



REPRESENTATIVE FOR
CHILDREN AND YOUTH

*Children at Risk:
The Case for a Better Response
to Parental Addiction*

Investigative Report

June 2014

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June 24, 2014

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

Dear Ms. Speaker,

I am pleased to submit the report *Children at Risk: The Case for a Better Response to Parental Addiction* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of critical injuries and deaths of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, reading "meturpellafond", written in a cursive style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Craig James
Clerk of the Legislative Assembly

Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth



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Executive Summary

When it comes to social work, protection of the child's best interests should trump everything else. Chief among those interests is the physical safety of a vulnerable child.

This report by the Representative for Children and Youth details the story of one British Columbia child who was not adequately protected because his safety and well-being were never made top priorities by the Ministry of Children and Family Development (MCFD). As a result, the 10-year-old boy suffered serious spinal and head injuries in a motor vehicle incident – injuries that are likely to affect him for the rest of his life.

This is the story of how parental substance misuse and addiction can have a detrimental effect on the lives of children. The boy in this case should not have been under the supervision of his mother and her boyfriend at all, let alone riding in a vehicle with these two adults who had been drinking that day as they visited a ski hill with the child.

Most importantly, this report recommends improvements that must be made to B.C.'s child protection and health care systems so that this boy's story is not repeated.

MCFD does not track the percentage of its child protection cases in which parental substance misuse or addiction are a factor. But anecdotally, ministry workers have expressed belief that the number is extremely high. In fact, in a 2002 survey of MCFD workers, staff estimated that 70 per cent of their child protection cases included substance misuse by the mother. According to the ministry's own practice guidelines, substance abuse by a parent is "*a dominant reality in child protection work.*"

In this boy's case, the mother had a long history of addiction including use of cocaine, amphetamines and opiates. The ministry was aware of these problems and aware that the child was at risk if left under the mother's care. MCFD was also aware that the child's maternal grandparents minimized the mother's substance problems and continually failed to follow safety plans by allowing the child to be supervised solely by the mother.

Despite five child protection reports and repeatedly ignored safety plans over nine years, MCFD did not take concrete action to remove the boy from the care of his family until after the motor vehicle incident that led to a five-month stay in hospital and permanent disability.

So what went wrong here? How were this child's best interests and safety not made the paramount concerns? The Representative's investigation turned up a number of reasons, which lead to the recommendations in this report.

While MCFD has had a policy in place since 2001 that spells out how to deal with issues of parental substance misuse and addiction, it seems that this policy is not widely used. In this child's case, only one of the 10 workers, including supervisors, assigned to the file over nine years had any formal training on how to work with families challenged by

addiction. Only one of the workers had heard of the 2001 MCFD policy and none of that policy's tools were used in this case.

As well, MCFD could provide the Representative's investigators with no information on overall funding of worker training on this subject as there is no dedicated budget within MCFD for training to address issues of parental substance misuse.

Another major factor in this case was the capacity of the child's elderly grandparents to care for him and to ensure he was protected from his mother's addiction. The report also finds that the ministry failed to properly engage the extended family in the child's care and safety planning and that their co-operation was difficult to obtain due to the denial and minimization that are such common family dynamics in cases of addiction.

The poor relationship between the ministry and the family led to the child suffering neglect and being repeatedly put at risk. As the mother's addictions intensified, the family's relationship with MCFD deteriorated leading, ultimately, to the critical injuries. Lost in this broken relationship between the family and ministry were the child's best interests.

Therefore, the Representative recommends in this report that MCFD take immediate steps to ensure that child protection practice is resolutely focused on serving the best interests of the child over any other interests – including the preservation of the family unit – in line with the principles articulated in the *Child, Family and Community Service Act (CFCS Act)*.

This recommendation includes a particular focus on parental substance use. It calls for the ministry to make specialist substance use consultants available in every service area of B.C. to assist in effective safety planning for children and, where appropriate, to assist in developing engagement strategies and support for family members.

The recommendation also speaks specifically to situations in which placement with members of the extended family is being contemplated for a child. It calls for a timely assessment of both the needs of the child and the capacity of the prospective relatives to meet those needs prior to a long-term placement.

The Representative is also recommending that MCFD create a learning tool, based on the findings of this report, to be disseminated to executive directors of practice, community service managers and team leaders across the province, along with directions on how to facilitate organizational learning using this tool.

Another finding of the report is that addiction services in B.C. differ widely from community to community and region to region. In this case, the mother may have received more effective help had she not encountered wait-lists in her initial attempts to seek treatment or been left to move in with a fellow addict following treatment. The report finds that there is a need in B.C. for a trauma-informed approach to addiction that is flexible to the unique needs of those being treated.

The Representative recommends that MCFD and the Ministry of Health work together to create a comprehensive addictions strategy and a system of care for parents with substance use issues. This effort must focus on filling the currently existing gaps in service, including supports for parents, children and other involved family members, and provide accessible and effective services.

Included in this recommendation is a call for the two ministries to provide priority access to addictions treatment and tailored, timely services for parents in cases where there are active child protection concerns.

Introduction

On a winter evening in January 2009, the child who is the subject of this report and his mother were passengers in a vehicle driven by the mother's boyfriend. Although he had been placed in the care of his grandparents, who were told to supervise all visits with his mother, this child with complex needs was with two intoxicated adults while they were travelling on a rural highway. Their vehicle crossed the centre line of the highway and hit an oncoming car.

The 10-year-old child sustained critical injuries, including damage to his spine and a closed-head injury.¹ His mother suffered injuries to her hand and wrist. The passenger of the other vehicle also sustained serious injuries, which would require two years for a full recovery. The mother's boyfriend was witnessed by several citizens fleeing the scene of the accident on foot and was later found by police at his home. According to the police report to Crown Counsel, he suffered a sore neck and shoulder and sustained bruising to his body as a result of the crash.

At the time of the motor vehicle incident, this family was receiving services from a child protection team at the local MCFD office. The impact of the mother's substance misuse had been a recurring child protection concern during the previous eight years. As a result, the child had often been in the care of his maternal grandparents.

Several months before the incident, the grandparents, both in their 70s, had taken over the care of this child with complex needs and had been instructed by MCFD not to allow the mother to care for the child without adequate supervision. However, neither grandparent was present on the evening of the motor vehicle collision.

After receiving a report of this critical injury in accordance with the *Representative for Children and Youth Act (RCY Act)*², the Representative undertook a review, concluding that a full investigation was warranted.

The objective of a Representative's investigation is to examine whether policies or practices of a reviewable service or public body may have contributed to the death or critical injury of a child. Essentially, an investigation seeks answers to the questions that inevitably arise when a child is harmed and the circumstances suggest that the incident could have been preventable, including:

- Why did this happen?
- How did it happen?
- Has anything changed as a result?
- Should anything change as a result?

¹ Closed-head injuries are a type of traumatic brain injury in which the skull and dura mater remain intact. (source: Wikipedia.org)

² *Representative for Children and Youth Act* [SBC 2006] c. 29, s. 11.

In the words of the Honourable Ted Hughes in his *BC Children and Youth Review* (2006), in cases such as these it is necessary to “*understand what went wrong and what went right.*”³

In the process of answering these questions, several points became clear:

- The issue of parental substance misuse is widespread among child protection caseloads;
- The impact of parental substance misuse on children’s well-being can be extremely detrimental and long-term⁴;
- Overcoming the detrimental impacts of substance misuse is extremely difficult.

During the investigation, it also became apparent that this family was served by front-line workers who demonstrated an impressive dedication to helping families and protecting children. It also became evident through this investigation that the child benefited from a loving family. Unfortunately, these favourable circumstances were not enough to protect him.

This report uses one specific case and one child’s life to illustrate the gaps and shortcomings within the child-serving system when it comes to addressing parental substance misuse. In his review, Hughes wrote that the primary purpose of an investigation such as this is to “*point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented.*”

It should be noted that this case is not unique, even though the injuries suffered by the child were extreme. Many of the circumstances of this case are, for vulnerable children, all too common.

In this report, care has been taken to avoid identifying the child, now 15-years-old, and his family members by name or location. This is out of respect for the privacy of the child and his family.

³ *BC Children and Youth Review*, Hughes, E.N. (2006)

⁴ Several studies have revealed the devastating impact of parental addiction including a recent Representative’s report *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*, in which 75 per cent of the mothers of the youth in that aggregate review struggled with substance use issues as well as others. Also see Dube (2003) and Felitti (1998).

Methodology

The Representative's investigation focused on a nine-year time period, from when the family first began receiving services from MCFD to the date of the child's critical injury.

In order to conduct an investigation pursuant to s. 12 of the *RCY Act*, the Representative's Office gathered information from a variety of sources. Documentary evidence was acquired from hospitals, schools, courts, the police and government offices. Interviews were conducted with 20 private individuals and professionals. Research was conducted into best practices in other jurisdictions. Services available to those dealing with a substance use problem were reviewed. Much of the personal information was acquired in accordance with s. 14 of the *RCY Act*, which gives the Representative's Office the power to request information from government bodies.

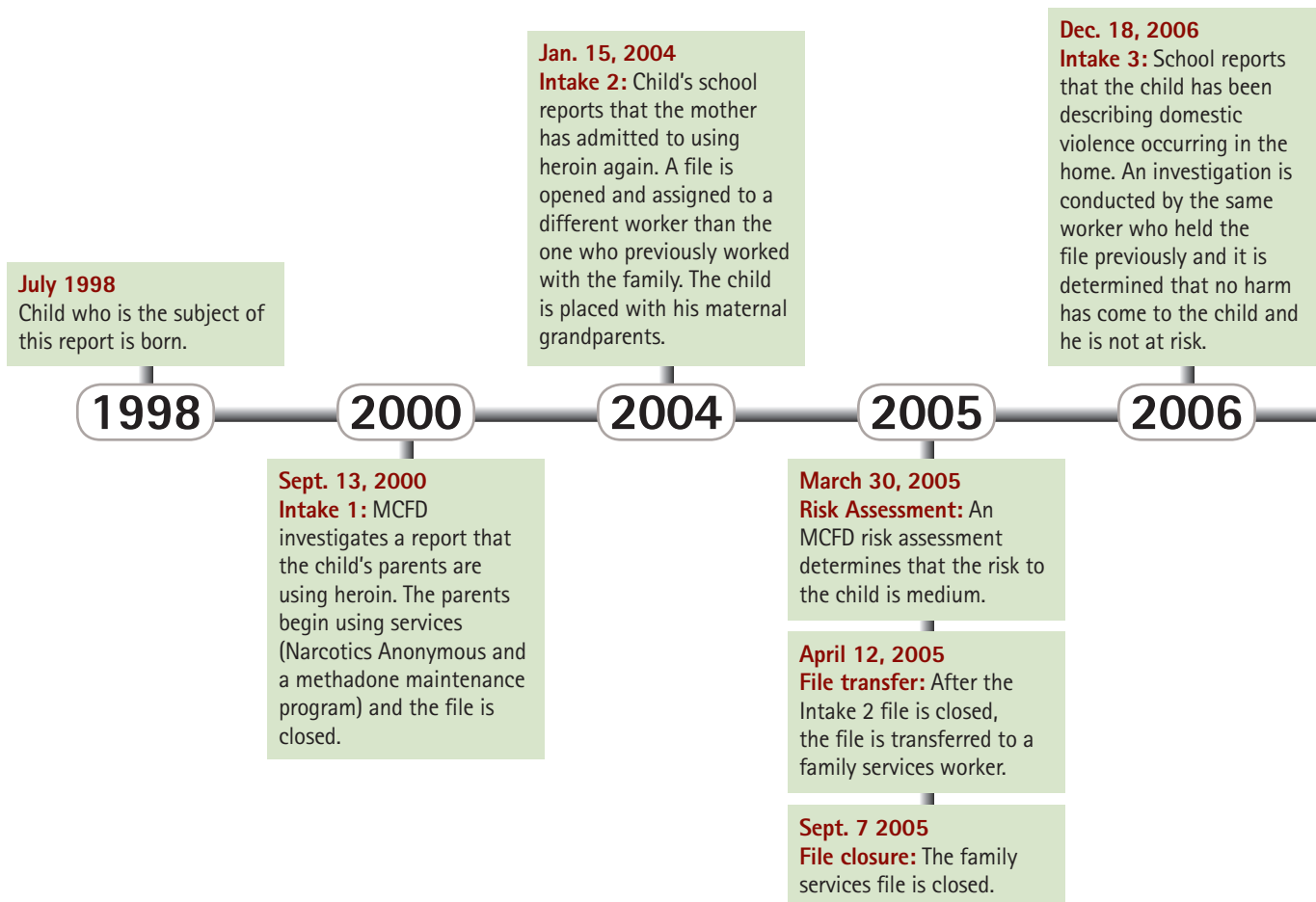
To avoid further traumatizing the child who is the subject of this report, he was not interviewed as part of the investigation. However, two of the Representative's investigators met with the child to see how he was doing.

The Representative's Multidisciplinary Team (see Appendix C) was provided with draft findings near the completion of the investigation for its review and input. An expert panel was also convened and provided advice on the report and the development of recommendations.

To provide for administrative fairness, educational, medical and government organizations that were involved in the investigation were given an opportunity to review this report and provide comments on the facts of this case prior to this report being finalized.



Timeline of Significant Events



Jan. 18, 2008

Intake 4: The mother is brought to the hospital by friends and reports having used crack, cocaine and amphetamines on and off for the past four months. The child is with his maternal grandparents and remains in their care. An investigation is conducted by the same worker who previously held the file. After several failed attempts to engage the mother in services, the file is closed after the family is told verbally and in writing to keep the child with the grandparents until the mother has been clean and sober for six months.

Feb. 15, 2008

Risk Assessment: An MCFD risk assessment determines that the risk to the child is medium.

April-May 2008

Treatment: The mother checks into a treatment centre and completes the two-month recovery program. The child is returned to her care.

2008

Aug. 12, 2008

Intake 5: The ministry receives a report that the mother is using substances regularly while caring for the child. An investigation is initiated by a worker assigned to the family's file.

Aug. 19, 2008

Safety Plan: The mother and the grandmother sign a safety plan that stipulates that the child will reside with the grandmother and that only a responsible adult will supervise the mother and child when the grandparents are unable to do so.

End of August, 2008

Move: The mother moves in with the grandparents and the child.

Sept. 9, 2008

Family Group Conference: A conference is held with the mother, grandmother, two service providers and ministry workers. A service plan is agreed upon.

October, 2008

Drug Test Results: Results from the drug test taken when the investigation was initiated come back indicating regular use by the mother. It is also becoming evident that the services laid out in the service plan are not being used.

Oct. 31, 2008

Risk Assessment: An MCFD risk assessment determines that the risk to the child is high.

Nov. 17, 2008

File Transfer and Letter: A letter is sent to the mother by the newly assigned family services worker. The letter outlines the need for the mother to complete treatment and undergo counselling. There is no response to this letter and numerous attempts to set up a meeting with the family fail.

Jan. 10, 2009

Critical Injury: The child is involved in a motor vehicle incident and suffers a critical injury while in the unsupervised care of his mother.

2009

Jan. 12, 2009

Removal: The child is removed from his mother's care under an interim custody order.

Chronology

The Child's Family

The child who is the focus of this report was born in July 1998 and is the only child of his parents. The hospital intake form indicated that he was healthy at birth with the “single parent” and “inadequate support systems” boxes both checked on the form.

Following the child's birth, he resided with his mother in the home of his maternal grandparents, and later they moved in with the child's father in the same community. The grandmother told the Representative's investigators that shortly after the child's birth, the mother and father began living together and both soon began using heroin. The grandmother speculated that post-partum depression may have had an impact on her daughter, leading to her drug use.

The father had previously suffered an injury in a motor vehicle incident and experienced chronic pain as a result. According to his correspondence with the Family Maintenance Enforcement Program,⁵ he began using illegal drugs in order to manage his pain.

Throughout much of the child's life, he has resided with his mother, his maternal grandparents or all three together. His grandparents have provided a significant amount of care and have often stepped in when the child's mother was unable to care for her son due to struggles with addiction. Now in their late 70s and early 80s, they continue to care for the child, whose complex behavioural, social and learning challenges of unknown origin have been compounded by the injuries sustained in the 2009 motor vehicle incident.

The Child's Life

First Report to the Ministry

On Sept. 13, 2000, when the child was two-years-old, MCFD received a child protection report alleging that the parents were using heroin while caring for him. The ministry opened an intake file and began an investigation. The child protection concerns were “*neglect by a parent with a likelihood of physical harm.*”⁶ A social worker visited the home, interviewed the parents and spoke with the maternal grandparents as well as other family members and a doctor involved in the methadone program.

The MCFD investigation determined that, due to the parents' heroin addiction, the grandparents were actively involved in monitoring the child's safety and well-being. At this time, the grandparents were in their mid- to late-60s. Both of the child's parents agreed to get addiction services and attend support groups, counselling and methadone treatment.

⁵ The British Columbia Family Maintenance Enforcement Program monitors and enforces maintenance orders and agreements for either child support or spousal support.

⁶ S. 13 of the *Child, Family and Community Service Act (CFCS Act)*.

One month after this investigation began, the child was seen by a pediatrician because he was exhibiting head-banging behaviour. The physician's report stated: *"Head banging is a common unharmed behaviour in infants and toddlers. Reassurance and providing love and security is all that is needed. Proper discipline is needed as well."*

The Representative's investigators could find no record of MCFD being made aware of the pediatrician's assessment, nor any evidence of what, if any, actions occurred as a result of these suggestions.

The MCFD investigation concluded that there was no immediate risk to the child's safety and that there were no obvious signs of neglect. After more than four months of involvement with the family, the MCFD worker concluded that the parents had participated in all services as required and were no longer using heroin. The intake was closed on Jan. 26, 2001. A letter from the social worker to the family on this date stated: *"To date, you have been able to complete all of the expectations that you agreed to meet and you are both continuing your recovery in a responsible manner. As such, I have made a decision to close your file with the MCFD at this time."*

Prior to and following this investigation, the grandparents checked on the child and his parents regularly and occasionally took over caring for him for brief periods of time. The mother continued with the methadone program that she commenced during the ministry's involvement; however, her medical record indicates that she may have continued to inject other drugs. The child's father continued to struggle with substance use and the injuries resulting from a motor vehicle incident and he was no longer able to operate his small business. The mother applied for income assistance for herself and the child on Nov. 19, 2001, although she has had periods of low-wage employment in retail stores and fast food restaurants.

The mother told the Representative's investigators that the father was occasionally violent toward her and that they eventually ended the relationship when the child was approximately four-years-old.

When the child was almost five-years-old, he was examined by a number of physicians due to concerns about his behaviours. These included not interacting appropriately with his peers, behaving aggressively, demonstrating unusual fears of eating in front of others and fears of using the bathroom at school. Additional concerns were raised regarding his challenges with comprehension, delayed speech and lack of toilet training. A pediatrician was concerned that the child played violent video games and raised this issue with his mother.

In a letter to the child's general practitioner, dated April 3, 2003, the same pediatrician stated that the child was seen for *"assessment with regards to concerns of behavioural problems and developmental delay."*

"The concern about his behaviour relates mostly to his tendency to be physically abusive to other children and my discussion with mom did not elicit any particular concerns about his development," the pediatrician wrote, later adding: *"[The father] is heavily involved*

in computer building and computer games. He apparently encourages [the child] to play those games and basically [allows] unregulated access to the child which we thought was quite inappropriate for his age to have access to those types of games that have a high violence content.”

The pediatrician also wrote: *“In any case, the long discussion appears to have provided some ideas to mom who seems satisfied with the conversation and intent on making some changes in the child’s life.”*

After the child began Kindergarten in September 2003, he underwent an assessment by his school and a second assessment by Sunny Hill Health Center for Children in Vancouver as a result of the concerns raised previously by both physicians and his school. The school assessment determined that the child had intensive behaviour intervention needs.⁷ The Sunny Hill assessment determined that he had a number of challenges with his ability to pay attention, social isolation and sensory integration, which were impacting his ability to learn and to interact with others. That assessment also noted that the child had difficulty managing anger: *“Primary concerns expressed by the school and family involve difficulties with anger management, aggressive behaviour, attention, social skills and peer relationships.”*

Sunny Hill recommended a highly structured school environment for the child as well as a number of educational supports such as a speech pathologist, a counsellor, and a learning assistant. Sunny Hill also recommended that the child participate in after-school day care programming to develop his social skills.

The child’s school implemented the Sunny Hill recommendations. A child and youth care worker was also assigned to support him by assisting the child in interacting with his peers, developing his self-esteem and helping him to feel comfortable in a classroom setting. The child and youth care worker spent one hour with the child each week. The worker noted that the child appeared to have difficulty regulating his emotions and that at times *“he could just blow up.”*

Halfway through the Kindergarten year, on Jan. 12, 2004, a school district counsellor met with the mother regarding the child’s needs. According to information on the school file, the mother cried throughout the meeting. The counsellor told her that *“her job is to parent,”* that the child needed a consistent bedtime and that he should be denied computer access for one month. When later asked by the Representative’s investigators, the counsellor could not recall the reasons for his comments.

The Sunny Hill assessment also noted that the child’s mother was on a wait-list for inpatient addiction treatment at the time and that there had been a referral to family support services. However, investigators could find no further information to indicate that the mother received these services.

⁷ According to the Ministry of Education’s policy document *Special Education Services: A Manual of Policies, Procedures and Guidelines*, students are eligible for special education funding when they display “antisocial, extremely disruptive behaviour in most environments” and the behaviours persist over time (Ministry of Education, 2011).

Second Report to the Ministry

Three days after the mother met with the school counsellor – on Jan. 15, 2004 – the ministry received a child protection report from the child’s school that the mother had admitted to using drugs and was having difficulty coping. The ministry was told that the mother had stated “*I can’t do this anymore,*” that the child had missed a number of days of school and that, even when he did attend, he was behaving violently.

The child protection report was assigned to a social worker who met with the mother and the grandmother. The worker assessed the child’s mother as having difficulty coping with everyday life. According to the worker, during the meeting the child’s mother reluctantly agreed to participate in a substance use treatment program. It also appeared to the worker that the child’s mother had coached the child to lie to the grandmother regarding his school attendance. During this school year, the child missed a total of 21 days of Kindergarten.

The mother was referred to residential treatment and counselling but she did not participate in either. The ministry worker told the Representative’s investigators that the mother appeared to oscillate between committing to undergo treatment and then refusing to participate.

As a result of the concerns reported, the grandmother, then 68-years-old, took over the child’s care on Jan. 20, 2004. The grandmother was told by the social worker that the mother was not to be given unsupervised access, meaning that the child could not be left in the mother’s care without the grandmother or another responsible adult present to supervise.

The worker later told the Representative’s investigators that she believed the impact to the child as a result of the mother’s drug use was “*total . . . chronic neglect*” and the worker viewed the mother’s substance use as the reason the child was often left alone to watch television or play video games. The worker coded the investigation as “*neglect by parent with likelihood of physical harm and unable to care,*” based on s. 13 of the *Child, Family and Community Service Act (CFCS Act)*.⁸

On Jan. 27, 2004, school staff and a ministry worker arranged for a care team to be set up for the child. At this point, the child was described by his child and youth care workers as being “*totally out of control.*” The care team consisted of school staff, ministry social workers and other professionals involved with monitoring the child. The team met regularly during the year to establish and maintain a school environment that could better support him and keep him on track. School staff later told the Representative’s investigators that at this time the child continued to have difficulty with social skills but was friendly and also appeared to be progressing well while he was in the care of his grandmother.

⁸ *Child, Family and Community Service Act*, RSBC 1996, C. 46.

During this time, the child's mother was receiving income assistance benefits from the Ministry of Employment and Income Assistance, now known as the Ministry of Social Development and Social Innovation (MSDSI). In February 2004, she was approved to receive benefits as a person with persistent multiple barriers to employment (PPMB). According to the medical report completed by the mother's doctor to demonstrate her eligibility for PPMB, the mother suffered from "*severe depression, chronic fatigue, low energy and motivation.*" The mother continued to qualify for these benefits for the duration of the nine-year time period covered by this report.

Despite clear direction given to the grandmother by the MCFD social worker to not allow the mother unsupervised access to the child, the social worker discovered that the grandmother had left the child with his mother for an entire day. It is unclear to the Representative's investigators when this occurred, but the grandmother reported it to the MCFD social worker in May 2004. Upon the grandmother's return on this occasion, she found the child had missed school that day and had been playing video games. The worker was concerned that the grandmother had not complied with her directions but the worker took no further action.

The worker discussed with the maternal grandmother the possibility of applying for permanent custody of the child. The grandmother felt such a step was unnecessary because she believed that the mother would not attempt to remove the child from her care.

The worker recalled speaking to the grandmother on June 24, 2004. The worker contacted her again on June 30 and July 14 but did not receive a response. To follow up, the worker went to the grandmother's home on July 19 and found that the child was again in the sole care of his mother, contrary to the agreement that had been made with the grandmother. The worker later told the Representative's investigators she was alarmed to find that the mother had been given unsupervised access to the child by the grandmother. However, the worker assessed the child as being well cared for despite not being taken to daycare that day. The worker took no further action. The worker also described the grandmother as "*strong,*" "*predictable,*" "*consistent*" and "*good*" with the child and his mother.

When the child was in Grade 1, he was diagnosed with Tourette syndrome and attention deficit hyperactivity disorder (ADHD) by a physician at BC Children's Hospital. File information does not indicate what led to the assessment or who referred him. The report suggested that some of his Tourette symptoms were associated with his excessive exposure to computers and noted that some of the symptoms appeared to diminish when the child was in the care of his grandmother and had more consistency in his home environment.

The worker wanted to conduct a Comprehensive Risk Assessment (CRA) and a Risk Reduction Service Plan, after which the file would be transferred to a family service worker to work with the mother on reducing the risks to the child identified in the CRA. However, the worker was unable to get the mother to meet with her to complete either of these documents. The worker told the Representative's investigators that she attempted to engage the mother for approximately 13 months. Eventually, the worker completed

both documents without the mother's participation. The CRA determined that the child was at medium risk when he was in the care of his mother. The Risk Reduction Service Plan required the mother to complete a drug treatment program by May 12, 2005.

The file was transferred to the family service worker approximately one month after the CRA was completed, on April 12, 2005, and closed in September 2005 because the family service worker believed that the mother had no interest in taking over the child's care from his grandmother. The worker also closed the file because she believed that the child's mother was not engaging in support services other than occasional visits to a counsellor.

In February and June 2005, the mother was evicted from two different homes. During that same year, she began a relationship with an individual who had a history of mental health problems.

Comprehensive Risk Assessment (CRA):

a process that analyzes and documents the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. Twenty-three different risk areas are looked at and given a risk rating from 0 to 4. If a rating of 3 or 4 is received, it is considered a high risk factor for that area. Some short descriptions are provided to explain what each rating would look like. For example, under the risk factor of Family Violence, *"a rating of 4 is described as "repeated or serious physical violence or substantial risk of serious physical violence in household."* A CRA is supposed to be completed whenever a child is found in need of protection.

Report of Violence

The maternal grandmother returned the child to his mother's care when he was in Grade 1 or 2; the Representative's investigators could not determine the exact date that this occurred.

According to school staff, the child's behaviour was improving and he was no longer as explosive. He had an occupational therapist and continued to benefit from a counsellor, child and youth care worker and educational assistant. His child and youth care worker at the time described him as a sweet child who was well liked by his friends. His behaviour in school no longer required an intensive behaviour plan but the school continued to use an Individual Education Plan (IEP).⁹

⁹ An Individual Education Plan is mandated by the Ministry of Education, ministerial order 638/95, to provide individualized plans to students identified with special needs and who require: more than minor adaptations to educational material or instructional or assessment methods; the expected learning outcomes to be modified; and require more than 15 hours of remedial help to meet the modified expected learning outcomes from someone other than the classroom teacher. Changes to policy have occurred over time. For the current ministerial order see: <http://www.bced.gov.bc.ca/legislation/schoollaw/e/m638-95.pdf>

A year-end review of the child's IEP was conducted by the school at the end of his Grade 2 year. It found improvement in his socialization and a decrease in his social anxieties. The child continued to demonstrate improvements, despite being frequently late for school.

Third Report to the Ministry

When the child was in Grade 3, concerns were reported to the ministry regarding possible domestic violence between the mother and her current boyfriend, based on statements the child had made at school. The child stated to school staff that he had heard the boyfriend slap his mother around. The child also reported seeing his mother with black eyes and listening to his mother being verbally abused by her boyfriend. He also stated that the mother's boyfriend would not allow her to phone police. At this time, employees at the child's school noted that the child had been exhibiting aggressive behaviours including pushing and punching others.

On Dec. 18, 2006, the ministry opened an intake file and conducted an investigation within days of receiving the report. This marked the third MCFD investigation into the child's safety. The social worker who conducted this investigation was the same family service worker who had received the file in 2005. The worker interviewed the child and staff at the child's school.

The child disclosed that he had observed his mother and her boyfriend drinking alcohol daily and that he had also witnessed verbal abuse and demonstrated a punching motion to the worker to show what he had observed. The worker later told the Representative's investigators that the child was difficult to interview and that he did not disclose that he had witnessed his mother being "slapped around" or having black eyes, which was contrary to the initial child protection report. The worker said that she believed the child was instead describing something he had only overheard. The worker considered the child to be consumed by violent video games, but concluded that he had not disclosed any abuse or neglect despite the statements made at school and during the interview.

The worker spoke with the mother, grandparents and the mother's landlords as part of the child protection investigation. School staff noted that, despite the grandmother being significantly involved in the child's care, his behavioural challenges were increasing.

After the interviews with the child, his family and the mother's landlords, the worker determined that there was no evidence of physical abuse or neglect. The worker found that the mother's boyfriend had a loud voice which had scared the child and had led to the child protection report. The worker spoke with the child's mother and gave her information regarding family counselling. The worker closed the file on March 22, 2007.

Three months later, in June 2007, emergency responders reported that the mother had fallen through a glass door at her boyfriend's house, which resulted in cuts to her face and arm. According to the medical file, she told emergency response personnel that she had recently smoked crack cocaine and they noted that she appeared to be very agitated and concerned about the reactions of her boyfriend and mother to her drug use.

Six months later, in December 2007, a child protection report was made to an income assistance worker regarding the mother's alcohol and drug use while caring for the child. The Representative's investigators were unable to find a record of these reported concerns in MCFD files, suggesting the concerns were never passed on.

Third and Fourth Reports to the Ministry

In January 2008, MCFD received another child protection report following the mother's disclosure to hospital staff in the Emergency Room that she had been using substances for the past five months while her son was in her care and that she was currently *"on a binge."*

She tested positive for cocaine, amphetamines and opiates. The mother told the hospital Emergency staff that her son was being cared for by his grandparents.

She had been brought to the hospital by her boyfriend and his mother. The nurse who contacted the ministry said that the mother had sold her car to support her drug use. The nurse also told the ministry that the mother had recently made phone calls to inquire about detoxification services but hung up when told that there was a wait-list.

The ministry opened an intake file on Jan. 18, 2008 and conducted its fourth investigation of the child's family. The social worker consulted with the team leader and they determined that the child's placement in the care of the grandparents, now in their early- to mid-70s, was an appropriate safety plan.

The child was now nine-years-old and in Grade 4. As part of the investigation, the MCFD worker attended the child's school and took him out of class to interview him. During the interview, the worker informed the child that his mother was using substances and the child became very upset. When the worker finished the interview, she returned the child to his classroom.

The mother's boyfriend later told the Representative's investigators that during this time she was becoming increasingly addicted to substances and was having difficulty coping with daily activities.

In February 2008, the ministry completed another CRA on the family. It found the child to be once again at medium risk and noted that the grandparents provided him with stability and adequate care when his mother was unable to do so. The CRA referenced the mother's boyfriend but it did not appear to consider him as having a significant role in the child's life or consider any potential risk he may have posed to the child.

The child's previous disclosure of domestic violence was not included in the assessment. Eight of 23 areas of risk were not reassessed — the assessment simply stated *"no updates"* for those areas. In an interview for this investigation, the worker who completed the CRA explained that she used that phrase when she believed that the risk had not changed in a given area.

According to MCFD file information, the worker made several attempts to meet with the mother to gather more information, making unannounced home visits and also scheduling home or office visits. However, a meeting with the mother never occurred.

The team leader told the Representative's investigators that in these cases, the ministry generally emphasized securing some stability for the child rather than assisting the mother with addiction support as the mother did not appear to be engaging in her recovery.

On March 6, 2008, the worker learned in a conversation with the grandmother at the MCFD office that the grandmother had allowed the mother an unsupervised overnight visit with the child, which was contrary to the agreed-upon safety plan. The worker told the Representative's investigators that the grandmother reported being very angry when she came home and found the mother sleeping and the child playing video games. The grandmother told the worker this would not happen again.

The worker determined the child was in need of protection. But after consulting with the team leader, a decision was made to close the file because the grandparents were considered to be adequately ensuring the child's safety and well-being.

The worker wrote a letter to the grandparents, stating that the child must remain with them as part of the agreed-upon safety plan and that, if the mother wanted to work toward having the child in her care, she was required to first contact the ministry. The letter recommended that the mother complete a residential treatment program and be clean for six months before the child was returned to her care. A copy of this letter was also sent to the mother. When asked about this letter by the ministry several months later, the grandparents and the mother stated that they had never received it.

The worker told the Representative's investigators that she spoke to the grandmother prior to the file closure and explained that the child's mother would have to abstain from drug use for a significant length of time in order for the child to return to her care. The worker also reported that she made an offer to the grandmother to keep the family service file open so that further support could be provided; however, the grandmother declined the offer. The file was closed on March 12, 2008.

Shortly after the file was closed, the child was assessed by an occupational therapist. This was not the first time he had been referred to the occupational therapist by his school for concerns related to motor skills and sensory processing. The therapist determined that:

- The child's social skills continued to improve but he still required assistance in this area;
- The child had difficulties with sensory integration and required time to process sensory information;
- The child continued to have social anxieties and unusual fears.

Several recommendations were made, including adaptations to the child's classroom, exercise strategies, anxiety management strategies and counselling for the child to help him address his anxieties and fears.

In May 2008, the mother began a 60-day residential treatment program to which she had been referred by the ministry worker. The mother explained that she entered treatment at this time rather than earlier because she *"wasn't gonna be told to do it, I had to do it on my own . . . I put myself in there."* The mother had recently lived for several months with someone else who struggled with addiction and believed that this

experience gave her an opportunity to observe addictive behaviour and gain insight into her own challenges.

A few days after the mother had completed treatment, the grandmother returned the child to the mother's care. The mother later told the Representative's investigators that the 10-year-old child was only in her care part of the time. The mother was not provided with access to any after-care supports. The ministry was not aware that the child was in the mother's care at this time.

In July 2008, the mother failed to attend some routine appointments with MSDSI to discuss her continued eligibility for the PPMB program. The mother told the Representative's investigators that she had relapsed after she moved back into a home with the roommate who was also struggling with addiction and *"it was around me as soon as I got home."*

Fifth Report to the Ministry

In August 2008, six weeks after the child's mother had completed substance use treatment, the ministry received a child protection report that the mother had been using cocaine regularly and had the child in her care. The caller reported that the mother's substance use had begun immediately upon her return from treatment and that the child was suffering from neglect. The caller also reported that the child's grandparents were not protecting the child from the alleged neglect.

The ministry opened a new intake file on Aug. 12, 2008 and a social worker conducted a home visit to the mother's home. During the visit, the child was playing in his room. The worker said that the child was not willing to engage in a conversation with her. The worker found that the cleanliness of the home met community standards, but that the mother looked unwell. The mother admitted to the worker that she had relapsed twice since completing addiction treatment. The worker informed the mother that she would have to complete a drug test to enable a thorough assessment of the reported child protection concerns. The worker subsequently told the Representative's investigators that she believed a drug test was necessary in order to confirm the extent of the mother's substance use.

The grandmother told the ministry worker that she had not noticed anything unusual in the mother's behaviour that would indicate that she was again using substances. The grandmother told the worker that she had seen the mother and the child almost every day. The grandmother also told the worker that the boyfriend frequently visited the mother's home.

Drug Testing

Use of drug tests by MCFD workers varies from office to office. Each ministry region has a guideline to assist workers in using their professional judgment in this matter. The method of drug testing depends upon the service provider used and the substance being tested for. In this mother's case, the worker utilized a service that conducted tests using hair samples and provided results in approximately six to eight weeks.

After the conversation with the grandmother, the social worker consulted with the team leader and developed another safety plan for the child as an interim measure until the results of the mother's drug test were available to the ministry. The safety plan called for the child to reside with the grandparents, who would not allow the mother unsupervised access to the child.

After consulting with the team leader and developing the interim safety plan, the worker arranged a meeting with the mother and grandmother at the ministry office. On Aug. 14, 2008, the social worker met first with the mother. The worker questioned the mother about the things that triggered her to relapse into substance use. The mother told the worker that she felt overwhelmed and that she may have taken over care of her child too soon but that she did not want the child's grandparents to be burdened with the responsibility because they had health issues.

When the worker explained the interim safety plan to the mother and told her that the child would have to be in the care of the grandparents, the mother became angry. She told the worker that she did not want her parents to know she was using drugs because she feared they would be angry. The worker obtained a hair sample from the mother for the purposes of drug-testing and the mother also signed a Risk Reduction Service Plan in which she committed to:

- seek medical assistance or assessment of any mental health concerns;
- follow through with all recommendations made by her doctor;
- seek family support; and
- participate in substance use counselling.

The worker informed the grandmother of the safety plan for the child. After a discussion about warning signs, the worker believed that the grandmother could accurately detect when the mother was using substances. The worker realized that the grandmother had not detected the mother's recent drug use but attributed this to the fact that the mother had been actively hiding it.

The worker noted that the grandmother appeared to be minimizing the extent of her daughter's drug use and that the grandmother did not believe the contents of the most recent child protection report. However, the worker believed that the anger exhibited by the grandmother over her daughter's actions was evidence that the grandmother was taking the issue seriously.

The worker recommended that the grandmother participate in addiction education, counselling or a support group. However, the Representative's investigators could find no evidence of referral to such supports.

Following the meeting with the grandmother, the worker did not believe that the health of the grandparents was an issue in their ability to care for a 10-year-old boy with complex needs. It appears no steps were taken to assess whether the health of either grandparent was an issue despite the mother raising the concern and the fact that the grandparents were in their mid-70s. Whether the grandparents were capable

of preventing the mother from taking the child with her whenever she desired does not appear to have been considered.

On Aug. 19, 2008, the mother and grandmother signed a safety plan, agreeing to the following conditions:

1. *The child shall reside with the maternal grandmother*
2. *The mother may move into the home of the maternal grandmother*
3. *The grandmother will reasonably supervise the mother and the child while in the family home*
4. *The grandmother will not allow the mother and the son to be alone in the home at any time*
5. *The grandmother will arrange for a responsible adult (e.g. not the mother's friends) to supervise the mother and the child when the grandmother is unable to supervise*
6. *The mother will not be present in the family home if she is under the influence and shall not return to the home within 24 hours of using*
7. *The grandmother will inform the social worker of any concerns/suspicion of drug use.*

Despite the worker's view that the grandmother was resistant and appeared to minimize the mother's substance use, the worker was confident that the grandparents would comply with this safety plan for the child's care. The worker believed the safety plan would protect the child if the grandmother had "*the right education and support*" and if the family understood the severity of the issue. However, based on the worker's own evidence from meetings with the mother and grandmother, it does not appear that the family understood the severity of the mother's substance use. Nevertheless, the worker did not believe that the grandmother required any support as the child's caregiver.

In addition to agreeing to the safety plan, the mother and grandmother also agreed to participate in a family group conference. The worker believed that this process could help the family understand the serious nature of the child protection concerns and provide an opportunity for them to participate in developing a permanent plan for the child's care.

The family group conference coordinator believed the conference would help facilitate services for the mother such as counselling, support groups and parenting education, which would in turn address the reported concerns regarding the child's neglect.

When the coordinator contacted the family to prepare them for the conference, they appeared reluctant to participate and the mother and grandmother denied there were any concerns about the mother's substance use. The coordinator shared this information with the social worker.

In preparation for the conference, the social worker completed a review of the family's file. The worker told the Representative's investigators that the purpose of this review was to understand the scope of the mother's substance use so that it could be made clear to the family during the conference.

By the time the conference was held, on Sept. 9, 2008, the mother had moved into the grandparents' home and was residing there with the child. The mother, grandmother, the intake worker and two community service providers attended the conference. The grandfather did not attend because his health was poor. The result of the conference was the creation of another plan, in addition to the previously agreed-upon safety plan, which was signed by the mother and the grandmother. The new plan included:

1. *The mother will work with a drug and alcohol counsellor. The mother will keep the appointments and follow through with counsellor recommendations*
2. *The mother and grandmother will participate in the Positive Parenting Group as soon as possible. The mother and grandmother will also engage in individual parenting sessions*
3. *The mother and grandmother will ensure that the child participates in counselling sessions with a therapist.*

The grandmother told the Representative's investigators that she found the conference useful as it appeared to help the mother understand that the child required an adequate caregiver. The grandmother also said that it also increased her own understanding of the child's need for permanent and stable care.

One month after the family group conference, the ministry received the results of the mother's drug test. The test results showed a much higher level of use than the mother had admitted to the social worker. When the social worker shared the results of the test with the grandmother, the grandmother appeared to be angry with her daughter.

On Oct. 31, 2008, the worker completed the third CRA, which determined that the child was at high risk. The assessment also indicated that the grandmother minimized the mother's substance use and that this resulted in the grandmother enabling the mother to continue this behaviour. Further, the CRA indicated that the grandmother believed it was unnecessary to supervise visits between the child and his mother. The grandmother also denied that the mother had relapsed as described in the most recent child protection report. Once again, the issue of any potential risk posed by the mother's boyfriend was not included in the CRA.

The file was transferred to a family service worker for follow up on Oct. 21, 2008. The family service worker told the Representative's investigators that, when she took over responsibility for the file, there was a safety plan for the child in place. This worker sent a letter to the mother on Nov. 17, 2008, indicating that the child's need for a consistent, stable and healthy caregiver had not yet been addressed and that the mother was expected to complete a residential treatment program as well as one-to-one addictions counselling. The mother was asked to meet with the social worker if she was unable or unwilling to address child protection concerns by utilizing these services.

The worker did not receive a response to the letter. The worker interpreted the lack of response as an indication that the mother was currently using substances. As a result, the worker planned to have the grandparents care for the child through a more permanent custody arrangement.

In December 2008, the family service worker attempted to set up a meeting with the family regarding the child's need for stability. When the worker spoke with the grandmother and suggested another family group conference, the grandmother resisted the idea but agreed to meet with the worker in person. It was not clear to the Representative's investigators why the worker believed a second family group conference would be helpful. During the next month, a number of attempts to meet were cancelled or missed for various reasons.

On Jan. 7, 2009, the worker called the grandmother to arrange a meeting. The grandmother told the worker she did not think that long-term planning was necessary and then ended the phone call by hanging up.

The worker consulted with the acting team leader and was advised that an unannounced home visit to the grandparents' residence was necessary in order to determine whether the child was safe. The ministry determined that the child could not continue to reside with the grandparents if they were unwilling to cooperate with MCFD or apply for custody, and that it was necessary to meet with the grandparents in order to make that decision.

The worker was unable to complete a planned home visit on Jan. 7, 2009 due to poor road conditions. She also attempted to contact the child's school but received a busy signal all three times that she called.

The Critical Injury

Three days later, on Jan. 10, 2009, the child, the mother and the mother's boyfriend were involved in a motor vehicle incident as they were returning home from a day of tobogganing. Contrary to the safety plan agreed upon with the MCFD social worker, neither the grandmother nor any other appropriate supervisor was present. The mother's boyfriend was driving the vehicle, which crossed the centre line of a busy road at a high rate of speed. Their vehicle struck an oncoming vehicle head-on. Contrary to BCAA recommendations, the child was wearing only a lap belt and not restrained with a shoulder belt.¹⁰

According to police evidence, whether the boyfriend was intoxicated at the time of the accident could not be established because he consumed alcohol immediately following the incident. Hospital records indicate that the mother's blood-alcohol content shortly after the incident was over the legal limit, at 140 milligrams of alcohol per 100 millilitres of blood (0.14). Hospital records also indicated that the mother admitted to staff at the hospital that she and her boyfriend had consumed alcohol prior to the incident.

The mother sustained minor injuries. The child suffered severe trauma, including a closed head injury, spinal fracture, ligament damage, lung contusions and a laceration to his right arm. He required surgery to have his skull reconnected to his spine, as well as a

¹⁰ The BCAA website states that children must use a lap/shoulder seat belt if one is available, even if that means they must sit in the front passenger seat. <http://www.bcaaroadsafety.com/child-passenger-safety/children-over-9-years-old/>; Vancouver Island Car Seat Technicians website states that a lap-only belt places a passenger at increased risk of neck injuries. <http://vicarseattechs.com/stage-4-seat-belt/>

tracheostomy. The police report stated that police were advised by the hospital that his chances of survival were considered to be 50 per cent.

Upon the child's admission to the hospital, the hospital social worker performed an initial assessment. Her notes from this assessment state that the grandmother *"reported MCFD is involved with the family, however she is not in agreement with some Ministry 'rules.'"* The notes go on to state that the grandmother *"mentioned MCFD has asked for [the child] not to be alone with Mom, but she feels strongly that mom has a right to be trusted with her son."*

The hospital social worker also met with the mother and made the following note regarding this conversation: *"[The mother] reported she and her boyfriend took [the child] tobogganing at [local mountain] today. Unfortunately, [the mother] and her boyfriend were drinking during today's outdoor fun, before the accident."*

Within a few days of the incident, the child was in critical but stable condition. He had a gastric-tube inserted due to difficulty with swallowing as a result of the brain injury. He remained in the hospital for five months.

After the Incident

When the ministry was informed of the incident, the worker decided to immediately remove the child from the grandparents' care on the basis that the agreed-upon safety plan had not protected the child from harm. At this time, the worker made the following observation in the file: *"A previous file review suggests that [the grandparents] have been the child's safety plan in the past but they seem to keep giving [the child] back to [the mother's] care and she continues to relapse."* The child was legally removed from the care of his mother within a few days of his critical injury. The immediate effect of this was that his family could not make decisions regarding his care and treatment by the hospital.

When the child was discharged from hospital on June 26, 2009, he was released back into the grandparents' care under a Supervision Order, which placed the child in the custody of the grandparents under the supervision of MCFD, pursuant to s. 41(1)(b) of the *CFCAS Act*. The duration of the Supervision Order was three months, following which the ministry successfully applied to have it extended for another six months. Shortly before the order expired on April 6, 2010, MCFD began the process of applying for the child to be permanently removed from the mother's care and to be placed permanently in care of the ministry.

In 2010, the grandparents successfully applied for custody of the child pursuant to the *Family Relations Act (FRA)*¹¹ and the ministry closed the family service file immediately afterwards. The child is currently in the care and custody of his grandparents, both over the age of 80.

¹¹ *Family Relations Act* [RSBC 1996] c. 128.

Interviews with the grandparents and school personnel indicate that the 15-year-old child still experiences some effects from his injury. The movement of his limbs on the right side is still impaired, affecting his gait and his writing. His writing and speech are both much slower than they were prior to the injuries. These effects have led to incidents at school in which he has become upset and agitated, sometimes hitting himself in the head and saying “*my brain is broken.*” The child can perform in line with academic expectations if he is given a significantly longer period of time to complete tasks and given some tools, such as a computer, to assist with completing his work.

According to interviews with family and school staff, he has continued to experience difficulty with his speech and has continued to have a right hemiparesis which impacts his ability to perform tasks such as writing. He also experiences ongoing emotional trauma from the incident and continues to experience significant frustration and anxiety as a result of his injuries.

Analysis

Parental Substance Misuse

An estimated eight per cent of children ages 17 years and younger live with an alcohol-dependent parent while an estimated four per cent live with a drug-dependent parent.¹² There is significant evidence of the detrimental impact of addiction on parenting and child safety, such as neglect, trauma and accident-related fatalities.¹³ Many, but not all, families with one or more parents with substance use issues will come to the attention of child protection authorities. One study found that substance-addicted mothers were more likely to receive child protection services if they were younger and had fewer supports available to them.¹⁴

It is impossible to determine the percentage of parents with substance use problems involved in a typical child protection caseload as these statistics are not collected by MCFD. However, one survey conducted in 2002 of 40 child protection workers in B.C. found they estimated substance-using mothers to comprise approximately 70 per cent of their caseloads.¹⁵ The U.S. Department of Health and Human Services reported that between one-third and two-thirds of children in child welfare services were affected by parental substance misuse.¹⁶ One 2007 study of children in foster care in the U.S. found that in 87 per cent of the families with children in foster care, at least one parent was using drugs or alcohol; and in 67 per cent of families, both parents were using.¹⁷ Given the prevalence of parental substance misuse as a child protection concern and that it is a “*dominant reality in child protection work*,”¹⁸ it would seem imperative to invest resources in dealing as effectively as possible with this issue.

¹² LX Huang, FG Cerbone, & FG Gforerer, (1998) Children at risk because of parental substance abuse. In *Analyses of Substance Abuse and Treatment Need Issues*. Rockville, MD: Office of Applied Statistics, Substance Abuse and Mental Health Services Administration.

¹³ K Street, P Whittlingum, P Gibson, P Cairns & M Ellis, (2007) Is adequate parenting compatible with maternal drug use? A 5-year follow-up. *Child: Care, health and Development*, 24(2):204-206.; K Wells, (2009) Substance abuse and Child Maltreatment *Pediatric Clinics of North America* 56:345-362.

¹⁴ K Lussier, M Laventure & K Bertrand, (2010) Parenting and Maternal Substance Addiction: Factors Affecting Utilization of Child Protective Services. In *Substance Use Misuse*, 2010 Aug, 45(10).

¹⁵ SM Weaver, (2006) “‘Work with Me:’ Training for Best Practice With Substance-Using Mothers – Diminishing Risk by Promoting Strengths”, International Conference Towards Strength Based Strategies that Work with Individuals, Groups and Communities 10 – 12 November 2006 – Hyderabad – India. Retrieved from http://www.strengthsbasedpractice.com.au/Inaugural_Conference.htm.

¹⁶ U.S. Dept. Of Health and Human Services. (1999) *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection*. Washington, D.C.: U.S. Government Printing Office.

¹⁷ DK Smith, AB Johnson, KC Pears, PA Fisher, DS DeGarmo, (2007) Child maltreatment and foster care: Unpacking the effects of prenatal and postnatal parental substance abuse. *Child Maltreatment*, 12, 150-162.

¹⁸ Ministry of Children and Family Development, (2001) *Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases*, Victoria, B.C. p.5.

This problem is also tremendously difficult to overcome for struggling families. Parents with substance use disorders involved in the child welfare system have the lowest likelihood of successful reunification with their children and their children are often in foster care longer than other families.¹⁹ Gaining the cooperation of substance misusing parents in child protection work is very challenging as a result of the denial and resistance inherent in having a substance misuse problem.²⁰ This resistance could be aggravated by a lack of training of workers on substance use issues, particularly on strengths-based approaches as well as a lack of understanding of the culture of substance use, a larger culture of shame and blame that makes getting help difficult and criminalization that drives people to hide their use.²¹ As family members can also become embroiled in this denial and minimization of the problem, it follows that gaining the cooperation of the rest of the family in tackling the child protection concerns can also be a challenge.²² Engaging with substance using parents was also noted as a significant challenge by the social workers interviewed by the Representative's investigators for this report.

Current Approaches

One worker interviewed said that practice in engaging parents was “*all over the place*” and was different depending on which MCFD office was involved. Evidently, the ministry response to the challenge of parental substance misuse is to complete assessments in the usual manner rather than to apply a specialized policy, skill or knowledge base. This practice is the same in several other jurisdictions including Ontario and the United Kingdom.²³

Of the 10 workers and team leaders assigned to this child's file over a nine-year period, only one had any formal training in how to work with families challenged by addiction. A survey from 2002 indicated that BC child protection workers at that time were not well informed about drug-use or current theories or models of assessment and intervention, indicating that this lack of applicable skills and knowledge in the issue of parental addiction is not recent.²⁴

While the ministry has issued a policy specifically focusing on working with parents with problematic substance use, only one of the 10 workers and team leaders who were assigned to this child's file referred to using it in her work. Most workers questioned by the Representative's investigators had never heard of the policy.

¹⁹ KA Gregoire, & DJ Schultz, (2001) Substance-abusing and child welfare parents: Treatment and child placement outcomes. *Child Welfare*, 80, 433-452.

²⁰ D Forrester & J Harwin, (2011) *Parents Who Misuse Drugs and Alcohol: Effective Interventions in Social Work and Child Protection*. John Wiley & Sons, Ltd. Chichester ; Taylor A. and Kroll B. Working with Parental Substance Misuse: Dilemmas for Practice. *British Journal of Social Work* (2004) 34 (8): 1115-1132, p. 1121.

²¹ S Weaver, Make it More Welcome: Best-Practice Child Welfare Work With Substance-Using Mothers – Diminishing Risks by Promoting Strengths in S Boyd & L Marcellus (2007) *With Child: Substance Use During Pregnancy: A Woman-Centred Approach*, Fernwood Publishing.

²² Taylor & Kroll, (2004), see note above; Schafer G., Family Functioning in families with alcohol and other drug addiction *Social Police Journal of New Zealand*, June 2011, Issue 37, 1.

²³ D Forrester & J Harwin, (2011) *Parents Who Misuse Drugs and Alcohol: Effective Interventions in Social Work and Child Protection*. John Wiley & Sons, Ltd. Chichester.

²⁴ Weaver, (2006), see note 15.

That policy document – *Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases* – was produced in 2001 and is meant to be used when a CRA is being completed. It includes several tools to assist with assessment and planning, including a questionnaire for assessing the parents' substance use and an addiction planning screen. Neither of these tools was used in this child's file.

The guidelines also refer to the importance of corroborating the parents' report of their use, working with other professionals involved and the use of Supervision Orders to monitor the family. Despite these helpful elements, this policy does not appear to have widespread use, at least not in the office or region where this child and his family live.

In 2012, the ministry implemented a Child Protection Response Model (CPRM) to replace many of its previous Child and Family Development Service Standards. The CPRM does not include any specialized policy or procedure for addressing parental substance misuse but does emphasize some effective practice responses such as the promotion of collaboration with other professionals and an emphasis on concurrent planning (making efforts to return a child home to parents while also developing an alternate permanency plan). However, without a specialized and informed approach to the issue of parental substance misuse, it falls short of being an adequate response to this issue.

Addressing parental substance misuse and its impact on child safety and development is complex and critical work requiring strong clinical knowledge and supervision. Unfortunately, MCFD was not able to provide information on overall funding of worker training on this issue as it has no dedicated budget for addiction or parental substance misuse training. A review of worker training on the topic in the mid-2000s found the offerings to be “*short-lived, scanty and unavailable since 1999.*”²⁵

The Representative finds it unacceptable that ministry practice is not better informed by knowledge regarding addiction and relevant effective interventions. Current efforts to ensure that child protection workers have the skills necessary to engage families in cases of parental substance misuse are inadequate. Given the impact on families, children and communities, much more focus on this issue is warranted.

Other Approaches

In the U.S., a need has arisen to find effective responses to the issue of parental substance misuse as a result of recently legislated limits on the length of time children can live in government care. This has led to the proliferation of drug and alcohol courts. By 2006, there were more than 180 of these courts in 43 states.²⁶ By June 2010, there were more than 2,600 courts in all 50 states.²⁷ They often include individualized care plans, an integrated team, more coordinated service delivery, relapse support and accessible, appropriate treatment resources. They can also include family-based treatment and family workers who assist families in navigating and accessing the social service system.

²⁵ Weaver, (2006), see note 15.

²⁶ Forrester & Harwin, (2011), see note 20.

²⁷ National Council on Alcoholism and Drug Dependence, Inc. website, accessed June 5, 2013. <http://www.ncadd.org/index.php/learn-about-drugs/drugs-and-crime>

Results of these programs have been positive, with parents who take part being more likely to complete treatment and their children less likely to go into care.²⁸ Some researchers have noted that significant attention was paid to ensuring workers had sufficient skills.²⁹ Other initiatives in the U.S. include a greater emphasis on the need for collaborative work between the different systems that these families encounter to ensure that they are supported as well as possible.³⁰

Fragmented service systems can be a barrier to treatment for women with children as can wait-lists, admission criteria, low self-esteem and a fear of feeling the stigma towards women who are mothering and have substance use problems. Further, a lack of support for women's needs as parents may make some mothers reluctant to enter into treatment as they may fear losing their children or struggling with a lack of secure child care arrangements.³¹

Motivational interviewing, a counselling approach that works on engaging with client motivations to change behaviour, is gaining recognition as an effective approach in dealing with individuals with addiction problems and in gaining the cooperation of parents to work with child protection professionals.³² One study found that a social service program focused on enhancing family functioning led to a higher likelihood of successful reunification for families struggling with parental substance use.³³

Other possible responses to the issue of parental substance misuse include having a substance misuse expert assigned to each child protection team, having a checklist or protocol to assist with conducting assessments, ensuring stronger collaboration between the ministry and the health authorities that treat substance misuse, and training workers regarding the role that families and communities play in substance misuse. Some other possible strategies mentioned by the workers interviewed as part of this investigation included more services for families, smaller caseloads, and greater collaboration with

²⁸ D Knoke, (2009), Strategies to enhance substance abuse treatment for parents involved with child welfare, CECW Information Sheet #72E. Toronto, ON. Canada: University of Toronto Factor-Inwentash Faculty of Social Work; Minnesota Department of Human Services (2006) Through the Eyes of the Child: CJI-AOD Tool Kit – Catch the Vision, children's justice initiative; Center for Substance Abuse Treatment. *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts Considerations for Program Designers and Evaluators*. HHS Pub. No. (SMA) 10-4557 Rockville, MD: Substance Abuse and Mental Health Services Administration (2010).

²⁹ Forrester & Harwin, (2011), see note 20.

³⁰ EM Breshears, S Yeh, & NK Young, (2009), *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*. U.S. Department of Health and Human Services. Rockville, MD: Substance Abuse and Mental Health Services Administration, (2009); U.S. Dept of Health & Human Services, (2009), Parental Substance Use and the Child Welfare System, Bulletins for Professionals Series.

³¹ BC Centre of Excellence for Women's Health, (2010), *Mothering and Substance Use: Approaches to Prevention, Harm Reduction, and Treatment: Gendering the National Framework*. Retrieved from <http://www.coalescing-vc.org/virtualLearning/section2/info-sheets.htm>; N Poole & B Isaac, (2001), Apprehensions: Barriers to Treatment for Substance-Using Mothers. BC Centre of Excellence for Women's Health. Retrieved from <http://www.coalescing-vc.org/virtualLearning/section2/other-documents.htm>; J C Marsh, BD Smith, M Bruni, "Integrated substance abuse and child welfare services for women: A progress review" *Children and Youth Services Review* 33 (2011) 466-472.

³² Breshears, (2009), see note above; Forrester & Harwin, (2011), see note 20.

³³ J Brook, T McDonald, Y Yan, (2012). An analysis of the impact of the Strengthening Families Program on family reunification in child welfare. *Children and Youth Services Review* 34 (2012) 691-695.

involved professionals. Integration and collaboration of addiction and child protection services could lead to a more effective and responsive system³⁴ and has been found to lead to enhanced outcomes for children.³⁵

Addiction Services in B.C.

In B.C., addiction treatment services are provided by the six health authorities as well as privately funded service providers. The public services offered vary significantly across the province and include short-term or long-term residential treatment and day treatment withdrawal management services. For example, Vancouver offers a variety of options as it is a dense urban centre, while a suburban health authority may focus on outpatient and residential treatment models.

A study completed by the Centre for Addiction Research in BC found that of those accessing treatment in B.C. in 2009-2010, alcohol was the primary problem substance in all but one health authority, where it was a close second. However, there are some significant differences across the health authorities in terms of the primary problem substance use. In the Northern Health Authority, the primary problem substance was alcohol (48.3 per cent) while in the Fraser Health Authority, alcohol was at 32.1 per cent, second to cocaine/crack at 34.7 per cent.³⁶

Social workers, health and education professionals informed the Representative's investigators of a number of gaps with respect to treatment services in the community in which the child and his family reside. Although his community is close to an urban centre and is a heavily populated area, the professionals interviewed reported a lack of detoxification services, wait times to get into services and a requirement to telephone daily in order to keep a place on wait-lists. The requirement to make daily phone calls was noted by some as being particularly difficult for those with limited access to a phone and a barrier for those individuals with a short-lived desire to change, a common condition with addiction problems. A need for comprehensive care that addresses issues of poverty, violence and depression that are related to the substance use, as well as programs and services that serve parents and children together, has been noted.³⁷

³⁴ N Poole, (n.d.) *Mothering and Substance Use – Info Sheet 4 Making the Systems Work & Info Sheet 2 Mothering and Substance Use Coalescing on Women and Substance Use: Linking Research, Practice and Policy*, retrieved from <http://www.coalescing-vc.org/virtualLearning/section2/info-sheets.htm>.

³⁵ A Niccols, K Milligan et. al, Integrated programs for mothers with substance abuse issues and their children: A systematic review of studies reporting on child outcomes, *Child Abuse & Neglect* 36 (2012) 308 – 322.; JC Marsh, BD Smith, M Bruni, Integrated substance abuse and child welfare services for women: A progress review, *Children and Youth Services Review* 33 (2011) 466-472.

³⁶ C Chow, J Carsley, (2010). *BC Alcohol and Other Drug Monitoring Project: Addiction treatment in British Columbia for Fiscal 2009/2010*. Centre for Addictions Research of BC.

³⁷ Poole & Isaac, (2001), see note 31.

The mother of the child who is the subject of this report was dealing with depression and domestic violence in conjunction with her addictions. This is not an unusual set of circumstances. Recent studies have shown that many women face a similar combination of issues. In some shelters for women fleeing domestic violence, as many as 50 per cent of the clients are likely to have suffered from depression and post-traumatic stress disorder. The prevalence of substance use disorders among women in these shelters has been estimated to range from 33 per cent to 86 per cent. In substance use treatment centres, 40 per cent of women have been found to also have a major mental health disorder, 67 per cent to have a history of being abused and 50 per cent to be in an abusive relationship.³⁸ Increasingly, it is being recognized that parents struggling with substance use are also likely dealing with trauma.³⁹

This presents important implications for service delivery that have not been widely recognized. The Building Bridges initiative, part of the Woman Abuse Response Program at the BC Women's Hospital and Health Centre, has identified that women who experience a combination of domestic violence, addictions and mental health problems will have difficulty finding appropriate support and services.⁴⁰ Addressing substance misuse should include a trauma-informed approach and the means to address root causes and contributors to substance misuse, including violence in relationships, trauma and mental health problems. Interventions that are designed specifically to address the consequences of trauma in the individual and to facilitate healing are needed. This should include recognizing the survivor's need for respect, connection, information and hope regarding his or her own recovery, the relationship between trauma and its symptoms such as substance misuse.⁴¹

Additionally, treatment services need to be responsive to the unique needs and circumstances of parents by supporting the parent-child relationship, as well as addressing the developmental needs of parents and children.⁴² By attending to both parent and child needs, such specialized services would be in the best interests of children being impacted by their parent's substance use.

³⁸ K Appleyard, LJ Berlin, KD Rosenbalm & KA Dodge, (2011). *Preventing early child maltreatment: Implications from a longitudinal study of maternal abuse history, substance use problems, and offspring victimization*. Society for Prevention Research, 12, 139-149

³⁹ LM Najavits, RD Weiss, & SR Shaw, (1997). The link between substance abuse and posttraumatic stress disorder in women. *The American Journal on Addictions*, 6, 273-283; S Covington, February 2010. *The Addiction-Trauma Connection: Spirals of Recovery and Healing. Presentation at the Regional Partnership Grantee (RPG) Special Topics Meeting*. Continuing the Journey: Strengthening Connections – Improving Outcomes. Arlington, VA.

⁴⁰ J Cory, L Godard, A Abi-Jaoude, & L Wallace, (2010). *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health, Woman Abuse Response Program* – BC Women's Hospital and Health Centre, Vancouver, BC.

⁴¹ National Centre for Trauma-Informed Care. (2013). *Trauma-informed care and trauma services. Substance Abuse and Mental Health Services Administration*. Retrieved from: <http://www.samhsa.gov/nctic/trauma.asp>

⁴² Poole, see note 34.

Noticeably lacking for the mother of this child – and in the system generally – is case management by a central worker or agency. Without a thorough assessment of an individual's substance use problem, including their history, concerns and needs, it is difficult to determine which service would be an appropriate match. Offering a service responsive to his or her needs can considerably decrease an individual's resistance to accepting treatment.

Public treatment options in B.C. require improvement. While the previous discussion is focused on a consideration of public addiction services, many of these comments may apply to private treatment options as well.

Findings

MCFD was aware that the child who is the subject of this report was suffering neglect as a result of his mother's addiction for a number of years before he sustained a critical injury through a motor vehicle incident in January 2009. In 2008, after child protection concerns had been reported and documented about this child for the fifth time, the child welfare system could have responded in a more tangible way but did not. While the mother's struggle with addiction intensified, the family's relationship with MCFD deteriorated.

This child was repeatedly placed at risk due to his mother's struggle with addiction and the family had demonstrated a lack of engagement with child protection workers for at least one year prior to his critical injury. Yet there was no tangible, legally binding agreement put in place that would allow MCFD to have supervisory oversight of the child.

Instead, the ministry removed the child from his mother's care only after he had suffered a traumatic injury and remained in hospital for five months.

Overall Finding: *The reliance on family members to follow through with a safety plan that they themselves did not endorse was questionable at best. This approach appears to have been the result of two main flaws with child protection practice – poor clinical supervision and a lack of knowledge in the areas of substance misuse and how to effectively engage families. As a result of these systemic shortcomings, appropriate protective action, such as a Supervision Order or a Temporary Custody Order through the CFCS Act, was not taken.*

Child Welfare Services

Finding: *The child welfare practice was not effective in engaging this child's family.*

The family did not share MCFD's perspective on the child protection issues. On more than one occasion, the family did not return ministry phone calls, the mother was given unsupervised access to her child contrary to ministry direction and the grandparents returned the child to the mother's care without consulting with MCFD. Furthermore, it is possible that an adversarial approach toward the mother made her reluctant to work with MCFD.

The Representative's investigators found that the plan from the family group conference was vague and lacked clarity. It included no concrete, measurable steps or timelines specific to the child and his needs. Other than participation in a parenting group with the grandmother, the plan appeared to focus solely on the mother. Prior to the conference, the social worker was aware of the mother's tendency to deny her substance use, and was also aware of the grandmother's "resistance" and "minimizing" of the mother's substance use issues that had previously resulted in the child being neglected.

Given this history, the Representative believes that it would have been reasonable to presume that the family was unlikely to follow through on a plan, particularly one that

lacked meaningful targets or timelines and appeared to be without consequences for non-compliance.

In the lead-up to the family group conference, both the mother and grandmother minimized the substance misuse problem and the grandmother revealed that she had doubts about the safety plan. The mother and grandmother did not follow through with the safety plan agreed to at the family group conference. According to the CRA completed in October 2008, the grandmother was reluctant to accept that the mother had relapsed or that supervised visits were necessary.

Finally, in November 2008 and thereafter, the family largely ignored or avoided meeting with the social worker. According to the initial social worker assessment at the hospital, the grandmother expressed a disagreement with the ministry “rules” and did not share the belief that supervised access for the mother was a necessary precaution. The failure to acquire the family’s cooperation was evident throughout MCFD’s nine-year involvement.

However, it does not appear that this shortcoming was evident to ministry social workers until near the time of the critical injury when the worker determined that a home visit was necessary. Though several of the workers assigned to the file attempted to engage the family, in the end these attempts failed as the knowledge and skills required to secure the family’s cooperation and partnership were simply not present.

Furthermore, while being raised by family members is a worthy goal for the long-term plan of a child, this route should not be taken without an adequate assessment of the parenting capacity of the family members involved. Family members of those who are addicted will often be impacted by the illness as well.⁴³

Supervision

Finding: *Case management supervision of this child protection case was inadequate.*

Case management supervision was inconsistent at best and almost nonexistent. Although it appears that monthly supervision appointments were aspired to, they were often derailed by the consultation required on more urgent cases. According to the individual who was the team leader while this family received services, the local ministry office did not usually hold regularly scheduled supervision sessions. If the worker felt that there was nothing to consult on in a case in which a parent would not commit to getting help, then clinical supervision did not happen.

This suggests two possible issues. First, that consultation on urgent cases occurred while cases of a less urgent nature might have been frequently overlooked. Second, the decision as to whether consultation was needed was left up to the worker. Both of these situations are problematic. In the former case, a child protection matter which may not be urgent may nevertheless eclipse others in terms of importance. In the latter case, a worker may feel

⁴³ Laurie Knis-Matthews PhD (2007): *The Role of Spouses and Extended Family Members as Primary Caretakers of Children During a Parent’s Drug Addiction, Occupational Therapy in Mental Health*, 23:1, 1-19.

that his or her plan or information gathering to date has been sufficient when it has not. Even adequate work can benefit from the insight of an experienced supervisor. Some of the workers interviewed told the Representative's investigators that if a parent is not engaging in services and the child has been placed elsewhere, there is no need for consultation.

A related issue is the qualifications of the person tasked with providing case supervision. Often the supervisor role is filled by someone who is acting in the position on a temporary basis. This is usually someone who has seniority on a child protection team; however, no training is required to be placed in an acting supervisory position. The evidence provided by workers in this investigation indicates that an office may frequently be supervised by a worker who has had no training for that role and who is also expected to provide service to his or her caseload of files. In the 1990s, MCFD team leaders received weeks of training that included components on administration, finances and case supervision. Current MCFD training for team leaders includes a two-day workshop on clinical supervision.

The lack of consistent clinical supervision may provide an explanation about why none of the ministry workers considered a middle road between removing the child from his mother's or grandparents' home and leaving him unmonitored. There are several provisions under the *CFCS Act*⁴⁴ that would have had the strength of a formal legal order requiring the family to access services or allowing the ministry to closely monitor the child's care.

A lack of case management supervision may also explain why the CRAs in this case were insufficient. A thorough assessment considers every aspect of a family's strengths as well as its risks, even if they appear to be unchanged. Also, a thorough assessment goes beyond the presenting issues to fully examine the impacts of those issues on the child. Unfortunately, it does not appear that the assessments were used to inform the work done with this family but, rather, they were considered paperwork that needed to be completed before a file could be transferred.

In the second intake, a CRA was not completed until 13 months after the file had first been opened and just before the file was transferred to a family service worker. Similarly, in the fifth intake, the CRA was completed six weeks after the worker had determined the course of action for the file and just before the file was transferred to a family service worker.

In the third intake, the CRA was not changed when new information was received and the social worker did not consider the risk to the child while in the grandparents' care even though this worker discovered that the grandmother had allowed the mother unsupervised access. For the third intake, it does not appear that a CRA was completed, despite the serious disclosures of domestic violence made by the child.

MCFD Service Standard 18 states that strategies to keep a child safe must be based on "*a careful assessment of identified strengths and risks.*" However, the child protection

⁴⁴ For example, s. 41(1)(a) or s. 35.2(d).

assessments did not include all information and were not used to determine practice decisions. Instead, these were usually made informally, leaving the risk assessment to be completed after key decisions had already been made.

Additionally, the child welfare practice was not informed by a thorough assessment of the mother's history and needs in regards to her addictions. Most of the workers pushed for the mother to receive residential treatment; however, this treatment option did not appear to be based on an assessment of the mother's situation and may not have been an appropriate match of service to needs.

Caregivers' Support Services

Finding: *This family was not adequately supported by services from MCFD or the provincial health system.*

Raising a child with complex needs while simultaneously supporting an adult child with addictions presented many challenges for the grandparents. They would have benefited greatly from services to help provide the child with developmentally appropriate activities, provide childcare or homemaking assistance, and supply the family with knowledge and support to help deal with the mother's substance use problem.

One of the workers who spoke with the Representative's investigators said that the child's family could properly care for him if they were given *"the right education and support."* To this end, this worker suggested a family support group to the grandmother and was responsible for holding the family group conference in which a service plan was signed that included counselling and parenting education for the grandmother. However, there was no recognition of the support that the elderly grandparents, one with failing health, might require to access these services. There was also no attempt to assess the capacity of the grandparents to care for a child with complex needs.

At times, this family did not make use of services that were offered or suggested, such as respite. They appeared to have a general reluctance to use professional services and the ministry appeared unable to engage them. Provision of services to families is governed by Ministry Child and Family Service Standard 7, which states that current research demonstrates the importance of *"a trusting relationship with a family and an agreement to work together to resolve issues"* in achieving positive outcomes for families. Unfortunately, it does not appear that such a relationship was established in this case.

Pervasive in the child protection service in this file is a reliance on the grandmother, not only to care for the child but also to assess when the mother was an adequate caregiver and, at times, to prevent the mother from spending time with her own child. This placed the grandmother in a difficult position, one which might have been workable if she had been better supported. Furthermore, the grandmother either did not detect or did not report the substance use that gave rise to the fifth child protection report and had minimized the mother's substance misuse problem during this intake. Under these circumstances, the plan of relying on the grandmother to ensure the child's safety was seriously problematic.

Addiction Services

Finding: *The mother's service needs as an individual struggling with addictions were not effectively met.*

In the fourth intake, the ministry was informed that the mother had recently taken the steps of contacting local detoxification services but became discouraged when she was told that there was a wait-list. When the mother did finally access a treatment program several months later, it was because there was an immediate opening available. As a person with a substance misuse problem will often oscillate between reluctance and interest in accessing treatment, the immediate availability of services can be instrumental to recovery.

The mother reported that she relapsed soon after completing treatment because her home environment included a roommate who was an addict. Some post-treatment care or a transitory program could have assisted the mother in planning for a home environment that was more supportive of her recovery and attended to her role as mother.

From social workers to school personnel, substance use experts and the mental health nurse interviewed for this report, all were in agreement about the lack of readily available treatment services. A full spectrum of out-patient and residential treatments as well as after-care are also severely lacking in quantity. Wait-lists are common, rendering a wrap-around concept of services near impossible to implement. Most importantly, case management to assess and match those who struggle with substance use with the most beneficial services is non-existent.

Education

Finding: *The child was most consistently supported and served by his school.*

The child's best support came from his school, where he had the benefit of a child and youth care worker, an educational assistant and a school-based counsellor. These supports were implemented almost immediately upon the recommendations made by the Sunny Hill Health Centre for Children. It is clear that many of his strengths are due in part to the support he has been provided at his school and his behaviours showed progress after he had been in the school setting for awhile. His behaviour escalated again sometime later; however, this was likely a result of the issues at his home that he disclosed in the third intake.

Unfortunately, the support services which were instrumental to the child's well-being have been eroded during the last several years. The school district has gone from having five full-time counsellors to having the equivalent of 0.8 of a single position. School-based child and youth workers have been cut back as well despite already carrying caseloads that had them feeling "*stretched*," as one of the child's previous child and youth workers described it, in seeing eight or nine children during the course of a five-hour school day. For a vulnerable child such as the one who is the subject of this report, losing these services could result in unmet developmental and emotional needs.



Recommendations

Recommendation 1

That MCFD take immediate steps to ensure that child protection practice is resolutely focused on serving the best interests of the child over any other interests, including the preservation of the family unit, in line with the principles articulated in the *Child, Family and Community Service Act*.

Details:

To support this work, particularly in the context of parental substance use, MCFD should ensure that:

- specialist substance use consultants be made available in every service area to assist in effective safety planning for children and, where appropriate, to assist in developing engagement strategies and support for family members.
- in situations where placement with relatives, including grandparents, is being contemplated for a child, a timely assessment of both the needs of the child and the capacity of the prospective relatives to meet those needs occurs prior to a long-term placement.
- MCFD create a learning tool, based on the findings of this report, to be disseminated to executive directors of practice, community service managers and team leaders across the province, along with directions on how to facilitate organizational learning using this tool.

A plan outlining steps to be taken in response to this recommendation should be provided to the Representative by Jan. 30, 2015.

Recommendation 2

That MCFD work with the Ministry of Health to create a comprehensive addictions strategy and a system of care for parents with substance use issues. This effort must focus on filling the currently existing gaps in service, including supports for parents, children and other involved family members, and provide accessible and effective services.

Details:

- MCFD and the Ministry of Health are to design and implement policy to provide priority access to addictions treatment for parents in cases where there are active child protection concerns. The services offered must be responsive and tailored to the specific needs of this group.
- The capacity of existing programs that focus on collaborative, holistic and family-friendly services to support parents with substance use issues should be increased to ensure timely access to those services.
- MCFD should take the lead role in creating linkages between services to ensure continuity of care and a constant focus on the best interests of the child.
- Services should be targeted to parents and caregivers and clearer education should be provided to health service providers and others regarding the risks and impacts of parental addiction on children and youth.

A status update on the development of this strategy should be provided to the Representative by Jan. 30, 2015 and implementation of the strategy should begin in the first quarter of fiscal 2015/2016.

Conclusion

B.C.'s child-serving system failed this child and his family in three fundamental ways. First, MCFD workers displayed a lack of knowledge in both their ability to effectively engage with parents who have substance use problems, and the complex task of utilizing family members in providing practical care for the children of drug-addicted parents.

MCFD workers did not fully engage the family, and were slow to detect that the family was not responding to their soft intervention style. While the mother battled an increasingly difficult drug addiction, the grandparents struggled with maintaining their dual roles as caregivers to the grandchild, and supportive parents to their struggling adult daughter.

Second, poor clinical supervision also played a role in the injury of this child. Family dynamics can be complex for workers to navigate, even in the most high-functioning families. The issues related to parental drug addiction, child safety, and multiple, sometimes conflicting, roles for family members intensify family dynamics. Working with families under these conditions requires a robust system of clinical support and supervision to ensure the health, safety, and well-being of children.

Third, the system of services designed to respond to people struggling with problematic substance use on an individual basis failed to provide this family with the services they required. There were few open doors for this parent struggling with an immensely difficult and complicated health problem. Her requests for help were frequently met with wait-lists and the services she did receive were piece-meal did not fully meet her needs.

As a result of these failures of the system, this child will be forever impacted by the injuries acquired in the motor vehicle incident. Problematic parental substance use can have drastic consequences for any child. Children whose lives are impacted by the substance use of their families deserve better.

Glossary

Addiction: the continued use of a mood-altering substance despite adverse dependency consequences.

Attention deficit hyperactivity disorder: a psychiatric and neurobehavioural disorder characterized by either significant difficulties of inattention, or hyperactivity and impulsiveness, or a combination of the two.

Child protection report: a report received by MCFD about a child's need for protection due to suspected abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include: taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth, or conducting a child protection investigation.

Detoxification: a process in which a person is treated for the acute physiological effects of halting substance use.

Family service file: the MCFD legal record of services provided to a family through the *CFCS Act* and/or *Adoption Act*.

Family group conference: a type of dispute resolution proceeding designed to enable and assist a family to develop a plan of care. This is a shared decision-making process in which members of a child or youth's family come together with extended family, close friends and members of the community to develop a plan for the child.

Hemiparesis: Weakness on one side of the body.

Intake: the process by which cases are introduced into a MCFD or agency office. Workers are assigned the role of intake worker to receive phone calls or interview persons seeking help in order to determine the nature and extent of the problems.

Persons with Persistent Multiple Barriers: in B.C., income assistance benefits are now provided by the Ministry of Social Development and Social Innovation. Regular benefits provide a single person with a support rate of \$235 per month and a shelter amount of \$375 per month. For an individual who has health and other barriers to employment that meet the eligibility criteria for Person with Persistent Multiple Barrier status, the support rate is \$282.92 per month. If that individual is a single parent, the support rate is \$423.58 per month. For a single parent with one child, the shelter rate is increased to \$570.

Risk Reduction Service Plan: a portion of a service plan that outlines how specific risks to the child will be addressed and reduced.

School counsellor: The school-based counsellor's role is to provide counselling to students who appear to require it, as well as write behaviour plans and make contact with MCFD when appropriate.

Tourette syndrome: an inherited neuropsychiatric disorder with onset in childhood, characterized by multiple physical tics and at least one vocal tic. These tics characteristically wax and wane, can be suppressed temporarily, and are preceded by a premonitory urge. Tourette syndrome is defined as part of a spectrum of tic disorders, which includes transient and chronic tics.

Tracheostomy: also referred to as a tracheotomy, involving making a direct airway in the neck through which a tube is inserted which allows a person to breathe without using his or her nose or mouth.

Substance misuse: the stage when the use of drugs, including alcohol, has a harmful effect on a person's life.

Appendix A: Documents Reviewed During the Representative's Investigation

Case file records

- The mother's MCFD family service file: 2 volumes
- The child's MCFD child service file: 1 volume
- The mother's income assistance file
- The father's and mother's Family Maintenance Enforcement Program files

Medical records

- Medical records for the child's mother
- Medical records for the driver of the vehicle
- Medical records for the child

Police records

- Police file regarding critical incident
- Police records on the mother and father

School records for the child

Interviews conducted in this investigation

- Three family members
- One mental health nurse
- Ten MCFD social workers
- One regional director of practice, MCFD
- Five school personnel

Legislation

- British Columbia *Representative for Children and Youth Act* (2006). Victoria, BC: Queen's Printer.
- British Columbia *Child, Family and Community Service Act* (1996). Victoria, BC: Queen's Printer.

Appendix B:

Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* (2006) authorizes the Representative for Children and Youth to conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development.

Section 15 authorizes the establishment of a Multidisciplinary Team to provide advice respecting reviews and investigations.

Section 12 – Investigations of critical injuries and deaths

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

Section 15 – Multidisciplinary team

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

Appendix C:

Multidisciplinary Team

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

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

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

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

Multidisciplinary Team Members

Following is the list of members that comprised the team when the report was reviewed in May 2013:

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Lucy Barney - Lillooet Nation, RN, completed her Master of Science in Nursing from the University of British Columbia, and she is currently employed as a perinatal nurse consultant with Perinatal Services BC. She is the vice-president of the Native and Inuit Nurses Association of BC and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal health, and she developed the braid theory, which looks at the mind, body and spirit and demonstrates a holistic view on health.

Randy Beck – A/Commr. Beck is the RCMP “E” Division Officer in Charge (OIC) Criminal Operations – Core Policing. He is responsible for the operational oversight of the over 150 RCMP detachments in the Province of British Columbia. A/Commr. Beck has a broad policing background in General Duty, plain clothes investigations (GIS & Major Crimes) and Federal Policing throughout his career across the western provinces of Canada.

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

Doug Hughes – Mr. Hughes served as the Provincial Director of Child Welfare for the Province of British Columbia. He has 26 years experience in child welfare as a child protection social worker, community development worker, community services manager, regional executive director and finally as an Assistant Deputy Minister. He graduated from the University of Calgary with a Master of Social Work in 1992.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service. He has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

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

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

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

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