of age could only remain in their residential setting if they were in continuous care of the DCYFS prior to their 16<sup>th</sup> birthdays. They understood that if a child was in care through a temporary order, this option would not be available. Section 4 *Youth Services Overview* located in the *CYFS Standards and Policy Manual (2007)* does not contain any such policy directive.

In an interview with the Advocate, this program manager referenced an undocumented consultation she had with a senior manager during which they discussed their understanding that John could not remain in the ALA. When interviewed by the Advocate, this senior manager did state that keeping John in the ALA would be outside the mandate and policy; however, she indicated that she consulted with a senior official to determine whether John could remain in the ALA until further arrangements were made (Transcript of ACY Interview, 2012). The senior manager informed the Advocate

that this request was not approved by the senior official therefore she directed the program manager to look at other options for John including shelters.

When interviewed, the senior official stated that there was no directive in March 2011 stating that only children who had been in continuous custody of a director could remain in their residential setting under a YSA. She stated: "...if somebody was practicing under that belief, then that was an error in practice" (Transcript of ACY Interview, 2012, p.45). Additionally, the senior official informed the Advocate that she did not recall the alleged consultation whereby she reportedly denied a request for John to stay in the ALA. The senior official stated:

... I still find it very difficult to believe, even comprehend, that I would have said that a child would have had to...leave an ALA on his 16<sup>th</sup> birthday and to move into a shelter that wasn't designed for youth. That is, you know, inconceivable that I would have done that... (Transcript of ACY Interview, 2012, p.25).

This senior official did state that she would not have approved John to live at the ALA for more than a few days as ALAs were not designed for sixteen (16) year-olds.

The undocumented consultations had serious implications for John. Despite professionals at multiple levels claiming they disagreed with this action, John's 16<sup>th</sup> birthday marked his transition from a supervised residential placement to a shelter. The ACY was unable to locate or identify a policy in place at the time preventing John from remaining in the ALA under a YSA for any length of time. It is concerning that a program manager and senior manager, both responsible for the direction of social workers, were interpreting and applying policy incorrectly. This major discrepancy in the recollection of events by senior management again highlights the need for documented detailed accounts of meetings and consultations at all management levels.

It should also be noted that during the investigation the Advocate found correspondence in John's file from a senior manager with the DCYFS approving John's placement at the ALA for a date after his 16<sup>th</sup> birthday. When interviewed, the senior manager who signed this letter explained to the Advocate that such letters were written approving ALA placements in three (3) month increments for funding purposes only. It appears that the approval date on this letter was a formality and did not permit John to reside in the ALA past his 16<sup>th</sup> birthday.

### **Recommendation 8**

***The Department of Child, Youth and Family Services ensure that all levels of management and frontline social workers are trained in, and demonstrate a clear understanding of, their applicable program areas and respective policies in order to provide accurate and consistent case management, direction and supervision.***

### ***Delayed File Transfers***

From May 2010 to March 2011, John's file should have been transferred through a minimum of three (3) program areas: Assessment, In Care, and Youth Services. While the files were electronically opened in CRMS to reflect the appropriate program, a social worker assigned to the Assessment Program remained the assigned social worker responsible for the file from August 2010 until May 2011.

While the file was active from August 2010 until January 2011, there was no documented action taken by Assessment Social Worker (#2) during this time. Inaction on this active file could explain why it was not transferred. The Assessment Program did not adequately finish its assessment of the file thus allowing the file to be transferred to the appropriate program or closed. John's file remained with Assessment Social Worker (#2) for the duration of his time in care. This social worker explained that the short period of time John was in care prevented the transfer of the file to the In Care Program (Transcript of ACY Interview, 2012).

The program manager explained in an interview that when the process is completed correctly, assessment should take thirty (30) days, after which a file is closed or long term service is deemed necessary (Transcript of ACY Interview, 2012). In John's case, his file was retained with a social worker working with the Assessment Program for over eleven (11) months, before it was transferred to the youth services social worker.

When interviewed, both the program manager and Assessment Social Worker (#2) stated that they had limited knowledge of the Youth Service Program and had to rely on consultations with social workers within that program area. As Assessment Social Worker (#2) did not have previous experience with the transfer of an In Care file to the Youth Services Program, she was hoping a youth services social worker would meet with her and John to talk about the YSA prior to his birthday. The social worker explained: "...it just didn't seem like that was something they were going to do" (Transcript of ACY Interview, 2012, p.89). When asked if she consulted with her program manager about the issue, she stated:

I talked to [Program Manager] about it how like this to me seems like a better option, right, let's have him – have someone explain it to him who does this daily with other youth, right. So they have – they know what the housing looks like, they know that type of thing... but it didn't happen because Youth Services expects us to have it set up, everything ready to go, then they step in (Transcript of ACY Interview, 2012, p.89).

Despite her uncertainty, Assessment Social Worker (#2) completed the YSA with John without the assistance of a youth services social worker. She also completed the *Youth Risk Screening Tool* which determines the service needs for youth entering into a

YSA (*CYFS Standards and Policy Manual*, March 2007). In an interview with the Advocate, Assessment Social Worker (#2) stated:

...if he asked specific questions, I wasn't going to answer with this is your answer because I didn't know. I wasn't going to give him false hope of anything... the impression that I was getting from Youth Services was that they would step in once the worker had things arranged. So it wasn't explored (Transcript of ACY Interview, 2012, p.91).

When asked if he recalled what was on his YSA, John stated: "It just said once you turn 16 – talk to the Choices workers or whatever...and you were legally seen as an adult in the eyes of the community, I guess, or something" (Transcript of ACY Interview, 2012, p.71). Additionally, he stated: "I think I just kind of skimmed it over and just signed it just as soon as I was getting out of the group home" (Transcript of ACY Interview, 2012, p.71).

Signing the YSA and preparing to live independently was an important process for John and this process should have been undertaken by a social worker who felt competent with facilitating this transition. The In Care Program and the Youth Services Program both fall under the umbrella of programs provided by the DCYFS; therefore, the ACY cannot see any rationale as to why the transition could not have involved social workers from each program working collaboratively to fulfill John's best interests. In an interview with the Advocate, the program manager assigned to John's Youth Services file was asked if the Youth Services Program meets with children before they make decisions about the program, she stated:

We could I shouldn't say they wouldn't they could, but and that was something that, you know, in planning for that child it was felt it was needed, yes, that would happened. We could very easily have had a social worker from the site meet with them (Transcript of ACY Interview, 2012, p.37-38).

When John turned sixteen (16), his file should have been transferred to the Youth Services Program; however, the file was transferred two (2) months after this date. When Assessment Social Worker (#2) was asked why the file was not immediately transferred to the Youth Services Program, she stated: "There would have been the need for [John] to get the in care, like, all the documentation in to the in care file, all of the documentation into the Youth Services file" (Transcript of ACY Interview, 2012, p.93). Despite this reasoning, the majority of documentation was still not completed by this social worker until six (6) months after the file had been transferred.

Interviews completed by the Advocate revealed inconsistent responses regarding who was responsible for the Youth Services file from John's 16<sup>th</sup> birthday until the file was officially transferred to the program in May. Assessment Social Worker (#2) and her program manager believed that although John's file was still on her caseload, the youth services/youth corrections social worker had taken over the "face to face" work with John for the Youth Services file (Transcript of ACY Interview, 2012). However, in separate interviews with the Advocate, the youth services/youth corrections social



worker and her program manager both stated that Assessment Social Worker (#2) was responsible for the Youth Services program administration until the file was transferred. Based on these contradictory responses, it is apparent that for a period of two (2) months immediately after his 16<sup>th</sup> birthday, which marked his move to independence, neither of the two (2) social workers involved believed they were responsible for John's file. Rather than seeking clarification or attempting collaboration, John's file continued to be carried without an active case manager for the Youth Services Program. It is critical to note that during this time he moved from an ALA to two (2) shelters and then into a bedsitting room with no apparent involvement from a social worker fulfilling the Youth Services Program role.

Despite correspondence between Assessment Social Worker (#2) and the youth services/youth corrections worker indicating that they planned to get together for a transfer meeting, no such meeting is documented. Assessment Social Worker (#2) did provide the youth services/youth corrections worker with a transfer summary; however, most of her documentation at this point was not entered in the CRMS system. Therefore access to comprehensive historical file information would have been limited.

The purpose of having specific programs tailored to meet the needs of children and youth receiving services from the DCYFS is to ensure they receive the most appropriate service. In John's case, file inaction and transfer delays throughout all programs involved resulted in a reduced level of service and compromised the continuity of John's care.

#### **Recommendation 9**

***The Department of Child, Youth and Family Services ensure that within thirty (30) days of receiving a Child Protection Report, a determination is made as to whether or not a child is in need of protective intervention and the file is closed or transferred to Ongoing Protective Intervention Services as required by Standard #4 of the Risk Management Decision-Making Model (2013).***

#### **Recommendation 10**

***The Department of Child, Youth and Family Services develop and implement a policy to ensure that, when a child or youth is being transferred from one program area to another, a meeting is held between the sending and receiving staff persons prior to the transfer of the client's file.***

### ***Lack of incorporation of informed consent in Youth Services Agreements***

As discussed, signing the YSA and transitioning to the Youth Services Program was a pivotal point in John's life that should have been completed by a social worker with an in-depth knowledge of the process. In addition, Jain and Collins (2012) identified John's capacity to understand the YSA as an issue: "A significant portion of the case presented hinged on the capacity of a sixteen year old adolescent to truly understand the implications of the Youth Services Agreement (YSA)" (p.11). Jain and Collins (2012) further stated:

The legal standard is that an individual must have the capacity to understand the act to which they agree, the risks and benefits, the alternatives to the intervention proposed and an understanding of the possible outcome for the refusal of the offering. [John's] reaction of what was stated in the YSA would have been typical of his developmental cognitive age compounded by his need for "freedom" as he had perceived his life as being one controlled by outside forces" (p.11).

It did not appear that John fully understood what would happen after he signed the YSA. When asked by the Advocate about the first YSA he signed, John stated: "I might have read, like, the first page. I just more or less signed them to get them done" (Transcript of ACY Interview, 2013, p.15). Additionally, in reference to his conversation with Assessment Social Worker (#2), John stated:

We only spoke about it for brief periods, and I just basically said I wanted to go, but she never really explained – I don't think she really explained to me too much of what was going to happen. Like, she briefly explained that, yes, you're going to be living on your own, you're going to basically be an adult (Transcript of ACY Interview, 2013, p.6).

When asked about his expectations of living arrangements before he signed the YSA, John stated: "...I figured I would end up somewhere in a smaller apartment or something, or sharing a board and room, but not exactly where I was to..." (Transcript of ACY Interview, 2013, p.7).

Jain and Collins (2012) commented on the assessment of John's understanding of the YSA:

The workers should have understood the impulsive urge for freedom versus true understanding of responsibility and should have set the bar higher to ensure that the basic tenements of Informed Consent were adhered to. It is insufficient to simply ask, 'Do you understand what you are signing?'" (p.19).

Jain and Collins (2012) suggested that when signing a YSA without a guardian present, youth should have access to a legal representative or public trustee.

Jain and Collins (2012) also noted that there was no attempt to review issues of informed consent with John when the YSA was signed again in August. At this time, the youth services/youth corrections social worker and the community youth worker were aware that John was using drugs and alcohol. Jain and Collins (2012) stated:

The Social Workers knew that [John] had an active substance use potential which was blatantly obvious at six months given his relative level of functioning. His prior history of selling drugs would also be an obvious clue that [John] was a risk candidate. It does not appear that there was any attempt to establish whether [John] actually had a competency to sign the YSA in the face of his known risks (p.11).

When asked about the second YSA he signed with his youth services/youth corrections worker, John stated: “Yeah, no, I think I just kind of grabbed that and signed it really, just like, yeah, well, I signed this paper before” (Transcript of ACY Interview, 2013, p.24). Jain and Collins (2012) suggested: “At six months, there needed to be a clear review of Informed Consent which should have included his relative functioning from the previous visit” (p.19).

While John was involved in the actual signing of each YSA, it appeared he was not fully informed and neither his understanding of the YSAs nor his ability to provide consent was assessed by the social workers. In the case of signing these documents, John was not engaged as a true participant due to the lack of information provided to him and the lack of assessment for his understanding of the YSA.

#### **Recommendation 11**

***The Department of Child, Youth and Family Services develop and implement a policy to ensure that social workers are trained in and comply with the rules of informed consent when completing Youth Services Agreements with youth.***

**Recommendation 12**

***The Department of Child, Youth and Family Services develop and implement a policy to ensure that when signing or re-signing a Youth Services Agreement, all young people receiving services from the Youth Services Program:***

***(a) must be fully informed and demonstrate a clear understanding of what the YSA entails; and***

***(b) must have a guardian, support person or legal representative present during the signing of the Youth Services Agreement.***

**Recommendation 13**

***The Department of Child, Youth and Family Services research and review the feasibility of creating a provincial youth services coordinator position. This person would be solely responsible for meeting (face-to-face, or via telephone or video conference) with all youth transitioning into the Youth Services Program. This person will ensure that all youth receive consistent assessment of competency by an expert physician, and the necessary education and guidance required in signing and re-signing a Youth Services Agreement.***

***Inadequate/Inappropriate services through the Youth Services Program***

When John signed his first YSA, the DCYFS was operating under the *CYFS Act*. On June 30, 2011, changes were made to services when the Province proclaimed new legislation, the *Children and Youth Care and Protection Act (CYCP Act)*. At the time of John's 16<sup>th</sup> birthday, successful transition to adulthood was the underlying goal of the Youth Services Program (*CYFS Standards and Policy Manual, 2007*). The primary focus of the program, as stated in Section 4 of the *CYFS Standards and Policy Manual (2007)*, was: "the safety, health, and well-being of youth."

Reid and Dudding (2006) identified eight (8) crucial areas of support that contribute to successful outcomes for youth transitioning out of care: relationships, education, housing, life skills, identity, youth engagement, emotional healing and financial support. John embarked on a steady decline of overall health and well-being when he became a client of the Youth Services Program. The program did not provide support crucial to John's successful transition to independence. The Youth Services Program did not achieve its aim of adequately addressing John's safety, health, and well-being and of providing a platform for a successful transition to adulthood.

It was after his transition to the Youth Services Program that key indicators of John's decline became obvious: his school attendance dropped, his drug use increased and he stopped working at his part-time job. Travelling to school became difficult as he now had to utilize public transportation. In an interview, John stated: "...I couldn't really take much going to school for two metro buses six o'clock every morning from [residence] to [school], and I eventually stopped going" (Transcript of ACY Interview, 2012, p.47). If John had continued to work part time while under a YSA, his limited funding would have been cut back due to his employment status. Notably, it was also during this critical time that Assessment Social Worker (#2) and the youth services/youth corrections worker were both under the assumption that it was the other professional's responsibility to provide the administrative role for the Youth Services Program. Major life changes were occurring for John as a result of his transitioning to the Youth Services Program, yet there was no one from the DCYFS providing case management for his Youth Services Program file or supporting him through this transition.

While in receipt of Youth Services, John's living accommodations were inappropriate for a sixteen (16) year old transitioning out of a supervised residential setting. When John turned sixteen (16), he spent almost two (2) weeks in a homeless shelter followed by over three (3) weeks at a shelter for young men, 16 to 29 years of age. After leaving the second shelter, he moved to a bedsitting house where he resided with one youth and several adult men. While the initial recommendation of Choices for Youth was for John to reside in a supportive board and lodging arrangement, at the time there was no availability of such living accommodations.

Even though John's assigned community youth worker assisted him in securing housing at the bedsitting room, the ultimate decision about where he would reside was John's to make. John informed the Advocate that he learned while he was residing at a shelter that he had to look for housing himself: "Like, you got to look in the housing ads or whatever, and then Choices would decide if it was an appropriate place to live" (Transcript of ACY Interview, 2012, p.57). A community youth worker explained to the Advocate that if Choices for Youth was not comfortable with the living arrangement for a youth then the organization would not support the youth going there:

Say if there was like a safety reason, say there was somebody in the house who we thought would be dangerous to the young person, or say the house itself was not in good condition and we thought the house itself wasn't safe, we would not support it... now recognizing that a lot of these bedsitters, people are transient, you don't always know who's living there (Transcript of ACY Interview, 2012, p.13).

In an interview with the Advocate, John described his process of securing his living accommodations at a bedsitting room:

... I was looking around and I couldn't really get any meeting set up or whatever, and then one of my friends I met who lived in a house told me to tell the Choices workers about a landlord, and then eventually I went and looked in two houses they were fairly old, I mean, like, they weren't the cleanest houses ever – like, most of my friends that were living on Choices didn't exactly live in the best living arrangements, not all the houses – like, houses really old. Some of them had bed bugs and they're moldy, and they're not exactly really clean kind of spots you want to live in (Transcript of ACY Interview, 2012, p.58).

After John and his community youth worker viewed two (2) options from this landlord, John said he chose to live at the location that seemed quieter as he felt he would not have to worry about someone breaking into his room which he said was a common occurrence at “boarding houses.” John informed the Advocate that also residing at the bedsitting house were four (4) adults and another youth. In an interview, John spoke about the other residents in the house:

...every one of them drank a lot and used to sit around for their cheque to come, or they'd be getting loans and they'd just be going down the store and they'd just be sitting around drinking all the time (Transcript of ACY Interview, 2012, p.61).

He said the other residents “laid down the rules” and John explained that he could not have visitors at his residence: “...I couldn't really have friends over or they'd make a big deal of out of it” (Transcript of ACY Interview, 2012, p.64). When asked if he brought this complaint forth to staff at Choices for Youth, he stated: “I think I might have mentioned it once or twice, but it was never really causing a concern. They were just, like, you might as well just listen” (Transcript of ACY Interview, 2012, p.64).

The staff of the Supportive Housing Program were familiar with the landlord of the bedsitting room, as they were supporting another youth residing at this location. A community youth worker was asked by the Advocate if there had been concerns with any of the other residents in the bedsitting house. The worker stated:

I think, for the most part it was a pretty quiet house. I mean, I think, you know, when the older gentlemen get their cheques and they'll spend it on their liquor and then they might have a couple of days when they're on a bit of a tear, and then it quiets down until the next cheque or whatever, but the place was always clean and tidy (Transcript of ACY Interview, 2012, p.8).

John was knowingly struggling with alcohol and drug use throughout his time at the bedsitting room as documented by both Choices for Youth and Youth Services. Despite such concerns, he was living in an unstable and transient environment that quite evidently did not support his health, safety, and well-being.

While it is recognized that there is a shortage of affordable and suitable accommodations for youth living independently, the bedsitting room where John resided for over seven (7) months was an inappropriate option. Choices for Youth staff and Youth Services staff interviewed by the Advocate, all expressed a concern about housing options available to youth. The youth services/youth corrections social worker spoke about the housing situation for youth living on their own:

I guess, you know, what can we do, you can't see him on the street with nowhere, so you give him whatever is available and all that tends to be slums, right, five or six guys in one house and everybody doing their own thing. They got their own bedroom and everybody is breaking into everybody's room stealing everything belong to each other, and it's just gross what goes on... (Transcript of ACY Interview, 2012, p.88).

The financial supports available for youth receiving services from the Youth Services Program since June 30, 2011 are outlined in *Policy no: 5.5 of the Protection and In Care Policy and Procedure Manual (2011)*. Refer to Appendix E for a complete list of allowances for youth approved for Residential Services under the *CYFS Act* and the *CYCP Act*. For both supportive board and lodging and bedsitting arrangements the allowance is up to \$500 monthly, which given the rising costs of housing, significantly limits the options available. Youth are also permitted to receive \$180 personal allowance and \$200 grocery allowance monthly. In an interview, John reported that he was receiving \$66.75 every week while he was residing in the bedsitting room. John was expected, at sixteen (16) years of age, to budget \$66.75 per week to support his needs. This money had to account for any items he wanted or needed to purchase and for day-to-day living expenses including personal hygiene items, transportation, entertainment and meals. Despite his grocery allowance, documentation indicates that John often ate meals at the Choices for Youth site and availed of food bags from the Choices for Youth shelter; these options were provided free of charge.

John reported to the Advocate that while he was in the ALA he didn't feel "free" and he wanted to pursue the Supportive Housing Program. He stated: "I can live on my own, I can take care of myself" (Transcript of ACY Interview, 2012, p.45). John further stated:

Can you think back to when you were sixteen, how great it would have been to be able to not have your parents saying anything for you to do, or you're on your own, you don't got to listen to your parents... That sounds like a dream come true, but really in the end, I do regret going to a boarding house (Transcript of ACY Interview, 2012, p.45).

Reid and Dudding (2006) describe factors of success as seven (7) pillars (relationships, education, housing, life skills, identity, youth engagement, emotional healing) and a foundation (financial support). These factors, when considered as interconnected, can contribute to successful outcomes for youth. John's journey to

independence was significantly impeded by services that did not adequately support him relationally or financially. This was evidenced by John's concurrent struggle with multiple areas when he left care which included isolation from his former neighborhood and school, a move from a highly supervised residential setting to an unsupervised arrangement, significant decline in school attendance, reported inadequate life skills for the transition, increased drug use and low income. When combined, the stressors John faced at such a young age created an environment that was not conducive to a successful transition to adulthood but in fact placed him at further risk.

Not only did this atmosphere contradict both the mandate of the Youth Services Program and evidenced-based practice, it impacted John's right to an adequate standard of living as stipulated in the *United Nations Convention on the Rights of the Child (UNCRC)*. Article 27 of the *UNCRC (1989)* recognizes that children under the age of eighteen (18) have a right to an adequate standard of living in terms of their physical, mental, spiritual, moral and social development. Hodgkin and Newell (2007) explain these multi-dimensional aspects:

Article 27 recognizes that the child's development cannot be divorced from his or her conditions of living. By listing the different components of full development – physical, mental, spiritual, moral and social – article 27 makes clear that an adequate standard of living is not just limited to the basics of food, clothing and housing, important though these are (p. 394).

The Government of Newfoundland and Labrador has the responsibility to ensure that all relevant services and programs are provided effectively and efficiently by the responsible departments and agencies in a manner that maintains and upholds Article 27 of the *UNCRC*. While John had housing and a limited source of income provided to him through the Youth Services Program, his environment did not provide a standard of living adequate for his development as outlined in Article 27.

#### **Recommendation 14**

***The Department of Child, Youth and Family Services review and revise as necessary the Residential and Supportive Services provided under the Youth Services Program to ensure that youth have access to:***

- (a) sufficient funding for safe and affordable housing options; and***
- (b) services that support the crucial areas that Reid and Dudding (2006) identified as contributing to successful outcomes: relationships, education, housing, life skills, identity, youth engagement, emotional healing and financial support.***



### ***Disjointed relationship between the DCYFS and Choices for Youth***

When John signed a YSA with the Youth Services Program, he became a client of the Choices for Youth Supportive Housing Program. The DCYFS funded John's YSA through block funding to Choices for Youth and his rent was paid directly to his landlord. Choices for Youth were also responsible for providing John with an allowance. In addition to the assignment of a youth services social worker with the DCYFS, he was assigned a community youth worker with the Supportive Housing Program.

A Memorandum of Understanding between the St. John's Regional Health and Community Services Board and Choices for Youth was signed and dated on June 30, 2004. Part of this agreement stipulates the services provided through the Supportive Housing Program for youth who are under YSAs. The agreement outlines obligations of Choices for Youth, including: "Choices agrees that the services will be provided in accordance with the policies and requirements of the Health and Community Services Board/Integrated Board and Department of Health and Community Services" (p.3). This agreement was requested and received by the ACY during this investigation. It does not appear that an updated agreement has been signed between the DCYFS and Choices for Youth to reflect the current organization names and agreement between both partner organizations.

In interviews with the Advocate there were contradictory responses from employees from the Youth Services Program and the Supportive Housing Program regarding the responsibility of case management. The youth services/youth corrections social worker described her youth services role as primarily an administrative function. She stated:

It's like keeping the Youth Services thing up to order, keeping the file and a record for the most part of – you know, you're supposed to put your notes in there and any other documents that's required, but the day to day grind of providing actual youth services, Choices has been doing it. They're doing all the hands on stuff (Transcript of ACY Interview, 2012, p.99).

The youth services/youth corrections program manager supported this interpretation in her interview with the Advocate. She explained to the Advocate that because John was involved with the Supportive Housing Program, the youth services/youth corrections social worker's role was, "much less than a child who was not involved with the Choices for Youth Program" (Transcript of ACY Interview, 2012, p.10). A senior official with DCYFS informed the Advocate that Choices for Youth were viewed as having an "expertise in working with young people" (Transcript of ACY Interview, 2012, p.59). When asked about the accountability framework she stated: "I would probably see it more of a shared accountability, but Choices had more of a – had a defined role there, yes" (Transcript of ACY Interview, 2012, p.59).

In contrast, a Choices for Youth coordinator clearly indicated that CYFS maintains a case management role:

...even though a young person is with our Supportive Housing Program, they are still case managed by a social worker with Child Youth and Family Services. That's where the Youth Services Agreement would need to be signed. I think, and again I'm not sure specifically, but I think once a month is the requirement that they need to still see the young person that's participating in our program... (Transcript of ACY Interview, 2012, p.21).

Significant concerns regarding accountability are evident from these contradictory responses. The service providers involved in John's case did not have a clear understanding of their roles within the partnership between Choices for Youth and the DCYFS. Additionally, youth services workers were required to abide by the standards outlined in Section 4 of the *CYFS Standards and Policy Manual, (2007)* (prior to June 30, 2011), and currently Section 5 of the *CYCP Protection and In Care Policy and Procedure Manual, (2011)* (June 30, 2011 onward). Despite the existence of an agreement between Choices for Youth and the St. John's Regional Health and Community Services Board, it appeared that Choices for Youth staff were not actively following the standards set by the DCYFS in their practice. As the youth services worker was relying on Choices for Youth to fulfill the service provision role, there was no one ensuring that John was receiving case management consistent with the policies of the DCYFS for the Youth Services Program.

In addition to the appearance of role confusion, information sharing between the community youth workers and the youth services/youth corrections worker was informal and inconsistent. As many of the youth services workers are located in the same building as the Supportive Housing Program, a coordinator with Choices for Youth explained to the Advocate that collaboration is very informal. There were no required regular meetings in place for the youth services/youth corrections social worker and the community youth workers. Yet it is obvious that such meetings are important not only for information sharing but also for the overall management of the file and support for the youth. In an interview, a Choices for Youth coordinator informed the Advocate that the program has monthly team meetings to discuss clients. She explained that while youth services workers are welcome to attend these meetings, it has historically been difficult to coordinate scheduling. She stated: "... I kind of just had to say if you can make it, you can make it; if you can't, you can't, because we'd try and it would be too much trying to re-arrange things" (Transcript of ACY interview, 2012, p.22).

Jain and Collins (2012) recognized communication between Choices for Youth and Youth Services/Youth Corrections as an issue:

...Choices for Youth and Corrections were in the same building and this should have allowed for a better connection between staff. Yet, it appeared their relationship was largely informal and dependent upon the initiative of the case managers as opposed to a policy by senior administrators (p.8).

In late 2011, when John was brought to the Janeway by the RNC, the youth services/youth corrections social worker received a Child Protection Report (CPR) that was faxed to her office by another office within the DCYFS. The information on the CPR included details indicating that John did not know if he was going to hurt himself or someone else and that he claimed he wanted to burn down his house. When interviewed by the Advocate, the youth services/youth corrections social worker could not recall the details of her response; however, she advised that she went upstairs in her office building and notified the community youth worker of the information. The youth services/youth corrections worker explained that she did not think that she or the community youth worker had a role with regard to the incident. The worker further explained that John was receiving voluntary services and that he was not under anyone's care. She stated: "...Nobody has any responsibility for him other than to see that he gets the services that he's applied for..." (Transcript of ACY Interview, 2012, p.180). This worker did not take any further action on this date. In an interview with the Advocate she stated: "I don't think there's a specific thing I was supposed to do, but I certainly would have talked to him about it as soon as I seen him" (Transcript of ACY Interview, 2012, p.185).

The youth services/youth corrections program manager informed the Advocate that she was not aware of the information contained in the faxed CPR until the following week. She explained that she would have expected the youth services/youth corrections social worker to speak with the Choices for Youth staff and to try and contact John immediately on that same day. In contrast to the response from the youth services/youth corrections worker, the program manager informed the Advocate that she would have viewed speaking with John on that day as both the role of the worker and the role of staff with Choices for Youth (Transcript of ACY Interview, 2012).

A Choices for Youth community youth worker informed the Advocate that she tried to contact John via telephone after she received the information but she could not reach him. The community youth worker spoke with another tenant of John's bedsitting house who advised that John had packed a bag and was gone for a few days. The community youth worker assumed that John had gone to stay with his aunt but did not confirm this with John or his aunt (Transcript of ACY Interview, 2012).

The response to the receipt of this information was uncoordinated and illustrated a lack of clarity by those involved of the professional roles of the Youth Services Program and the Supportive Housing Program. Both the youth service/youth corrections worker and community youth worker were aware of critical information regarding their client. While John was receiving voluntary services and these professionals were not

responsible for his care, an opportunity for critical intervention with a vulnerable youth presented itself on this date. As the Youth Services Program aims to improve the quality of life for youth, a collaborative response that addressed John's emotional and physical well-being was warranted, but did not occur.

#### **Recommendation 15**

***The Department of Child, Youth and Family Services in collaboration with Choices for Youth:***

- (a) update and revise the 2004 MOU between the St. John's Regional Health and Community Services Board and Choices for Youth to reflect the current partner organizations and agreement of services; and***
- (b) ensure that all staff working in the Youth Services Program and Supportive Housing Program are trained in and demonstrate a clear understanding of their specific roles and responsibilities with respect to case management.***

#### ***Inappropriate dual role of Youth Service/Youth Corrections social worker***

John's youth corrections worker served a dual role as she was also his youth services worker. The assigned youth services/youth corrections program manager explained to the Advocate that the purpose of having both programs offered through the same worker was to ensure that youth were receiving the best service they could while reducing the number of people a youth was required to see (Transcript of ACY Interview, 2012). When asked in an interview, a senior official informed the Advocate that she supported this practice rather than requiring a youth to see two (2) different social workers. However, when questioned in a separate interview, the youth services/youth corrections social worker raised concerns with the dual role, she stated: "When you try to be both, you're not, I don't think, being the best Youth Services worker you can be..." (Transcript of ACY Interview, 2012, p.15). She cited potential issues with trust as youth corrections workers had the ability to breach a youth's probation.

It appeared that John did not fully understand the dual role that the youth services/youth corrections social worker held. In an interview, John informed the Advocate that he did not know his youth corrections worker was actually performing a dual role that included being his youth services worker. John stated that he assumed his youth services worker was his assigned community youth worker with Choices for Youth. John also raised concerns with disclosing information to his youth services/youth corrections worker. In a discussion about his youth services/youth corrections worker, John stated:

My understanding was that...is my corrections worker and stuff like that. I only found out later that I could have got help from [Youth Services/Youth Corrections Worker]... I was afraid to kind of tell anybody about my drug issues or anything like that because I figured I would have got a breach of probation for it (Transcript of ACY Interview, 2013, p.19).

Although reducing the number of service providers involved with John, the dual assignment of the youth services/youth corrections role was inappropriate and presented a potential conflict of interest. A youth corrections worker is responsible for supervising a youth's probation. The nature of this role could impede the formation of an open and supportive relationship with a client, which is an important part of a youth services worker's role. Since these two (2) programs are not synonymous, assigning the same worker to both roles did not reflect best practice and was not in keeping with John's best interests.

#### **Recommendation 16**

***The Department of Child, Youth and Family Services ensure that when a youth is in receipt of services from multiple programs within the DCYFS, he or she is assigned a separate worker for each program area (i.e. Assessment, Long-Term Protection, Youth Services, Corrections). This will ensure the provision of expert services, clear communication and the avoidance of any potential conflict of interest in meeting the needs of youth.***

#### ***Use of Standardized Tool (YLS-CMI)***

Policy 8.2 *Case Administration and Management of the Community Youth Corrections Standards and Practices Manual (2002)* outlines standards for the completion of the *Youth Level of Service/Case Management Inventory (YLS-CMI)*. Policy 8.2 states: "A well-established principle of case management is that the intensity of supervision should be matched to the risk-need levels of the offender. The higher the overall risk/need level presented, the more program services required" (p.1 of 5). As part of the Community Youth Corrections Program, the YLS-CMI was utilized by an intake social worker to assess John when he entered the program and eight (8) months later by his assigned youth services/youth corrections worker. When John was re-assessed after (8) months, his overall risk was lowered from 'high' to 'moderate.' It seems unusual that John's level of risk was assessed as being lower at a time when his stressors were intensifying in all realms of his life. The ACY found that John's decline in well-being since his initial intake assessment was clearly evidenced by increased drug use and time spent at a detoxification facility, lack of attendance in school, arrest for involvement with a stolen car, and inappropriate living accommodations.

When asked by the Advocate to rationalize the results of the YLS-CMI, the youth services/youth corrections worker's response indicated that she did not appear to complete this standardized tool in a systematic way. For instance, the youth services/youth corrections social worker lowered the rating in the 'Family Circumstances/Parenting' section of the YLS-CMI from 'high' to 'low' when she completed the re-assessment. The intake worker who completed the first assessment indicated the following risk factors within this section including: inadequate supervision, difficulty in controlling behaviour, inappropriate discipline, poor relations – father/child, and poor relations – mother/child. The youth services/youth corrections worker only marked 'poor relations – mother/child' in this section, which lowered the risk level in the section from 'high' to 'low'. In an interview with the Advocate, she explained her actions:

...So all of them there they no longer apply as far as I was concerned...."difficulty in controlling behaviours", sure there was nobody controlling any behaviour he wasn't in – he was emancipated he was on his own, right... (Transcript of ACY Interview, 2012, p.159)

When further questioned, she stated: "it probably is inadequate supervision" (Transcript of ACY Interview, 2012, p.159). This worker explained to the Advocate that it was possible she was reading this tool incorrectly. Still, she did not appear to be concerned with the potential impact of the misuse of the standardized assessment tool: "...even if I gave him a stroke for that it wouldn't have made no difference on the outcome. That one little mark I can tell you now because of the range of moderate is 10-22 or something..." (Transcript of ACY Interview, 2012, p.160).

By November, John had stopped attending school; however, the worker indicated on the YLS-CMI re-assessment that John was attending school and there were no issues identified with his behaviour. The worker identified that this was a 'strength' and the risk was rated as 'low' as compared with the previous rating of 'high.' The worker informed the Advocate that John had advised her he was attending school and that she had no requirement to check with the school as John did not have a condition in his probation order to attend. Two (2) additional sections lowered on the re-assessment form included personality/behaviour and attitudes/orientation. A program manager described the tool as subjective: "...I might look at it and write copious amounts and you might look at it – it's very subjective" (Transcript of ACY Interview, 2012, p.73).

The purpose of using standardized assessment tools is to ensure reliability and validity in service provision within program areas. Based on interviews, it was determined that John's YLS-CMI re-assessment was not completed using a systematic approach. Additionally, the worker did not recognize the importance of completing such assessments in a standardized manner. As a result of this assessment, John's required meeting frequency for the Community Youth Corrections Program decreased from bi-weekly to monthly at a time when he was in need of heightened guidance and supervision.

**Recommendation 17*****The Department of Child, Youth and Family Services:***

- (a) develop and implement a training module to train social workers in the use of the YLS-CMI tool; and***
- (b) educate all applicable social workers in the completion of the YLS-CMI assessments to ensure reliability and validity of service provision.***

**DEPARTMENT OF JUSTICE*****Absence of Notification of Arrest and Detention to Youth Corrections***

The Advocate learned of a significant gap with regards to the notification of John's youth services/youth corrections worker following John's arrest in relation to the theft of a vehicle in August 2011. It appears that the youth services/youth corrections social worker was not notified by the arresting officers or staff at the Youth Detention Centre upon John's arrest and detention. In an interview with the Advocate, the youth services/youth corrections worker stated that when a youth on her Youth Corrections caseload commits a crime, there is no official notification given to her. The youth services/youth corrections worker said that notification is sometimes provided to her but it depends on how severe the charges are. She did confirm that she has access to the youth court docket where such information would appear.

Review of the *Section 1.11: Overnight Detention (Revised April 2010)* and *Section 1.1.2 Operational Admissions (Revised April 2010)* in the *Facility Rules Policy Manual: NL Youth Centre* revealed no directive that required staff at the Youth Detention Centre to provide notification to a youth's current youth corrections worker following an arrest and detention. In addition, there is no directive in *General Order 176, Youth Criminal Justice Act/Youth Investigations (March 31, 2003)* in the *Royal Newfoundland Constabulary Policy and Procedure Manual* requiring RNC officers to provide notification to a youth's current youth corrections worker following an arrest and detention.

The youth services/youth corrections social worker did not visit John while he was detained at the Youth Detention Centre overnight nor did she attend court the following day. The worker explained that as she was supervising John's current order at the time, she would not have had a role since John was not convicted. When asked by the Advocate if she viewed the lack of notification as a problem, the youth services/youth corrections worker stated: "Not really because I can't chase around dealing with every little matter. The thing is, they haven't done anything until they're convicted. You're only alleged" (Transcript from ACY Interview, 2012, p.107). The youth

services/youth corrections worker stated that rather than seeking formal information about John's arrest and subsequent charges, she relied on information provided to her by John at their next meeting.

Review of file documentation indicates that the circumstances surrounding the car theft incident appeared to have had an impact on John; his aunt expressed concern to a community youth worker at Choices for Youth. Regardless of the outcome of these charges, in order to effectively carry out the role of youth corrections worker which includes ensuring youth have access to supports/services, the worker could have benefited from having been provided with official notification of John's arrest and detention.

#### **Recommendation 18**

***The Department of Justice develop and implement a protocol to ensure that notification is provided to a youth corrections social worker when a youth on his or her caseload is arrested and/or detained under the Youth Criminal Justice Act.***

#### **DEPARTMENT OF JUSTICE** **ROYAL NEWFOUNDLAND CONSTABULARY**

##### ***Nonadherence to RNC documentation and record keeping policies***

During this investigation the Advocate became aware of information pertaining to John having involvement with the RNC during a weekend in December 2010. The incident is referenced in a CRMS note of the DCYFS documenting a home visit to John by Assessment Social Worker (#3). The Advocate also obtained information about the incident through interviews with John and John's friend's father.

CRMS notes and evidence from interviewees raised concerns that John, then fifteen (15) years of age, was stopped by police in the early morning hours, searched and had his wallet taken by a police officer. Such allegations are quite serious given that they indicate that John, only fifteen (15) years of age, was wandering the streets in the middle of the night and no action was taken to address his safety such as contacting his guardian or making a referral to the DCYFS. John alleged that he was searched by the RNC and it is unknown whether the search was warranted by *General Order 170 Search and Seizure (February 5, 2002)* in the *Royal Newfoundland Constabulary Policy and Procedure Manual*. It is also concerning that John allegedly had his wallet taken by the RNC and not returned. As John's wallet was not found in the Property Control Centre, it would appear that *General Order 180 Property and Exhibit Handling Procedures (October 2, 2003)* in the *Royal Newfoundland Constabulary*



*Policy and Procedure Manual* may have been contravened. As there is no RNC documentation of this incident, including a call for service or police notes, details pertaining to potential breaches of RNC policies and procedures cannot be confirmed.

*General Order 188 Criminal Reporting Procedures (July 20, 2005)* in the *Royal Newfoundland Constabulary Policy and Procedure Manual* states: "All matters requiring police attention must be recorded within the Integrated Constabulary Automated Network (ICAN) system and the appropriate forms completed" (p.1). *General Order 169 Police Note Books (January 21, 2002)* states: "Note taking is a mandatory requirement for all police members, regardless of their level of involvement in a particular event or occurrence" (p.1). *General Order 176 Youth Criminal Justice Act/Youth Investigations (March 31, 2003)* stipulates the information required in reports concerning youth:

13.1 For the information of the RNC and agencies involved in the judicial process, members will make a reasonable effort to obtain and include the following information when preparing reports on young persons, whether charged or not:

- a. full name and address;
- b. whether the young person is a student, is employed, and if so, where;
- c. date of birth;
- d. surnames and given names of each parent;
- e. name of guardian if young person is not under parental control; and
- f. address of each parent (if different than that of the young person).

13.2 In situations where members are unable to include all of the above data they must provide an explanation for the missing information in their report (p.19).

The Advocate requested RNC documentation pertaining to the incident; however, no such written or electronic documents were located by the RNC. In addition, the Advocate inquired into the names of the RNC officers working in the area where the incident allegedly occurred. While the hardcopy attendance record was received, for two (2) of the three (3) evenings in question, no electronic record was found of the RNC daily roster.

The Advocate spoke with a senior official with the RNC regarding the incident in question. The senior official contacted a retired RNC sergeant who recalled meeting with a young male and an adult male who were looking for a wallet that was misplaced by an RNC officer. This recollection was very similar in detail to the one provided by John's friend's father in an interview with the Advocate. The constable involved was identified and he submitted a written account of the incident to the Advocate. The constable recalled this incident to be in the same geographic area as John had

indicated. The Advocate subsequently interviewed the RNC constable believed to be involved in this similar incident; however, it could not be confirmed to be the same occurrence. There was no documentation found regarding this incident and the officer could not recall details including the young male's name, the date of the incident and the name of the other RNC constable involved.

In an interview with the Advocate, this constable was asked if information pertaining to this incident was located in his police notebook as per *General Order 169*. The officer stated:

But that's the thing, it's not in my notebook, so I'm thinking I provided it to the other officer because maybe it was his call... Or if it was my call, I may not have documented it just for the fact that it was an unfounded call (Transcript of ACY Interview, 2013, p.37).

When asked by the Advocate what he records in his notebook, the constable stated: It depends on the circumstances, I guess. Every call is different. Every situation we come across is different. We do thousands of calls a year. Just personally. So if I documented everything I did in my twelve hour shift, I'd never be able to do it (Transcript of ACY Interview, 2013, p.41).

*General Order 169* mandates note taking regardless of the level of involvement by a police member. The Advocate brought this to the attention of the constable. He stated: "The thing is there was two of us there. So I'm assuming there was some type of note taking, so it wouldn't be – I don't think it would be necessary for both of us in an unfounded case" (Transcript of ACY Interview, 2013, p.42).

When asked by the Advocate whether *General Order 188* was followed, which requires all matters requiring the attention of the RNC to be recorded in the ICAN system, the constable stated:

I think the issue here is 'requiring police attention'. I think where it's unfounded, the call was unfounded, it came in as an incident, some type of criminal offence taking place, and when we got there, it was unfounded... it wouldn't have been any reason for an follow-up and any reason for any report to be taken (Transcript of ACY Interview, 2013, p.45).

Given that this constable involved in the similar incident conducted a search of a young person and ended up mistakenly taking his wallet, it would be reasonable to expect details to be recorded in the ICAN system despite the origin of the call being unfounded. In fact, *General Order 176* specifically states that the stipulated information for reports on young persons be obtained "whether charged or not." In addition, *General Order 188* also stipulates that "all complaints and investigations require a police file number." There was no police file number provided to the Advocate regarding this incident.

It should also be noted that while the hardcopy attendance records for the timeframe of the alleged incident were located, there was no electronic record of the daily roster of areas of assignment found for the one night this officer worked on the weekend in question. This further impeded the Advocate's investigation into this alleged incident.

As no documentation could be found pertaining to this incident, it was never confirmed to be linked to John and his friend's father. The search for records pertaining to the alleged incident with John and the similar incident proved to be unsuccessful, which identifies a gap in RNC record keeping. Without record of the daily roster, the call for RNC service and details of RNC response, a comprehensive and complete investigation into service provision could not be completed. The lack of documentation and schedules also brings into question the ability for both internal and external parties to investigate complaints made regarding RNC service provision.

#### **Recommendation 19**

***The Department of Justice ensure that the Royal Newfoundland Constabulary:***

- (a) uphold record keeping standards as outlined in General Order 169 Police Note Books;***
- (b) uphold record keeping standards as outlined in General Order 188 Criminal Reporting Procedures;***
- (c) uphold 13.0 Information Required in Reports Concerning Young Persons outlined in General Order 176 Youth Criminal Justice Act/Youth Investigations; and***
- (d) keep complete electronic records of all shift daily rosters.***

#### **Recommendation 20**

***The Department of Justice ensure that all Royal Newfoundland Constabulary and Royal Canadian Mounted Police employees are educated on their duty to report pursuant to Section 11 of the Children and Youth Care and Protection Act (2010).***

**DEPARTMENT OF HEALTH AND COMMUNITY SERVICES**  
**EASTERN REGIONAL INTEGRATED HEALTH AUTHORITY**

***Lack of Proactive Engagement with the DCYFS and the Client***

John visited the Janeway ER twice in January 2011 and attended a follow-up appointment with psychiatry shortly after these visits. During these interactions, a lack of proactive engagement and communication with John and the DCYFS was evident. Specifically, information was presented to physicians that was not communicated to a DCYFS social worker or the Intake Program. Additionally, John was not fully informed of services available to him and there was a lack of privacy during appointments.

Under Section 15 of the *CYFS Act (SNL 1998)*, health care professionals were mandated to report information that a child is or may be in need of protective intervention. When John attended the ER for the first time in January 2011, the ER physician documented statements about self-harm. When asked by the Advocate if the ER physician felt she needed to complete a CPR, she stated: "Not at the time, no, it sounds like it's more emotional things that's going on for a while. It didn't seem like there was any violent things" (Transcript of ACY Interview, 2012, p.16). In a follow-up appointment, the psychiatry resident involved in January 2011 learned of verbal abuse in the home and that John wanted to harm his mother. The resident confirmed to the Advocate that she did not communicate this information to the DCYFS.

In addition to failing to report important information to the DCYFS regarding their client, some medical professionals involved did not appear to engage proactively with John about potential services available to him. When John attended a follow-up appointment with the psychiatry resident at the Janeway, he abruptly left the appointment and there was no further contact initiated by the resident. The resident explained to the Advocate that she did tell the ALA worker that he could come back. She explained that she could not force John to meet with her again and there was no legal recourse to do so. In an interview with the supervising psychiatrist, he informed the Advocate that he would share information with a social worker if one were to inquire. When asked if he would contact the DCYFS in an instance whereby a child, like John, walked out of his follow-up appointment, he stated: "Probably not, unless they contacted me. A child who – if he walked off and doesn't want any help in the future, we don't solicit business" (Transcript of ACY Interview, 2012, p.39-40). On these two (2) occasions in 2011, the onus was on John to follow up for psychiatry services at the Janeway. It also should be noted that the Rowan Centre, an addictions day treatment program for youth, existed at the time; however, there is no evidence in file documentation that a referral to this service was made. While these services were voluntary, there was no reason the medical professionals could not have encouraged John to avail of help. Given John's young age and circumstances, follow-up contact should have been made with him directly to discuss services and supports available to him.

Lack of privacy when meeting with medical professionals could have had an impact on John engaging with these professionals to receive help. Another person was present at two (2) appointments John had at the Janeway; an ALA worker in February 2011 and his mother in May 2011. While none of the ER physicians and psychiatrists that John saw documented having the police present during their meetings with him, John informed the Advocate that he recalled a meeting with a professional who refused to talk with him alone without police officers present. He stated:

That made me uncomfortable. And I don't really think that would have been the best time to do a psychiatric assessment on somebody for health like that. I mean, I just got hauled out of my house by police. I'm really upset, and I'm not going home, and she won't talk to me without a police officer there (Transcript of ACY Interview, 2013, p.34).

The presence of other adults in the room while meeting with professionals may have impacted John's disclosure of important information, and therefore impeded the application of appropriate treatment options.

Article 16 of the *UNCRC (1989)* addresses a child's right to privacy. Furthermore, *General Comment No.4* issued by the Committee on the Rights of the Child (2003) states:

In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment (p .3-4).

Given the importance of ensuring a child's right to privacy as per Article 16 of the *UNCRC (1989)*, John should have been provided with the opportunity to speak privately with the medical professionals.

### **Recommendation 21**

***The Department of Health and Community Services ensure that all health care professionals in the four (4) Regional Integrated Health Authorities are educated on their duty to report pursuant to Section 11 of the Children and Youth Care and Protection Act (2010).***

**Recommendation 22**

***The Department of Health and Community Services ensure that when youth meet with medical professionals in any of the four (4) Regional Integrated Health Authorities:***

***(a) they are provided with the opportunity to meet privately and confidentially upholding their right to privacy as per Article 16 of the United Nations Convention on the Rights of the Child; and***

***(b) if the safety of the youth or professionals is a concern that alternative measures are taken (the use of handcuffs and/or a windowed room for observation) to accommodate a private and confidential meeting while ensuring safety.***

***Diagnosis of Conduct Disorder***

Conduct Disorder (CD) is defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (2000)*: "... a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (American Psychiatric Association, p. 93). The *DSM-IV-TR (2000)* identifies a list of criteria and the diagnosis requires the presence of at least three (3) criteria in the past twelve (12) months and at least one criterion in the past six (6) months. For the full *DSM-IV-TR* diagnosis definition see Appendix F.

When John was fifteen (15) years of age, a psychiatry resident noted the following impressions: CD, Polysubstance Abuse, Antisocial Personality Disorder traits, parent/child relational issues and drugs, and to rule out substance-induced mood disorder. In addition to scheduling a follow-up appointment with John three (3) days later, the resident urged Mom to press charges against her son as part of her duty to warn. When John attended the follow-up appointment, he left abruptly and, as discussed, the resident left the onus on John to follow up with the Janeway for services if he chose to do so.

In an interview with the Advocate, when asked what the typical intervention for a youth who presents as John did, the supervising psychiatrist stated:

We can offer follow-up. His major problem – we can't do anything about conduct disorder. The law takes care of that. All we can do is something about poly-substance abuse. If he does have a mood disorder and he stops his poly-substance abuse, then that mood should improve once the drugs are taken away (Transcript of ACY Interview, 2012, p.16).

The psychiatrist further described CD as “a pervasive underlying disorder with kids who just don’t care” (Transcript of ACY Interview, 2012, p.17). With regards to treatment for CD the psychiatrist stated:

I’m sure you’re aware of many studies that happened on treatment of these kids, and the best treatment is this boot camp that they put them in for 12 months. So after 12 months they are misbehaviour free because they have been in a confined situation where they get rewards for sociable behaviours and there are consequences attached for unsociable misbehaviours (Transcript of ACY Interview, 2012, p.19).

Dr. Umesh Jain and Dr. Peter Collins commented on John’s diagnosis: “Drs Collins and Jain never assessed [John] so a confirmatory diagnosis cannot be provided. It would appear, based on the material provided, that [John] met the criteria for a Conduct Disorder (CD) and Substance Abuse Disorder...” (Jain and Collins, 2012, p.12). Jain and Collins (2012) identified the impact of diagnostic bias for John: “Conduct disorder does invoke bias amongst mental health professionals and this was readily apparent during the course of [John’s] involvement with the system” (p.12).

Jain and Collins (2012) referenced the impact of generalization of CD: Juvenile antisocial and aggressive behaviours are heterogeneous and vary widely in their form and severity. As a result, lumping all individuals into the same pot is a gross generalization and an acknowledgement of the lack of understanding of the complexity of the disorder and their various outcomes. Evidence of inadequate training was noticeable from the Corrections Officer to the Emergency Room Physician (and their deliberation of risk)... (p.12).

Further, Jain and Collins (2012) discussed Conduct Disorder co-occurring with other disorders:

Conduct Disorder frequently co-occurs with other mental and adjustment problems and different developmental pathways can lead to similar conduct-like problems. Masked depression sometimes presents with CD when, in fact, the basis of the CD is an individual who is so overwhelmed by their depression that acting out behavior is a call to help... ADHD is a frequent predisposing factor that leads to CD diagnosis and it is eminently treatable (p.12).

With regards to treatment for CD, they stated:

Conduct disordered juveniles can be difficult to treat and manage and, as a result, a perception is fostered that their only solution is the justice system and NOT the mental health system. There is stigma attached to the diagnosis in that psychiatrists, psychologists and members of social service agencies will assume they cannot be helped (Murrie, Cornell & McCoy, 2005; Pottick et al., 2007). [John], in his post offence interview with the Office of the Child Advocate, perceived that nothing was ever being done for him (Jain and Collins, 2012, p.12).

Jain and Collins (2012) referenced the possibility that John may have been struggling with adolescent depression. They stated:

...depressed boys tend toward more disruptive and aggressive behaviour. Often not one disorder is apparent. At times, one set of symptoms or behaviours may shadow an underlying disorder, such as a teenager's increasing alcohol or drug abuse used to self-treat their depression (p.13).

Jain and Collins (2012) further stated:

In the case of [John], he was a risk for suicidal acting out because of the repeat statements that he was thinking of suicide as a viable option for him and the risk increased with his substances abuse, conduct disorder and what likely may have been a depression or dysthymic disorder. In the absence of any other factor a deterioration of school performance, in an adolescent, is due to an underlying mood disorder (p. 13).

In referencing John's diagnosis of CD, Jain and Collins (2012) stated: "This is a diagnosis that should not be given lightly as the ramifications of the diagnosis had significant consequences" (p.16).

After the initial meeting with the psychiatry resident, John had a follow-up appointment three (3) days later and abruptly left. As part of an educational case conference, the psychiatry resident presented John's case to her colleagues eleven (11) days after this appointment. Notes taken from this case conference indicate that her colleagues presented different impressions for the case. The resident confirmed this:

Yes, it's sort of – we talk about someone around the table and people come up with other diagnoses to consider or things we may have not considered. I mean, that's the beauty and difficulty of psychiatry, it's not an exact science... (Transcript of ACY Interview, 2012, p.42).

The resident informed the Advocate that the suggestions made by her colleagues would have been explored in followup. Since John did not seek services from the Janeway after the appointment, these options were not explored.



Jain and Collins (2012) discussed the differing impressions of John's diagnosis by the resident and her colleagues:

... [The resident], did the initial psychiatric assessment and reviewed the case with the on-call physician, [Dr.-----]. [The resident] then presented the case in rounds to colleagues. Yet, despite these collective reviews, one is left with a disturbing feeling that something must have been missed if the assessment post-incarceration came to an alternative conclusion as to the diagnosis (p.14).

Jain and Collins (2012) further stated:

If the diagnosis is being considered then every attempt should be made to have a thorough and detailed assessment that discounts any other factor that might be driving the CD. Because the Resident advanced the diagnosis without any further investigations, the diagnosis persisted despite being scrutinized by peers. The danger of the diagnosis is so strong that once created it is difficult to reverse people's opinion as evidenced with [John]. That is not to say that [John] does not meet the diagnosis of CD, but the driving forces behind the diagnosis were not given much consideration (p. 16-17).

Following John's diagnosis of CD, there was no comprehensive treatment plan provided by the Janeway. In addition, the perception held by both the supervising psychiatrist and psychiatry resident that the justice system (i.e. boot camp and pressing charges) would address John's diagnosis of CD did not prove to be effective. While charges were laid against John and he did become involved with PTS and subsequently Youth Corrections, these programs did not address his mental health needs.

### ***Inadequate Assessment***

In their review of John's case, Jain and Collins (2012) identified a number of barriers for John in accessing an adequate mental health assessment. Issues identified included a lack of available admission beds, an inadequate ER assessment and the absence of a structured professional judgment tool as part of the assessments completed.

Despite attending the Janeway ER on three (3) occasions in 2011 with mental health concerns, John was never admitted. In an interview, the Advocate asked the supervising psychiatrist if the frequency of emergency visits was a criterion of hospital admission. He stated: "No not just the frequency it would have to be an indication for admission and there are very few indications for admission. We only have seven beds at the Janeway" (Transcript of ACY Interview, 2012, p.9). Jain and Collins (2012) considered the impact of the lack of available admission beds in their review of John's case. They identified the importance of assessing risk through observation: "One way of assessing risk is to admit patients for observation to determine how much of the

pathology is emanating from the environment, to safely withdraw patients from their acute addictions and to evaluate risk” (Jain and Collins, 2012, p.9). Jain and Collins (2012) recommend: “Creating short-term beds in the emergency room to deal with situation emergencies as this will alleviate a significant portion of admissions freeing up valuable inpatient facilities for those patients that require more intensive evaluation” (Jain and Collins, 2012, p.18).

Jain and Collins (2012) also commented on the adequacy of the ER assessment of John in late 2011. When John was brought to the ER by police he presented as angry and was assessed by the ER physician for a total of twelve (12) minutes. In an interview with the Advocate, the ER physician stated: “We are trained to do an assessment in eight minutes, and that’s what we were taught in medical school for sort of a family practice emergency room visit” (Transcript of ACY Interview, 2012, p.18). When asked by the Advocate if twelve (12) minutes would be sufficient to arrive at her diagnosis of John, the ER physician stated: “For him, yeah, he was able to tell me all the information that I needed to assess whether he needed further management from a psychiatric point of view within that time period” (Transcript of ACY Interview, 2012, p.19).

Jain and Collins (2012) stated:

Although Emergency Rooms are busy, it is incumbent on the casualty officer to get information, first hand from the police, in order to receive the history and ask police questions that may not have been posed by the triage nurse. Twelve minutes is not an adequate time to assess an individual who has been brought in crisis (p.14).

Jain and Collins (2012) recommend what they describe as a better course of action:

Allowing the youth to ventilate and then return to conduct an assessment would have been a better course of action. Information is more likely to be provided if the interviewee does not perceive the interviewer as angry or dismissive. [John] was perceived as angry and had the diagnosis of a Conduct Disorder. It does not appear there was adequate collection of collateral, appropriate referrals to social agencies and a call to the psychiatry team to alert them to the possible risks (p.14).

According to Jain and Collins (2012), this course of action would permit a more appropriate therapeutic rapport:

With the establishment of a more appropriate therapeutic rapport, the casualty officer may have been in a better position to assess for potential for harm to self or harm to others. It addresses the level of training of the ER physician to understand acute psychiatric emergencies in youth (p.16).

The ER physician informed the Advocate in an interview that she was unaware that John had threatened to harm himself or someone else on the evening the police escorted him to the ER. When asked by the Advocate to explain why she did not consult with psychiatry on this occasion, she stated:

In [John's] case, for me as an emergency physician, the only reason I have to consult psychiatry is acutely, if there's concern for the child's harm to himself. So if he had said to me he was suicidal, if there was any homicidal ideation, I also would have contacted them, which he denied, and if he had any features of psychosis. So if he was seeing or hearing things that were not there, then I would have also contacted them. He also had – he didn't have what we consider an Axis 1 diagnosis. So he wasn't depressed, he wasn't bi-polar, he didn't have - he wasn't on any psychiatric medications, he had been given a diagnosis of conduct disorder which is kind of a personality type of diagnosis, Axis 2. So I didn't feel there was any service that the psychiatry team could provide to him at that point in time which they hadn't already provided (Transcript of ACY Interview, 2012, p.11).

Jain and Collins (2012) discussed the relationship historically found between a diagnosis of CD and homicide committed by persons with this diagnosis:

There is an association with conduct disorder and homicide. Cornell et al (1987) classified 72 youths charged with homicide into 3 groups: psychotic – adolescents who manifested overt psychotic symptoms at the time of the offence; crime – adolescents who murdered in the course of another criminal activity; and conflict – those who were involved in an interpersonal conflict or dispute. Others have extrapolated conflict as being a generalized conflict as opposed to a direct personal conflict. This would appear to be [John], who was angry... In a study of juvenile homicide, conducted by Myers and Scott (1998), where they compared conduct disordered youth who committed homicide to conduct disordered youth who had not, the only significant differences was that the homicidal group had more history of stealing and the homicidal group had more involvement with the court. Shared factors included running away from home, fire setting, truancy, lying, vandalism, break & enter, stealing with victim confrontation, cruelty to animals, initiating fights, using weapons in fights, school suspension or expulsion (Jain and Collins, 2012, p.13).

Jain and Collins (2012) also recognized the correlation of depressed adolescents and homicide:

Clinically, according to Malmquist (2006) antisocial behaviour, including homicidal violence, occurs more frequently in depressed adolescents than is indicated by official statistics. Although depression is routinely associated with suicide there is also a relationship with homicide. Depressed adolescents who harbor homicidal ideation may also have some factors in common with suicidal adolescents. They believe the state of despair, they are in, will continue without relief. A corollary belief is that acting out violently, even if they were not intending to kill an individual; (manslaughter), will relieve anxiety and tension. Malmquist (2006) also states, in regards to juvenile homicide, that some type of event representing a personal failure with a resultant loss of self-esteem can often be identified as precipitating the violent act (p.14).

An additional observation by Jain and Collins (2012) concerns the process of assessment in the absence of the use of a structured professional judgment tool. The use of such tools did not appear to be utilized by psychiatrists or ER physicians involved in this file. Jain and Collins (2012) state:

Risk of violence refers to the probability that the examinee will engage in a certain kind of behaviour, in the future, typically either violence or violence offending of any kind, with high risk individuals receiving more intensive intervention and management services. As a guideline, a Structured Professional Judgment (SPJ) tool, or at least knowledge of the key factors associated with an SPJ should have been utilized in the ER setting, as well when [John] was assessed previously by psychiatrists (p.16).

Jain and Collins (2012) identified that:

A few risk assessment tools are available for the assessment of adolescents, however the SPJ tool known as the Structured Assessment of Violence Risk in Youth (SAVRY) developed by Boruim, Bartel & Forth (2003) was found to be the most accurate predicatively when compared to two actuarial approaches (Catchpole & Gretton, 2003). The purpose of the SAVRY is not to “quantify” risk but to provide risk factors for examiners to apply across different assessments. It is designed as an “aid” or a “guide” in risk assessments, and intervention planning, for violence risk management in youth. Risk assessment tools, like the SAVRY, or at least the factors associated with these tools can be used in Emergency Room settings and by psychiatrists (p.16).

**Recommendation 23*****The Eastern Regional Integrated Health Authority:***

- (a) research and review the feasibility of creating short-term beds in the pediatric emergency room for youth that present with mental health concerns and require intensive evaluation;***
- (b) research and review the feasibility of utilizing a structured professional judgment tool (e.g. the SAVRY tool) for the assessment of adolescents that present with mental health concerns; and***
- (c) report the findings of Recommendation 23(a) and 23(b) to the Department of Health and Community Services.***

**Recommendation 24**

***The Department of Health and Community Services review the findings reported by the Eastern Regional Integrated Health Authority as per Recommendation 23(c) and ensure implementation throughout the entire province.***

***Inadequate Access to Mental Health Services***

In reviewing John's case, Jain and Collins (2012) identified a number of macro systemic issues relating to the availability, adequacy and efficiency of mental health services. Macro issues identified included a lack of integrated detoxification and/or long-term facilities for concurrent disorders. Jain and Collins (2012) stated:

A common concern, within the mental health system, is the belief that addictions need to be dealt with first before mental health issues can be assessed and/or treated. The opposite is also true if the perspective is from the addictions side. The polarized stances have their roots emanating in the differences between the medical versus non-medical models. The concept of Concurrent Disorders was to address this division to help the client who had both mental health and addictions issues. In the case of John, the mental health services were unable to respond to someone with current addictions. At the same time, the detoxification programs did not have sufficient long term management and had inadequate outpatient follow-up (p.9).

In 2009, the Government of Newfoundland and Labrador announced the plan to develop two (2) youth treatment centres: a treatment centre for youth with complex mental health needs and a youth addictions treatment centre. While tenders were announced for both centres in 2011, limited program information is available and the treatment centres are not in operation at the time of this report. The Advocate requested information from the DHCS and was provided with confirmation in March 2013 that the addictions treatment centre will offer withdrawal management for youth who experience acute physical and/or psychological withdrawal from substances. The DHCS also noted that interventions for withdrawal management will involve transition planning and a community treatment plan.

Currently, youth needing residential treatment for mental health and/or addictions issues are required to travel out-of-province for services. While this option was discussed with John by social workers, planning was never implemented to access such treatment. Jain and Collins (2012) state:

Outsourcing out-of-province programs has been the default strategy of many provincial governments, most often to the United States or to Ontario (e.g. Portage, Homewood, Bellwood etc.). Management of addictions typically requires intensive and prolonged treatment to break apart the underlying problems often rooted in poor coping strategies and psychological pathology (p.9).

Article 24(1) of the *UNCRC (1989)* addresses a child's right to health and health services:

State parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

As the planned youth treatment facilities are not in operation, children and youth are still required to travel out-of-province for such residential services. Therefore a gap in mental health services continues to exist and available services do not reflect the province's fulfillment of Article 24(1) of the *UNCRC*. Only time will tell if the two (2) proposed centres will meet the needs of youth requiring treatment for complex mental health and for addictions issues.

#### **Recommendation 25**

***The Department of Health and Community Services ensure that when youth present with concurrent disorders to any of the four (4) Regional Integrated Health Authorities, they are provided with a comprehensive assessment, diagnosis and treatment plan addressing both their mental health issues and addictions issues.***

**DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES**  
**DEPARTMENT OF HEALTH AND COMMUNITY SERVICES**  
**EASTERN REGIONAL INTEGRATED HEALTH AUTHORITY**  
**DEPARTMENT OF JUSTICE**  
**ROYAL NEWFOUNDLAND CONSTABULARY**

***Lack of Collaboration, Communication and Information Sharing***

A consistent theme throughout the investigative process was the lack of collaboration and information sharing among the professional agencies involved with John. He was involved with multiple services throughout 2010 and 2011 but the professionals working with him were working independently of one another. The ACY's investigation revealed opportunities for collaboration which would have been in John's best interests, yet did not occur. Collaborative practice among all service providers involved did not appear to be a priority and this had a significant impact on the quality of service provided to John. Article 3 of the *UNCRC (1989)* directs that the best interests of children shall be the primary concern in all actions that affect children. All professionals involved in this case should have been working collaboratively with John's best interests as the foundation of their decisions.

During one of John's visits to the ER, a disagreement occurred between two (2) professionals regarding the best course of action for John. John had presented at the hospital with a broken nose and indicated to an ER nurse that he did not want to return home. The ER nurse contacted an on-call social worker with the DCYFS. Rather than visiting the hospital to gather further information, this social worker went to Mom's house as directed by her manager. There is no indication that any further followup was completed by the DCYFS with the Janeway ER to further explore their concerns or their assessment of John's injuries.

Ineffective collaborative practice occurred once again two (2) days following John's visit to the Janeway when Assessment Social Worker (#3) contacted the RNC Child Abuse and Sexual Abuse Division (CASA) via fax. This social worker forwarded a CPR to the RNC as there was information contained in the referral indicating John was injured. The responding RNC constable advised the social worker that the file would be closed as there were no criminal allegations. There was no further investigation into John's injuries by the RNC. While the DCYFS, the Janeway ER and the RNC were in contact about John's injuries, they did not actively work together to address the situation and the origin of the injury was never fully explored in a timely manner by any party involved.

When John came into the care of the DCYFS, he also became a client of Janeway Psychiatry and PTS. The *CYFS Standards and Policy Manual (2007)*, Section 3.22 addressed the *Model for Coordination of Services to Children and Youth*. The standard for children in care was as follows: "Where one or more services are being provided to a child by a government funded agency, the social worker must ensure that an ISSP is developed" (p.1). The *Individual Support Services Plan (ISSP)* model is a

provincially approved process that requires services to be delivered through an integrated and collaborative approach (*CYFS Standards and Policy Manual*, 2007). Despite the involvement of multiple government services and agencies, policy was contravened as an ISSP was not completed during John's several weeks in care. The policy manual currently in force, the *Protection and In Care Policy and Procedure Manual (2011)*, does not contain an ISSP policy similar to Section 3.22 of the previous manual requiring the process.

Following his time in care John became a client of two (2) additional programs that also had policies guiding an ISSP process: the Youth Services Program and Community Youth Corrections Program. Section 4.2 *Individual Service Support Plan* of the *CYFS Standards and Policy Manual (2007)* outlined the standards for completing an ISSP for youth receiving one or more services from government agencies. Under this policy, the ISSP was to be initiated within thirty (30) days of signing a YSA and completed within sixty (60) days. A youth who did not consent to an ISSP would continue to receive services. *Policy no. 5.3* of the *CYCP Protection and In Care Policy and Procedure Manual (2011)*, effective June 30, 2011 outlines the procedures for the Youth Services Plan. As part of this procedure, goals are identified by a youth and supported by a social worker. The policy states that goals may reflect: "a youth who has complex service needs and requires the development of an individualized service plan" (2011, p. 2). Additionally, *Policy Number 8.3 Individual Service and Support Plan* of the *Community Youth Corrections Standards and Practices Manual (2002)* requires consideration of an ISSP for youth receiving a community supervision sentence who are involved with two (2) or more service providers: "In this situation an ISSP should be considered. The social worker should coordinate a meeting between all service providers involved and the young person to assess the feasibility of an ISSP, in accordance with the ISSP Guidelines" (2002, p.1).

Assessment Social Worker (#2) who completed a checklist of requirements for the transfer of the file to the Youth Services Program, wrote "N/A" next to the section titled 'ISSP (if completed).' There was no ISSP or Youth Services Plan contained in any of John's DCYFS files reviewed by the ACY. Additionally, there was no written explanation as to why the ISSP was not completed. The completion of an ISSP was not required for the Youth Services Program or Community Youth Corrections Program, as it was for the In Care Program. However, given that John was receiving services from multiple agencies, it would have been in his best interests for the social workers to have encouraged him to participate in an ISSP process.

In the absence of a coordinated approach for information sharing, there were many missed opportunities for the DCYFS to work collaboratively with other agencies involved in John's life, to garner pertinent information and to develop a comprehensive plan. Despite Assessment Social Worker (#2) and the psychiatry resident having knowledge of the others' involvement, there was no documented communication between these professionals following John's first psychiatry appointment. The information gathered during this appointment, if shared in accordance with consent for release of information, could have had an impact on the services provided by the



DCYFS. The resident confirmed in an interview with the Advocate that she did not contact the DCYFS. When asked by the Advocate if it is typical practice to follow up with a social worker when a child is in care, the resident stated: "I'm not sure. I've never had a case like that before... It's the first time I ever had that where the child did not go back home..." (Transcript of ACY Interview, 2012, p.31). There is no indication in documentation that the social worker sought information about this appointment, or discussed the appointment with John. John did not return to the Janeway for psychiatry services until three (3) months later.

The resident recorded in her notes that John was not mandated to follow up with her services. While the resident did not have any mechanism to force John to follow up, John did become a client of PTS and one of the conditions of his Bail Verification and Supervision stated: "Attend and participate in any programs/counselling/meetings as outlined by the Pre-Trial Services Program." As Assessment Social Worker (#2) did not initiate an ISSP as per Policy 3.22, the resident and the PTS Coordinator did not have an opportunity to collaborate in their provision of services to John. Also contained in John's PTS program file was a *Consent for Release of Information* form that was signed by the DCYFS Assessment Social Worker (#2). This form allowed the release of information from four (4) government departments to the PTS Program, including the DHCS. Despite this, it appears that information sharing and collaboration rarely occurred among departments involved.

Lack of collaborative practice and information sharing continued to permeate service provision when John turned sixteen (16) and subsequently became a client of the Youth Services Program, Choices for Youth Supportive Housing Program and the Community Youth Corrections Program. In the absence of a file transfer meeting between Assessment Social Worker (#2) and the youth services/youth corrections social worker, important historical facts may have been missed and this may have had an impact on the continuity of John's services from one program to the next. As discussed previously, information sharing between the Supportive Housing Program and Youth Services Program was inconsistent and informal. These practices combined with confusion between both agencies regarding their roles impeded the already fragmented services provided to John.

It is important to note that there were discrepancies in the recollection of information shared between an RNC constable and a physician who were involved when the RNC escorted John to the Janeway Emergency Department in late 2011. An RNC constable was asked by the Advocate if he provided information to the ER physician that John had stated he had thoughts about burning down his house. The constable stated that he did, twice. The constable informed the Advocate that he had contacted John's aunt via telephone to clarify what John had told his aunt earlier that evening. The police officer said he completed this telephone call in the presence of two (2) nurses and the physician and he verbally repeated out loud what John's aunt told him on the telephone as she was speaking to him. When asked, the physician informed the Advocate that the RNC officers present that evening did not inform her that John had said that he might hurt himself or someone else and had spoken about burning

down his house. The physician stated: "...the only information I was received was that he had done damages to the property that he was residing in, and that he was angry and that was all I knew" (Transcript of ACY Interview, 2012, p.7).

The *Mental Health Care and Treatment Act Template* is an RNC report/escort form that is utilized by the RNC to record information about an escort, patient or detainee. The categories of information to record on the form include: suicide risk, security risk, medical risk, danger issues, medical information, appearance/behaviour, thinking, mood, orientation, dwelling, alcohol use and drug use. Instructions on the *Mental Health Care and Treatment Act Template* state: "This Form is to be completed by escorting/detaining member. White copy to be presented to health care official/yellow copy to be attached to file." An RNC constable did complete a *Mental Health Care and Treatment Act Template* form on the evening John was taken to the ER by police; however, there was no copy contained in the health documentation provided to the ACY. The document contained in the RNC file identifies the constable who completed the form. The sections that indicate who received the form and which facility it was received by were left blank. The constable who filled out the form noted on the form: "[John] said he was angry and that he had thoughts about burning down the house. He also said he wasn't sure if he would hurt himself or somebody else" (Mental Health Care and Treatment Act Template). As this document contained specific details about John's mental state, it could have informed the physician's assessment as well as ensured a record of the transfer of critical information from the police to the hospital staff.

In an interview with the Advocate, the constable who completed the form said that the Janeway Emergency Department did not have any forms available on that night. The Constable confirmed that she filled out the form later and the other constable involved on that night had informed hospital staff of the information. When asked by the Advocate if a copy of the form was given to the healthcare facility, the constable who said he verbally informed the physician of the information stated: "Not in this instance we didn't because they didn't have any over there... So the two copies just went right in the file..." (Transcript of ACY Interview, 2012, p.32). In an interview, the constable explained the process for completing the *Mental Health Care and Treatment Act Template* form:

So any time we detain someone under the Mental Health Care and Treatment Act, we're obligated to fill it out because if you look at it there's information there that's good for the doctor, for example, like you know things we noted about their behaviour, disorganized thinking, mood and all that sort of thing. So, but when someone voluntarily goes you're not detaining them under the Mental Health Care and Treatment Act, you're not expected or you're not required to fill out that form... to me it appears it doubles as an escort form (Transcript of ACY Interview, 2012, p.31).

In an interview with the Advocate, John advised that he did inform the staff at the hospital that he wanted to harm himself and burn his house down. John further stated:

“When I went to speak to the doctors and I said I was going to burn the house down or whatever, to be honest, I really think I should have been kept there overnight...” (Transcript of ACY Interview, 2012, p.115). It appears that when John came into contact with multiple service providers, each service was provided to John in isolation. This practice was not in John’s best interests and did not meet Article 3 of the *UNCRC*. Ultimately, as stated by Jain and Collins (2012), the system appeared to be in “utter fragmentation” (p.8).

### **Recommendation 26**

***The Department of Child, Youth and Family Services:***

- (a) develop and implement a policy requiring the completion of an Individualized Support Services Plan for all children in care who are receiving services from multiple agencies;***
- (b) ensure that a Youth Services Plan as per Policy no.: 5.3 of the Protection and In Care Policy and Procedure Manual is completed for any youth who is simultaneously receiving services from the Youth Services Program and from one or more other agencies; and***
- (c) ensure that an Individualized Support Services Plan as per Policy 8.3 of the Community Youth Corrections Standards and Practices Manual is completed for any youth who is simultaneously receiving services from the Community Youth Corrections Program and from one or more other agencies.***

**Recommendation 27**

***The Royal Newfoundland Constabulary and the Eastern Regional Integrated Health Authority:***

- (a) review and revise the Mental Health Care and Treatment Act Template form to ensure it is meeting the needs of youth presenting at Emergency Rooms by police escort;***
- (b) develop and implement a policy to ensure that when a youth requiring police services due to mental health issues presents at a hospital, communication between medical personnel and the police is acknowledged by the signatures of both the police officer and the hospital official (i.e. the nurse or physician) on the Mental Health Care and Treatment Act Template form and the signed form is placed in each file; and***
- (c) report the findings of Recommendation 27(a) and 27(b) to the Department of Justice and the Department of Health and Community Services for implementation throughout the province.***

**Recommendation 28**

***The Department of Justice and the Department of Health and Community Services review the findings reported by the Royal Newfoundland Constabulary and Eastern Regional Integrated Health Authority as per Recommendation 27(c) and ensure implementation throughout the province.***

**DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES**  
**DEPARTMENT OF HEALTH AND COMMUNITY SERVICES**  
**EASTERN REGIONAL INTEGRATED HEALTH AUTHORITY**

***Lack of Participation and Inclusion of Youth***

John was a teenager when he became involved with multiple agencies; therefore, his participation in decisions affecting his care would have been appropriate. There were instances when John may have benefited from the opportunity to learn about potential service options and engage in discussions that impacted his life.

Article 12(1) of the *UNCRC (1989)* states:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

There are two (2) policies in the *CYFS Standards and Policy Manual (2007)* that reflect the inclusion of children and youth in decisions impacting their care: Section 3.21 *Planning for the Child: Plan of Care*, and Section 3.22 *Planning for the Child: Model for the Coordination of Services to Children and Youth*. Section 3.21 of the *CYFS Standards and Policy Manual (2007)* specifically references a child's participation in the planning process. One of the factors for consideration in the assessment and planning is stated as: "... the child's involvement and the child's views about the plan of care" (p.3). Section 3.22 includes the child/youth as a participant in the collaboration process when one or more agencies are involved with a child/youth.

Unfortunately, there appeared to be a lack of proactive engagement by the DCYFS programs which created a barrier to John exercising his rights contained in Article 12(1). The last minute, crisis-oriented approach to John's transition out of care did not demonstrate a proactive planning approach that included John in the decision-making process.

The inclusion of children and youth in the Plan of Care and ISSP processes is crucial to fulfilling Article 12(1) of the *UNCRC*. As previously noted, while John was in care, Section 3.22 of the *CYFS Standards and Policy Manual (2007)* was contravened as Assessment Social Worker (#2) did not complete the required ISSP. While the Plan of Care was completed, there is no documentation indicating that John was consulted regarding this or given a copy. While John was in care, inclusion in the development of a Plan of Care and the ISSP process could have presented opportunities to have discussions about planning to sign his YSA and the process of moving to independent living. Had the Plan of Care been developed in consultation with John and/or an ISSP considered, there would have been at least two (2) opportunities to include John in significant decisions impacting his life.

In addition to not being engaged in any planning process by program areas within the DCYFS, John informed the Advocate in interviews that when he attended an ER in late 2011, he did not feel he was heard. As discussed previously, John reported that he had informed hospital staff that he had thought about harming himself and wanted to burn down his house. In an interview with the Advocate, the physician involved advised that she was not aware of these comments. On the night she met with John she recorded that he was "angry". John advised the Advocate that he had wanted help on that evening: "Everything just clashed and clashed, and I told them that I needed help, whatever, but nobody listened. They just said he's angry basically" (Transcript of ACY Interview, 2012, p.94). Further, John stated:

What do you do? So if I talk to a worker at the hospital and tell them that, how's it going to make any difference if I talk to my social worker about it, the Choices worker? How is that going to make anything different? ... So Basically – why wouldn't - so what's the difference if I told my probation officer or my Choices worker? If I told them the same thing I told the doctor and nothing happened, so what's it going to do if I told somebody else? How are they going to do something if the doctors never done something? (Transcript of ACY Interview, 2012, p.101).

When asked by the Advocate what he had wished had been done for him on that night, John stated:

When I went to speak to the doctors and I said I was going to burn the house down or whatever, to be honest, I really think I should have been kept there overnight or whatever, kept there for a little bit and actually spoken to, like, okay really actually deep why instead of just a quick talking to you, okay, we'll make this assumption or whatever, and, yeah, you go about your way or whatever and we'll tell you to come back or whatever... (Transcript of ACY Interview, 2012, p.115).

John's account of this critical incident illustrated a young person whose voice was not heard. In fact, in many instances throughout John's extensive contact with professionals, his views were not adequately explored. In some cases, John was not spoken to at all and instead collateral sources were relied on to provide details of his experiences. While John's experiences during the timeframe of this investigation cannot be changed, his story has the capacity to influence changes for other young people in similar circumstances. In an interview with the Advocate, John spoke about this investigation: "I hope it isn't all for nothing... I just hope this doesn't happen to somebody else really, it sucks" (Transcript of ACY Interview, 2012, p.117).

#### **Recommendation 29**

***The Department of Child, Youth and Family Services ensure that all children and youth:***

- (a) are provided with opportunities to express their views freely in all matters affecting them; and***
- (b) have their views considered in the development of their permanency plans.***

**Recommendation 30**

***The Department of Health and Community Services ensure that all children and youth:***

- (a) are provided with opportunities to express their views freely in all matters affecting them; and***
- (b) have their views considered in the development of their treatment plans***

## Conclusion

The purpose of this investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services (DCYFS); the Department of Justice; the Department of Health and Community Services (DHCS); and the Eastern Regional Integrated Health Authority (Eastern Health) met John's needs and whether his right to services was upheld. It was evident throughout the course of this investigation that there were times when John's voice was not heard, his rights were not respected and his right to services was not upheld. Despite the involvement of professionals from the DCYFS, the Department of Justice, the DHCS, the RNC and Eastern Health, John's best interests were not at the forefront of service provision.

While John was an active client of the DCYFS on paper, he was not of primary concern throughout the program areas he encountered. There was significant evidence of nonadherence to policies and/or best practices by social workers involved. Additionally, there was evidence of misinterpretation of the DCYFS policies at the management level. Failure to complete comprehensive assessments, delays in the input of file documentation and delays in file transfer further impeded the continuity of service provision in all of the DCYFS programs.

As John approached sixteen (16), his age continually presented as a barrier to the receipt of timely and appropriate service from the DCYFS. On his 16<sup>th</sup> birthday, an important milestone for most youth, John began an inadequately supported journey to independent living. The process by which John signed a Youth Services Agreement (YSA) did not incorporate informed consent or confirmation of his complete understanding of the important document. The signing of the YSA resulted in his transfer to a series of inappropriate living arrangements. A lack of appropriate housing for youth was evidenced by John's living conditions after his 16<sup>th</sup> birthday which identified a major gap in services for youth in this province who are part of the Youth Services Program. A disjointed relationship between the Youth Services Program and the Supportive Housing Program in addition to the assignment of one social worker to fulfill the role of youth services worker and youth corrections worker further impeded service delivery.

Evidence of nonadherence to policies for record keeping and documentation made it impossible to fully investigate allegations that John had contact with the RNC in December 2010. Without record of the daily roster, the call for RNC service and details of RNC response, a comprehensive investigation into service provision could not be completed. The lack of documentation and schedules also brings into question the ability of both internal and external parties to investigate complaints made regarding RNC service provision.



John's struggles in the area of mental health and addictions were not adequately addressed by the DHCS and Eastern Health. There were missed opportunities for proactive engagement with John and he was not provided with the privacy of a confidential appointment on two (2) occasions. Additionally, an inadequate assessment created barriers for John in obtaining appropriate mental health services. Furthermore, the gap in access to services for youth struggling with concurrent disorders was extremely evident in this investigation.

In John's case, he was a client of multiple provincial government programs. While this should have resulted in collaboration, communication, and information sharing among all professionals involved, there was an obvious disconnect among all departments and agencies. This lack of collaboration also resulted in missed opportunities for John to engage in his service planning as an active participant.

Jain and Collins concluded their report to the Advocate with the following statement:

Multiple agencies were involved in dealing with [John] but there seemed to be a lack of coordinated effort. In part this was due to poor communications between the agencies. [John] was not mature enough, emotionally, nor did he have the coping skills to be placed in what was, for the most part, an unsupervised placement. Impulsive, intermittently expressing both suicidal and homicidal ideation, increasingly helpless and hopeless and with a serious substance abuse problem in many respects, [John] was set up for failure (Jain and Collins, 2012, p.20).

In accordance with Article 3 of the *UNCRC*, services and service provision for youth transitioning from adolescence to adulthood should have the best interests of the child as the primary consideration in all actions taken. Thus children have a right to appropriate services that will support successful transitions into adulthood. This investigation determined that John did not receive appropriate services that would have been optimal for success during his adolescence. As John approached and reached the age of sixteen (16) he encountered multiple programs and services from government departments and agencies; yet there were times when his voice was not heard, his needs were not met and his rights to services were not upheld. Unfortunately John's experience cannot be changed; however, the recommendations put forward in this investigation aim to mitigate the occurrence of similar experiences for youth in Newfoundland and Labrador in the future.

# Recommendations

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their views are heard and considered. It is in keeping with this legislative duty that the ACY reports on the investigation and makes recommendations based on its findings. The goal is to prevent any reoccurrence of a similar matter. After completing a Review or Investigation under the *Child and Youth Advocate Act, SNL 2001*, the Advocate may, under section 15(1)(g), “make recommendations to government, an agency of government or communities about legislation, policies and practices respecting services to or the rights of children or youth.” Based on the findings of this investigation and as identified in the body of this report, the Advocate for Children and Youth makes the following recommendations to the departments and agencies to which they are applicable. Pursuant to Section 24(1) of the *Act*, the Advocate will continue to monitor and follow up on the recommendations arising from this investigation until they are all appropriately addressed by the applicable government department or agency.

## Recommendation 1

The Department of Child, Youth and Family Services develop and implement an auditing protocol to examine file documentation to ensure strict adherence to the documentation standards outlined in the Child, Youth and Family Services Documentation Guide (2012) and the Risk Management Decision-Making Model Manual (2013).

## Recommendation 2

The Department of Child, Youth and Family Services develop and implement a policy that ensures all Managers document all consultations and any decisions made pertaining to a child or youth.

## Recommendation 3

The Department of Child, Youth and Family Services ensure that social workers working in the Protective Intervention Program complete comprehensive assessments in accordance with the Risk Management Decision-Making Model Manual (2013), ensuring that when a referral is screened in for a Protection Investigation:

- (a) the social worker completes the Safety Assessment form within 24 hours of interviewing the child and parents as per Standard #3; and
- (b) the social worker, in consultation with a supervisor, completes the Protective Investigation within thirty (30) days after the report is received as per Standard #4.

**Recommendation 4**

The Department of Child, Youth and Family Services review and revise current on-call services standards throughout the province to ensure that:

- (a) there is sufficient human resources to meet the demand for these services;
- (b) all social workers providing on-call services provide those services from a DCYFS location or have sufficient portable technology to ensure appropriate and timely access to information; and
- (c) social workers who are not regularly assigned to on-call services only provide this service if they have completed on-call training within the previous twelve (12) months.

**Recommendation 5**

The Department of Child, Youth and Family Services ensure the provision of complete and comprehensive assessments of all children and youth, regardless of age, to determine the need for protective intervention based on the Risk Management Decision-Making Model (2013).

**Recommendation 6**

The Department of Child, Youth and Family Services ensure that all social workers comply with Policy no.: 2.16 Plan for the Child and Policy no.: 3.9 Planning: In Care Progress Report of the Protection and In Care Policy and Procedure Manual (2011) and utilize the Plan for the Child and In Care Progress Report to prepare for the transitioning of children who are in care and approaching the age of sixteen (16).

**Recommendation 7**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that children in care who express their intention to receive Residential Services through the Youth Services Program to live independently:

- (a) undergo a life skills assessment prior to any transition to independent living; and
- (b) be provided with training to assist with the demands and responsibilities of independent living.

**Recommendation 8**

The Department of Child, Youth and Family Services ensure that all levels of management and frontline social workers are trained in, and demonstrate a clear understanding of, their applicable program areas and respective policies in order to provide accurate and consistent case management, direction and supervision.

**Recommendation 9**

The Department of Child, Youth and Family Services ensure that within thirty (30) days of receiving a Child Protection Report, a determination is made as to whether or not a child is in need of protective intervention and the file is closed or transferred to Ongoing Protective Intervention Services as required by Standard #4 of the Risk Management Decision-Making Model (2013).

**Recommendation 10**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that, when a child or youth is being transferred from one program area to another, a meeting is held between the sending and receiving staff persons prior to the transfer of the client's file.

**Recommendation 11**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that social workers are trained in and comply with the rules of informed consent when completing Youth Services Agreements with youth.

**Recommendation 12**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that when signing or re-signing a Youth Services Agreement, all young people receiving services from the Youth Services Program:

- (a) must be fully informed and demonstrate a clear understanding of what the YSA entails; and
- (b) must have a guardian, support person or legal representative present during the signing of the Youth Services Agreement.

**Recommendation 13**

The Department of Child, Youth and Family Services research and review the feasibility of creating a provincial youth services coordinator position. This person would be solely responsible for meeting (face-to-face, or via telephone or video conference) with all youth transitioning into the Youth Services Program. This person will ensure that all youth receive consistent assessment of competency by an expert physician, and the necessary education and guidance required in signing and re-signing a Youth Services Agreement.

**Recommendation 14**

The Department of Child, Youth and Family Services review and revise as necessary the Residential and Supportive Services provided under the Youth Services Program to ensure that youth have access to:

- (a) sufficient funding for safe and affordable housing options; and
- (b) services that support the crucial areas that Reid and Dudding (2006) identified as contributing to successful outcomes: relationships, education, housing, life skills, identity, youth engagement, emotional healing and financial support.

**Recommendation 15**

The Department of Child, Youth and Family Services in collaboration with Choices for Youth:

- (a) update and revise the 2004 MOU between the St. John's Regional Health and Community Services Board and Choices for Youth to reflect the current partner organizations and agreement of services; and
- (b) ensure that all staff working in the Youth Services Program and Supportive Housing Program are trained in and demonstrate a clear understanding of their specific roles and responsibilities with respect to case management.

**Recommendation 16**

The Department of Child, Youth and Family Services ensure that when a youth is in receipt of services from multiple programs within the DCYFS, he or she is assigned a separate worker for each program area (i.e. Assessment, Long-Term Protection, Youth Services, Corrections). This will ensure the provision of expert services, clear communication and the avoidance of any potential conflict of interest in meeting the needs of youth.

**Recommendation 17**

The Department of Child, Youth and Family Services:

- (a) develop and implement a training module to train social workers in the use of the YLS-CMI tool; and
- (b) educate all applicable social workers in the completion of the YLS-CMI assessments to ensure reliability and validity of service provision.

**Recommendation 18**

The Department of Justice develop and implement a protocol to ensure that notification is provided to a youth corrections social worker when a youth on his or her caseload is arrested and/or detained under the Youth Criminal Justice Act.

**Recommendation 19**

The Department of Justice ensure that the Royal Newfoundland Constabulary:

- (a) uphold record keeping standards as outlined in General Order 169 Police Note Books;
- (b) uphold record keeping standards as outlined in General Order 188 Criminal Reporting Procedures;
- (c) uphold 13.0 Information Required in Reports Concerning Young Persons outlined in General Order 176 Youth Criminal Justice Act/Youth Investigations; and
- (d) keep complete electronic records of all shift daily rosters.

**Recommendation 20**

The Department of Justice ensure that all Royal Newfoundland Constabulary and Royal Canadian Mounted Police employees are educated on their duty to report pursuant to Section 11 of the Children and Youth Care and Protection Act (2010).

**Recommendation 21**

The Department of Health and Community Services ensure that all health care professionals in the four (4) Regional Integrated Health Authorities are educated on their duty to report pursuant to Section 11 of the Children and Youth Care and Protection Act (2010).

**Recommendation 22**

The Department of Health and Community Services ensure that when youth meet with medical professionals in any of the four (4) Regional Integrated Health Authorities:

- (a) they are provided with the opportunity to meet privately and confidentially upholding their right to privacy as per Article 16 of the United Nations Convention on the Rights of the Child; and
- (b) if the safety of the youth or professionals is a concern that alternative measures are taken (the use of handcuffs and/or a windowed room for observation) to accommodate a private and confidential meeting while ensuring safety.

**Recommendation 23**

The Eastern Regional Integrated Health Authority:

- (a) research and review the feasibility of creating short-term beds in the pediatric emergency room for youth that present with mental health concerns and require intensive evaluation;
- (b) research and review the feasibility of utilizing a structured professional judgment tool (e.g. the SAVRY tool) for the assessment of adolescents that present with mental health concerns; and
- (c) report the findings of Recommendation 23(a) and 23(b) to the Department of Health and Community Services.

**Recommendation 24**

The Department of Health and Community Services review the findings reported by the Eastern Regional Integrated Health Authority as per Recommendation 23(c) and ensure implementation throughout the entire province.

**Recommendation 25**

The Department of Health and Community Services ensure that when youth present with concurrent disorders to any of the four (4) Regional Integrated Health Authorities, they are provided with a comprehensive assessment, diagnosis and treatment plan addressing both their mental health issues and addictions issues.

**Recommendation 26**

The Department of Child, Youth and Family Services:

- (a) develop and implement a policy requiring the completion of an Individualized Support Services Plan for all children in care who are receiving services from multiple agencies;
- (b) ensure that a Youth Services Plan as per Policy no.: 5.3 of the Protection and In Care Policy and Procedure Manual is completed for any youth who is simultaneously receiving services from the Youth Services Program and from one or more other agencies; and
- (c) ensure that an Individualized Support Services Plan as per Policy 8.3 of the Community Youth Corrections Standards and Practices Manual is completed for any youth who is simultaneously receiving services from the Community Youth Corrections Program and from one or more other agencies.

**Recommendation 27**

The Royal Newfoundland Constabulary and the Eastern Regional Integrated Health Authority:

- (a) review and revise the Mental Health Care and Treatment Act Template form to ensure it is meeting the needs of youth presenting at Emergency Rooms by police escort;
- (b) develop and implement a policy to ensure that when a youth requiring police services due to mental health issues presents at a hospital, communication between medical personnel and the police is acknowledged by the signatures of both the police officer and the hospital official (i.e. the nurse or physician) on the Mental Health Care and Treatment Act Template form and the signed form is placed in each file; and
- (c) report the findings of Recommendation 27(a) and 27(b) to the Department of Justice and the Department of Health and Community Services for implementation throughout the province.



**Recommendation 28**

The Department of Justice and the Department of Health and Community Services review the findings reported by the Royal Newfoundland Constabulary and Eastern Regional Integrated Health Authority as per Recommendation 27(c) and ensure implementation throughout the province.

**Recommendation 29**

The Department of Child, Youth and Family Services ensure that all children and youth:

- (a) are provided with opportunities to express their views freely in all matters affecting them; and
- (b) have their views considered in the development of their permanency plans.

**Recommendation 30**

The Department of Health and Community Services ensure that all children and youth:

- (a) are provided with opportunities to express their views freely in all matters affecting them; and
- (b) have their views considered in the development of their treatment plans.

**For a list of the recommendations grouped specifically to each accountable government department or agency, refer to Appendix G.**

## Bibliography

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders – 4<sup>th</sup> Edition Text Revision (DSM-IV-TR)*. Virginia: American Psychiatric Association.

Canadian Association of Social Workers (CASW). (2005). *Guidelines for Ethical Practice*. Ottawa: Canadian Association of Social Workers.

*Child and Youth Advocate Act* SNL 2001 CHAPTER C-12.01.

*Children and Youth Care and Protection Act* SNL 2010 C-12.2.

*Child Welfare Act*. SNL 1990 C-12.

*Child, Youth and Family Services Act* SNL1998 C-12.1.

Choices for Youth. (2013a). *About Us, Choices for Youth*. Retrieved from: <http://www.choicesforyouth.ca/about-us/>.

Choices for Youth. (2013b). *Our Programs, Choices for Youth*. Retrieved from: <http://www.choicesforyouth.ca/programs/>.

Choices for Youth. (2013c). *Who we Serve, Choices for Youth*. Retrieved from: <http://www.choicesforyouth.ca/about-us/who-we-serve/>.

Committee on the Rights of the Child (2003). *General comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*. Retrieved from: <http://tb.ohchr.org/default.aspx?Symbol=CRC/GC/2003/4>.

Dr. Charles A. Janeway Child Health Centre (1993). *Administrative Overview Emergency Department*.

Eastern Health. (2008a). *Child and Adolescent Mental Health and Addictions: Central Intake Program, Operational Manual*.

Eastern Health. (2008b) *Mental Health and Addictions Program Overview*.

Eastern Health. (2011a). *Eastern Health – Did you know?* Retrieved from: <http://www.easternhealth.ca/AboutEH.aspx?d=1&id=1&p=73>

Eastern Health. (2011b). *Eastern Health – Vision, Mission, Values*. Retrieved from: <http://www.easternhealth.ca/AboutEH.aspx?d=2&id=49&p=709>

- Government of Newfoundland and Labrador, Department of Child, Youth and Family Services. (2011). *Protection and In Care Policy and Procedure Manual*.
- Government of Newfoundland and Labrador, Department of Child, Youth and Family Services. (2013). *Risk Management Decision-Making Model Manual*.
- Government of Newfoundland and Labrador, Department of Health and Community Services. (2002). *Community Youth Corrections Standards and Practices Manual*.
- Government of Newfoundland and Labrador, Department of Health and Community Services, Child, Youth and Family Services (2003). *Risk Management System Manual*.
- Government of Newfoundland and Labrador, Department of Health and Community Services, Child, Youth and Family Services (2007). *Standards and Policy Manual*.
- Government of Newfoundland and Labrador, Department of Health and Community Services, Child, Youth and Family Services (2002). *CYFS Best Practice Guidelines for using CRMS [Region]*.
- Government of Newfoundland and Labrador, Department of Health and Community Services. (2013a). *About the Department, Health and Community Services*. Retrieved from:  
<http://www.health.gov.nl.ca/health/department/>.
- Government of Newfoundland and Labrador, Department of Health and Community Services. (2013b). *Addictions Services, Health and Community Services*. Retrieved from:  
<http://www.health.gov.nl.ca/health/addictions/services.html>.
- Government of Newfoundland and Labrador, Department of Justice. (2013). *About the Department, Justice*. Retrieved from:  
<http://www.justice.gov.nl.ca/just/department/index.html>.
- Government of Newfoundland and Labrador, Department of Justice. *Facility Rules Policy Manual: NL Youth Centre. Overnight Detention (Revised April 2010) and Section 1.1.2 Operational Admissions (Revised April 2010)*.
- Government of Newfoundland and Labrador, Department of Justice. (2006). *Pre-Trial Services Program Standards and Procedures Manual*.

- Government of Newfoundland and Labrador, Department of Social Services (1993). *Child Welfare Policy and Procedures*.
- Government of Newfoundland and Labrador. (2012) *Pre-Trial Services Program*. In Department of Justice. Retrieved from [http://www.justice.gov.ca/just/corrections/pre\\_trial\\_services.html](http://www.justice.gov.ca/just/corrections/pre_trial_services.html)
- Hodgkin, R., & P., Newell. (2007). *Implementation Handbook for the Convention on the Rights of the Child ED(3)*. Geneva: UNICEF.
- Jain, U., & Collins. P. (2012). *Confidential Report to the Advocate for Children and Youth Re: [John]*.
- Mental Health Care and Treatment Act SNL 2006 CHAPTER M-9.1.*
- Newfoundland and Labrador Association of Social Workers (NLASW). (2005). *Standards for Social Work Recording*. Retrieved from: [http://www.nlasw.ca/pdf/Standards\\_for\\_Social\\_Work\\_Recording.pdf](http://www.nlasw.ca/pdf/Standards_for_Social_Work_Recording.pdf).
- Reid, C., & P., Dudding. (2006). *Building a Future Together: Issues and Outcomes for Transition-Aged Youth*. Ottawa, Ontario: Centre for Excellence for Child Welfare.
- Royal Newfoundland Constabulary (RNC). Royal Newfoundland Constabulary Policy and Procedure Manual. *General Order 180* (October 2, 2003), *General Order 169* (January 21, 2002), *General Order 188* ( July 20, 2005), *General Order 170* (February 25, 2002), *General Order 176* (March 31, 2003).
- Royal Newfoundland Constabulary (RNC). (2011-12) *Report on Police Service Activities 2011- 2012*. In *Royal Newfoundland Constabulary Newfoundland's Provincial Police Services*. Retrieved from: [http://www.rnc.gov.nl.ca/publications/rnc\\_annual\\_report\\_2011\\_2012.pdf](http://www.rnc.gov.nl.ca/publications/rnc_annual_report_2011_2012.pdf)
- St. John's Regional Health and Community Services Board and Choices for Youth (2004). *Memorandum of Understanding*.
- United Nations Convention on the Rights of the Child* (1989).



# **Appendices**

**Appendix A - Letters commencing Investigation**

**Appendix B - List of acronyms used in this report**

**Appendix C - Investigative Documents and Interviews**

**Appendix D - Expert Consultants**

**Appendix E - Allowances for Youth Approved for Residential Services**

**Appendix F - Conduct Disorder**

**Appendix G – Recommendations by Department/Agency**



## **Appendix A**

### **Letters commencing Investigation**







**Office of the Child and Youth Advocate**  
PROVINCE OF NEWFOUNDLAND AND LABRADOR

December 12, 2011

**CONFIDENTIAL**

**BY COURIER**

Ms. Sheree MacDonald  
Deputy Minister  
Child, Youth and Family Services  
5<sup>th</sup> Floor, Natural Resources Building  
50 Elizabeth Avenue  
St. John's, NL

Dear Ms. MacDonald:

**Re: Notice of Investigation Pursuant to Section 20 of the  
*Child and Youth Advocate Act***

This is to notify you that I will be conducting an investigation into the circumstances surrounding

I will be examining whether the services provided by the Department of Child, Youth and Family Services (CYFS) met the needs of this youth and whether his rights to services were upheld.

This investigation will be conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act*. Further to this Notice, I will also be requesting information pursuant to Section 21 to further advance the ability of the Office of the Child and Youth Advocate to carry out this investigation. Once I have identified the documentation required from your Department, I will contact you in writing with my request for this information. Thank you in advance for your cooperation in this matter.

Yours truly,

**Carol A. Chafe**  
**Child and Youth Advocate**





**Office of the Child and Youth Advocate**  
PROVINCE OF NEWFOUNDLAND AND LABRADOR

December 12, 2011

**CONFIDENTIAL**

**BY COURIER**

Mr. Bruce Cooper  
Deputy Minister  
Department of Health and Community Services  
1<sup>st</sup> Floor, West Block  
Confederation Building  
St. John's, NL

Dear Mr. Cooper:

**Re: Notice of Investigation Pursuant to Section 20 of the  
*Child and Youth Advocate Act***

This is to notify you that I will be conducting an investigation into the circumstances surrounding

I will be examining whether the services provided by the Department of Health and Community Services met the needs of this youth and whether his rights to services were upheld.

This investigation will be conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act*. Further to this Notice, I will also be requesting information pursuant to Section 21 to further advance the ability of the Office of the Child and Youth Advocate to carry out this investigation. Once I have identified the documentation required from your Department, I will contact you in writing with my request for this information. Thank you in advance for your cooperation in this matter.

Yours truly,

**Carol A. Chafe**  
**Child and Youth Advocate**





**Office of the Child and Youth Advocate**  
PROVINCE OF NEWFOUNDLAND AND LABRADOR

December 12, 2011

**CONFIDENTIAL**

**BY COURIER**

Ms. Vickie Kaminski  
President and Chief Executive Officer  
Eastern Health  
Eastern Health Executive Office – Level I – Room 1345  
Health Sciences Centre, Prince Philip Drive  
St. John's, NL A1B 3V6

Dear Ms. Kaminski:

**Re: Notice of Investigation Pursuant to Section 20 of the  
*Child and Youth Advocate Act***

This is to notify you that I will be conducting an investigation into the circumstances surrounding

I will be examining whether the services provided by Eastern Health met the needs of this youth and whether his rights to services were upheld.

This investigation will be conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act*. Further to this Notice, I will also be requesting information pursuant to Section 21 to further advance the ability of the Office of the Child and Youth Advocate to carry out this investigation. Once I have identified the documentation required from your organization, I will contact you in writing with my request for this information. Thank you in advance for your cooperation in this matter.

Yours truly,

**Carol A. Chafe**  
**Child and Youth Advocate**





**Office of the Child and Youth Advocate**  
PROVINCE OF NEWFOUNDLAND AND LABRADOR

December 12, 2011

**CONFIDENTIAL**

**BY COURIER**

Mr. Donald Burrage, Q.C.  
Deputy Minister  
Department of Justice  
4<sup>th</sup> Floor, East Block  
Confederation Building  
St. John's, NL

Dear Mr. Burrage:

**Re: Notice of Investigation Pursuant to Section 20 of the  
*Child and Youth Advocate Act***

This is to notify you that I will be conducting an investigation into the circumstances surrounding

I will be examining whether the services provided by the Department of Justice met the needs of this youth and whether his rights to services were upheld.

This investigation will be conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act*. Further to this Notice, I will also be requesting information pursuant to Section 21 to further advance the ability of the Office of the Child and Youth Advocate to carry out this investigation. Once I have identified the documentation required from your Department, I will contact you in writing with my request for this information. Thank you in advance for your cooperation in this matter.

Yours truly,

**Carol A. Chafe**  
**Child and Youth Advocate**





## **Appendix B**

### **Acronyms**

## Appendix B

Acronym	Official Title
ACY	Advocate for Children and Youth
ADHD	Attention Deficit Hyperactivity Disorder
ALA	Alternate Living Arrangement
CASA	Child Abuse Sexual Assault
CD	Conduct Disorder
Central Intake Program	Child and Adolescent Mental Health and Addictions Central Intake Program
CPR	Child Protection Report
CRMS	Client Referral Management System
CYCP	Children and Youth Care and Protection
CYFS	Child, Youth and Family Services
DCYFS	Department of Child, Youth and Family Services
DHCS	Department of Health and Community Services
DHRE	Department of Human Resources and Employment
DSS	Department of Social Services
EAP	Employee Assistance Program
Eastern Health	Eastern Regional Integrated Health Authority
ER	Emergency Room
HCS	Health and Community Services
ICAN	Integrated Constabulary Automated Network
ISSP	Individual Support Services Plan
Janeway	Janeway Children's Health and Rehabilitation Centre

<b>Acronym</b>	<b>Official Title</b>
PTS	Pre-Trial Services
RCMP	Royal Canadian Mounted Police
RMS	Risk Management System
RNC	Royal Newfoundland Constabulary
RS	Referral Source
SAVRY	Structured Assessment of Violence Risk in Youth
SPJ	Structured Professional Judgment
UNCRC	United Nations Convention on the Rights of the Child
YCJA	Youth Criminal Justice Act
YLS-CMI	Youth Level of Service Case Management Inventory
YSA	Youth Services Agreement



## **Appendix C**

### **Investigative Documents and Interviews**



## Appendix C

### Investigative Documents:

#### Department of Justice Records

- NLYC Closed Custody Facility File (2011-2012)
- Pre-Trial Services Program File (2011)
- Youth Detention Centre File (2011)

#### Royal Newfoundland Constabulary Records

- Royal Newfoundland Constabulary Files (2009-2011)

#### Department of Child, Youth and Family Services Records

- Protective Intervention File (1995-2011)
- In Care File (2011)
- Youth Services File (2011)
- Youth Corrections File (2011)
- Choices for Youth File (2011)

#### Eastern Regional Integrated Health Authority Records

- Janeway Childrens Health and Rehabilitative Centre File (1996-2011)

#### Department of Education Records

- Student Record (2000-2011)

### Investigative Interviews Conducted:

#### Total number of interviews conducted: 40

- 2: Caregivers Inc. (Blue Sky)
- 4: Choices for Youth
- 16: Department of Child Youth and Family Services
- 1: Department of Justice
- 5: Royal Newfoundland Constabulary
- 5: Eastern Regional Integrated Health Authority
- 5: Family Members/Caregivers
- 2: John





## **Appendix D**

### **Expert Consultants: Qualifications, Disclosure and Bibliography**

## **Appendix D**

### **Qualifications:**

#### **Peter Collins, CD, MCA, MD, FRCP(C)**

Dr. Collins is a staff psychiatrist with the Complex Mental Illness Program at the Centre for Addiction and Mental Health and an Associate Professor with the Division of Forensic Psychiatry at the University of Toronto. He is also the Forensic Psychiatrist for the Criminal Behaviour Analysis Unit of the Behavioural Sciences and Analysis Section - Ontario Provincial Police. He is an expert in violent crime, as well as suicidal behaviour and has experience in Emergency Psychiatry. From March 1978 to August 1980 he coordinated Juvenile Probation Services for the Yukon Territory. He has provided expert testimony, at all levels of Court, in Ontario as well as in Newfoundland, Nova Scotia, Manitoba, Saskatchewan, Alberta, British Columbia, Northwest Territories and Quebec. He has also lectured to, and worked with, numerous criminal justice agencies in Canada, the United States, the Caribbean, Central America, South America, Africa, South-West Asia, Micronesia, Australia and Europe including the FBI, Interpol and Europol.

#### **Umesh Jain, MD, FRCP(C), DABPN, MSc, PhD, MEd**

Dr. Jain is a staff child and adolescent psychiatrist with the Divisions of Child Psychiatry at the Centre for Addiction and Mental Health and the Hospital for Sick Children. He is an Associate Professor at the University of Toronto. He is Board Certified in Psychiatry in the US and Canada and holds post-graduate degrees (MSc, PhD, MEd) with particular application to Attention Deficit Hyperactivity Disorder (ADHD). He was awarded the Naomi Rae Grant Award and the Education Award by the Canadian Academy of Child and Adolescent Psychiatry for his national work. He has written over 125 published peer reviewed papers, book chapters, books, posters and symposia. He has over 300 academic presentations in five continents and has received numerous peer-reviewed government and institutional grants. He has worked on national and/or scientific policy for children and adolescents through the American Academy of Child Psychiatry (being on their National Scientific Board), CADDRA (writing the first National Guidelines for ADHD and currently writing guidelines for Australia/NZ), Health Canada, the Federal Commission on Children's Mental Health, Earthlink and he is currently, the senior consultant restructuring all programs in child & adolescent mental health services for the country of Qatar.

**Disclosure:** "Neither Dr. Collins nor Dr. Jain have any direct relationship with the parties involved in this case and they do not attest to any conflict of interest" (Jain and Collins, 2012, p.3).

## **Bibliography (Jain and Collins)**

- American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders – 4<sup>th</sup> Edition Text Revision (DSM-IV-TR). (2000). Washington: American Psychiatric Pub.
- Biederman, J., Faraone, S. V., Spencer, T., Wilens, T., Norman, D., Lapey, K. A., Mick, E., Lehman, B. K., & Doyle, A. (1993). Patterns of psychiatric comorbidity, cognition, and psychosocial functioning in adults with attention deficit hyperactivity disorder. *Am.J.Psychiatry*, 150, 1792-1798.
- Berman, A., Jobes, D., & Silverman, M. (2006). *Adolescent suicide: Assessment and intervention* (2<sup>nd</sup> Ed.). Washington, DC: American Psychological Association.
- Borum, R, Bartel, P & Forth, A. (2002). *Manual for the Structured Assessment of Violence Risk in Youth. Consultation version*. Tampa: University of South Florida, Florida Mental Health Clinic.
- Catchpole, R. & Gretton, M. (2003). The predictive validity of risk assessment with violent young offender: A 1-year examination of criminal outcome. *Criminal Justice and Behaviour*, 30, 688-708.
- Chaim, G., Speers, J. & Steering Committee (2011). *Best Practices for Treating Youth Substance Abuse: A workbook for Organizations that Serve Youth*. Ontario Youth Strategy Project- Addictions Ontario.
- Heilbrun, K., Yasuhara, K., & Shah, S. (2010) Violent risk assessment tools – Overview and critical analysis. In R.Otto & K. Douglas editors. *Handbook of Violence Risk Assessment* (pp. 1-17). New York: Routledge.
- Malmquist, C. (2006) Homicide: a psychiatric perspective. 2<sup>nd</sup> ed. Washington: American Psychiatric Pub.
- McMahon, R., & Frick, P. (2005). Evidence-based assessment of conduct problems in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, 34, 477-505.
- Mannuzza, S., Klein, R. G., Bessler, A., Malloy, P., & LaPadula, M. (1993). Adult outcome of hyperactive boys. Educational achievement, occupational rank, and psychiatric status. *Arch.Gen.Psychiatry*, 50, 565-576.
- Murrie, D., Cornell, D., & McCoy, W. (2005). Psychopathy, conduct disorder, and stigma: Does diagnostic labeling influence juvenile probation officers recommendations? *Law and Human Behavior*, 29, 323-342.
- Pottick KJ, Kirk SA, Hsieh DK, Tian X. (2007) Judging mental disorder in youths: Effects of client, clinician, and contextual differences. *Journal of Consulting Clinical Psychology*, 75(1):1-8.



## **Appendix E**

### **Allowances for Youth Approved for Residential Services**

**Appendix E**  
**Allowances for Youth Approved for Residential Services**

Type of Financial Support	CYFS Act: Prior to June, 30, 2011	CYCP Act: June 30, 2011 - present
Housing: Board and Lodging	\$500 monthly	Actual Cost up to \$500 monthly
Housing: Bedsitting	\$500 monthly	Actual Cost up to \$500 monthly
Housing: Shelter	Shelter per diem (emergency funding)	Shelter per diem (emergency funding)
Housing: Hotel/Bed & Breakfast	N/A	Most economical rate available in the youth's community (emergency funding)
Housing: Apartments	Rates for single parents as set by income support	Department of Advanced Education and Skills rates for single youth with dependents
Personal Allowance (hygiene items, entertainment, transportation)	207.60 monthly (youth not in a day program) 282.60 monthly (youth in a day program)	\$180 monthly
Grocery Allowance (if meals are not included in the accommodation)	N/A	\$200 monthly
Christmas Allowance	\$400 annually	\$400 annually
Clothing Allowance	Max \$50 monthly (Youth not in a day program) Max \$60 monthly (Youth in a day program)	\$300 annually

Type of Financial Support	CYFS Act: Prior to June 30, 2011	CYCP Act: June 30, 2011 - present
School Supply Allowance (high school, post-secondary, GED/ABE)	N/A	\$300 annually
High School Graduation Allowance	N/A	Up to \$500
Medical Care	Cost of medical services may be approved where required	Prescription drugs, medical equipment and other services with supervisory approval.
Dental Care	Exams, cleaning, x-rays, fillings, extraction and/or other necessary dental work as recommended by dentist	Yearly examination and cleaning, routine fillings and extractions and emergency exams. Other services with supervisory approval.
Vision Care	Eye exam (\$50) and glasses/contacts (\$150) (Annually)	Yearly eye exam, cost of glasses or contacts up to \$200(Annually)
Other Financial Supports	Damage deposits, moving costs, furniture, social recreational activities, driver training, child care services, counselling services and transportation	Damage deposits, moving costs, transportation, mental health services, social/recreational activities, burial expenses, child care for youth with children, moving expenses and driving school costs (supervisory approval).

\*Prior to the release of the Protection and In Care Policy and Procedure Manual in June 2011, there were regional variances in the rates provided to clients of the Youth Services Program as regions were following policies and practices established within each Regional Health Authority. The information provided for the *CYFS Act* reflects to the rates paid in the St. John's (Eastern Urban) region.





**Appendix F**  
**Conduct Disorder**



## Appendix F

According to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders – 4<sup>th</sup> Edition Text Revision (DSM-IV-TR) the diagnostic criterion for Conduct Disorder is as follows:

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

### Aggression to people and animals-

- (1) often bullies, threatens, or intimidates others
- (2) often initiates physical fights
- (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- (4) has been physically cruel to people
- (5) has been physically cruel to animals
- (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- (7) has forced someone into sexual activity

### Destruction of property

- (8) has deliberately engaged in fire setting with the intention of causing serious damage
- (9) has deliberately destroyed others' property (other than by fire setting)

### Deceitfulness or theft

- (10) has broken into someone else's house, building, or car
- (11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
- (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

### Serious violations of rules

- (13) often stays out at night despite parental prohibitions, beginning before age 13 years
- (14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- (15) is often truant from school, beginning before age 13 years. (p.98-99).



## **Appendix G**

### **Recommendations by Department/Agency**

# Appendix G

## Recommendations by Department/Agency

### Department of Child, Youth and Family Services – 19 Recommendations

#### **Recommendation 1**

The Department of Child, Youth and Family Services develop and implement an auditing protocol to examine file documentation to ensure strict adherence to the documentation standards outlined in the Child, Youth and Family Services Documentation Guide (2012) and the Risk Management Decision-Making Model Manual (2013).

#### **Recommendation 2**

The Department of Child, Youth and Family Services develop and implement a policy that ensures all Managers document all consultations and any decisions made pertaining to a child or youth.

#### **Recommendation 3**

The Department of Child, Youth and Family Services ensure that social workers working in the Protective Intervention Program complete comprehensive assessments in accordance with the Risk Management Decision-Making Model Manual (2013), ensuring that when a referral is screened in for a Protection Investigation:

- (a) the social worker completes the Safety Assessment form within 24 hours of interviewing the child and parents as per Standard #3; and
- (b) the social worker, in consultation with a supervisor, completes the Protective Investigation within thirty (30) days after the report is received as per Standard #4.

#### **Recommendation 4**

The Department of Child, Youth and Family Services review and revise current on-call services standards throughout the province to ensure that:

- (a) there is sufficient human resources to meet the demand for these services;
- (b) all social workers providing on-call services provide those services from a DCYFS location or have sufficient portable technology to ensure appropriate and timely access to information; and
- (c) social workers who are not regularly assigned to on-call services only provide this service if they have completed on-call training within the previous twelve (12) months.

**Recommendation 5**

The Department of Child, Youth and Family Services ensure the provision of complete and comprehensive assessments of all children and youth, regardless of age, to determine the need for protective intervention based on the Risk Management Decision-Making Model (2013).

**Recommendation 6**

The Department of Child, Youth and Family Services ensure that all social workers comply with Policy no.: 2.16 Plan for the Child and Policy no.: 3.9 Planning: In Care Progress Report of the Protection and In Care Policy and Procedure Manual (2011) and utilize the Plan for the Child and In Care Progress Report to prepare for the transitioning of children who are in care and approaching the age of sixteen (16).

**Recommendation 7**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that children in care who express their intention to receive Residential Services through the Youth Services Program to live independently:

- (a) undergo a life skills assessment prior to any transition to independent living; and
- (b) be provided with training to assist with the demands and responsibilities of independent living.

**Recommendation 8**

The Department of Child, Youth and Family Services ensure that all levels of management and frontline social workers are trained in, and demonstrate a clear understanding of, their applicable program areas and respective policies in order to provide accurate and consistent case management, direction and supervision.

**Recommendation 9**

The Department of Child, Youth and Family Services ensure that within thirty (30) days of receiving a Child Protection Report, a determination is made as to whether or not a child is in need of protective intervention and the file is closed or transferred to Ongoing Protective Intervention Services as required by Standard #4 of the Risk Management Decision-Making Model (2013).

**Recommendation 10**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that, when a child or youth is being transferred from one program area to another, a meeting is held between the sending and receiving staff persons prior to the transfer of the client's file.



**Recommendation 11**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that social workers are trained in and comply with the rules of informed consent when completing Youth Services Agreements with youth.

**Recommendation 12**

The Department of Child, Youth and Family Services develop and implement a policy to ensure that when signing or re-signing a Youth Services Agreement, all young people receiving services from the Youth Services Program:

- (a) must be fully informed and demonstrate a clear understanding of what the YSA entails; and
- (b) must have a guardian, support person or legal representative present during the signing of the Youth Services Agreement.

**Recommendation 13**

The Department of Child, Youth and Family Services research and review the feasibility of creating a provincial youth services coordinator position. This person would be solely responsible for meeting (face-to-face, or via telephone or video conference) with all youth transitioning into the Youth Services Program. This person will ensure that all youth receive consistent assessment of competency by an expert physician, and the necessary education and guidance required in signing and re-signing a Youth Services Agreement.

**Recommendation 14**

The Department of Child, Youth and Family Services review and revise as necessary the Residential and Supportive Services provided under the Youth Services Program to ensure that youth have access to:

- (a) sufficient funding for safe and affordable housing options; and
- (b) services that support the crucial areas that Reid and Dudding (2006) identified as contributing to successful outcomes: relationships, education, housing, life skills, identity, youth engagement, emotional healing and financial support.

**Recommendation 15**

The Department of Child, Youth and Family Services in collaboration with Choices for Youth:

- (a) update and revise the 2004 MOU between the St. John's Regional Health and Community Services Board and Choices for Youth to reflect the current partner organizations and agreement of services; and
- (b) ensure that all staff working in the Youth Services Program and Supportive Housing Program are trained in and demonstrate a clear understanding of their specific roles and responsibilities with respect to case management.

**Recommendation 16**

The Department of Child, Youth and Family Services ensure that when a youth is in receipt of services from multiple programs within the DCYFS, he or she is assigned a separate worker for each program area (i.e. Assessment, Long-Term Protection, Youth Services, Corrections). This will ensure the provision of expert services, clear communication and the avoidance of any potential conflict of interest in meeting the needs of youth.

**Recommendation 17**

The Department of Child, Youth and Family Services:

- (a) develop and implement a training module to train social workers in the use of the YLS-CMI tool; and
- (b) educate all applicable social workers in the completion of the YLS-CMI assessments to ensure reliability and validity of service provision.

**Recommendation 26**

The Department of Child, Youth and Family Services:

- (a) develop and implement a policy requiring the completion of an Individualized Support Services Plan for all children in care who are receiving services from multiple agencies;
- (b) ensure that a Youth Services Plan as per Policy no.: 5.3 of the Protection and In Care Policy and Procedure Manual is completed for any youth who is simultaneously receiving services from the Youth Services Program and from one or more other agencies; and
- (c) ensure that an Individualized Support Services Plan as per Policy 8.3 of the Community Youth Corrections Standards and Practices Manual is completed for any youth who is simultaneously receiving services from the Community Youth Corrections Program and from one or more other agencies.

**Recommendation 29**

The Department of Child, Youth and Family Services ensure that all children and youth:

- (a) are provided with opportunities to express their views freely in all matters affecting them; and
- (b) have their views considered in the development of their permanency plans.

## **Department of Justice– 4 Recommendations**

### **Recommendation 18**

The Department of Justice develop and implement a protocol to ensure that notification is provided to a youth corrections social worker when a youth on his or her caseload is arrested and/or detained under the Youth Criminal Justice Act.

### **Recommendation 19**

The Department of Justice ensure that the Royal Newfoundland Constabulary:

- (a) uphold record keeping standards as outlined in General Order 169 Police Note Books;
- (b) uphold record keeping standards as outlined in General Order 188 Criminal Reporting Procedures;
- (c) uphold 13.0 Information Required in Reports Concerning Young Persons outlined in General Order 176 Youth Criminal Justice Act/Youth Investigations; and
- (d) keep complete electronic records of all shift daily rosters.

### **Recommendation 20**

The Department of Justice ensure that all Royal Newfoundland Constabulary and Royal Canadian Mounted Police employees are educated on their duty to report pursuant to Section 11 of the Children and Youth Care and Protection Act (2010).

### **Recommendation 28**

The Department of Justice and the Department of Health and Community Services review the findings reported by the Royal Newfoundland Constabulary and Eastern Regional Integrated Health Authority as per Recommendation 27(c) and ensure implementation throughout the province.

## **Royal Newfoundland Constabulary– 1 Recommendation**

### **Recommendation 27**

The Royal Newfoundland Constabulary and the Eastern Regional Integrated Health Authority:

- (a) review and revise the Mental Health Care and Treatment Act Template form to ensure it is meeting the needs of youth presenting at Emergency Rooms by police escort;
- (b) develop and implement a policy to ensure that when a youth requiring police services due to mental health issues presents at a hospital, communication between medical personnel and the police is acknowledged by the signatures of both the police officer and the hospital official (i.e. the nurse or physician) on the Mental Health Care and Treatment Act Template form and the signed form is placed in each file; and
- (c) report the findings of Recommendation 27(a) and 27(b) to the Department of Justice and the Department of Health and Community Services for implementation throughout the province.

## **Department of Health and Community Services – 6 Recommendations**

### **Recommendation 21**

The Department of Health and Community Services ensure that all health care professionals in the four (4) Regional Integrated Health Authorities are educated on their duty to report pursuant to Section 11 of the Children and Youth Care and Protection Act (2010).

### **Recommendation 22**

The Department of Health and Community Services ensure that when youth meet with medical professionals in any of the four (4) Regional Integrated Health Authorities:

- (a) they are provided with the opportunity to meet privately and confidentially upholding their right to privacy as per Article 16 of the United Nations Convention on the Rights of the Child; and
- (b) if the safety of the youth or professionals is a concern that alternative measures are taken (the use of handcuffs and/or a windowed room for observation) to accommodate a private and confidential meeting while ensuring safety.

### **Recommendation 24**

The Department of Health and Community Services review the findings reported by the Eastern Regional Integrated Health Authority as per Recommendation 23(c) and ensure implementation throughout the entire province.

### **Recommendation 25**

The Department of Health and Community Services ensure that when youth present with concurrent disorders to any of the four (4) Regional Integrated Health Authorities, they are provided with a comprehensive assessment, diagnosis and treatment plan addressing both their mental health issues and addictions issues.

### **Recommendation 28**

The Department of Justice and the Department of Health and Community Services review the findings reported by the Royal Newfoundland Constabulary and Eastern Regional Integrated Health Authority as per Recommendation 27(c) and ensure implementation throughout the province.

### **Recommendation 30**

The Department of Health and Community Services ensure that all children and youth:

- (a) are provided with opportunities to express their views freely in all matters affecting them; and
- (b) have their views considered in the development of their treatment plans.

## **Eastern Regional Integrated Health Authority – 2 Recommendations**

### **Recommendation 23**

The Eastern Regional Integrated Health Authority:

- (a) research and review the feasibility of creating short-term beds in the pediatric emergency room for youth that present with mental health concerns and require intensive evaluation;
- (b) research and review the feasibility of utilizing a structured professional judgment tool (e.g. the SAVRY tool) for the assessment of adolescents that present with mental health concerns; and
- (c) report the findings of Recommendation 23(a) and 23(b) to the Department of Health and Community Services.

### **Recommendation 27**

The Royal Newfoundland Constabulary and the Eastern Regional Integrated Health Authority:

- (a) review and revise the Mental Health Care and Treatment Act Template form to ensure it is meeting the needs of youth presenting at Emergency Rooms by police escort;
- (b) develop and implement a policy to ensure that when a youth requiring police services due to mental health issues presents at a hospital, communication between medical personnel and the police is acknowledged by the signatures of both the police officer and the hospital official (i.e. the nurse or physician) on the Mental Health Care and Treatment Act Template form and the signed form is placed in each file; and
- (c) report the findings of Recommendation 27(a) and 27(b) to the Department of Justice and the Department of Health and Community Services for implementation throughout the province.



