

Exhibit: National Inquiry into Missing and
Murdered Indigenous Women and Girls

Location/Phase: Parts 2/3 Winnipeg

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“SAFE WITH INTERVENTION”

The Report of the Expert Panel on the Deaths of Children and Youth in Residential Placements

September 2018

This report was developed pursuant to section 15(4) of the Coroners Act, R.S.O. 1990, c. 37, on the basis that it is to be used for the sole purpose of a coroner's investigation, and not for any litigation or other proceedings unrelated to the coroner's investigation. Moreover, the opinions expressed by the Panel will be limited to the information provided and considered for the purposes of the report.

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A Message from the Expert Panel

Dear Dr. Huyer,

We thank you for the opportunity to participate in this very important initiative, and we would like to take the opportunity to share our findings with you.

The Panel found that in the twelve cases of young people that were reviewed, the systems that were involved repeatedly failed in their collective responsibility to meet the fundamental needs of the young people. While no one individual or organization is at fault for these failures, it is important to recognize that it is people that make organizations and systems work – and people that define how they must work.

The young people that were the subject of the Panel's review were in the care of Children's Aid Societies or Indigenous Wellbeing Societies, and they were placed in various environments, including environments referred to as group homes, parent-model foster homes, staff-model foster homes, agency operated homes, residential treatment facilities and foster care treatment homes. They all struggled with developmental and/or mental health challenges. Collectively, they represent a cross-section of the most vulnerable, high risk young people in Ontario.

Ontario's Safety Assessment is a tool used by child protection agencies to determine the level of immediate danger to a child. It considers the immediate threat of harm and the seriousness of the harm or danger given the current information and circumstances. Where imminent danger of harm to a child is present, the process considers which interventions are needed to mitigate the threat to the child. There are three outcomes to this assessment: safe, unsafe, and safe with intervention. The Panel was struck by the frequency with which the young people reviewed were found to be safe with intervention – in the absolute absence of any constructive intervention. None of these young people were safe, in their homes of origin or in most of, and in particular their final, placements. Child protection agencies seemed to be overwhelmingly concerned with immediate risk and more often than not failed to address longer term risks, which the Panel often felt were both predictable and preventable.

The Panel observed responses to challenges experienced by the young people and their families to be primarily crisis driven and reactionary. Often times, young people were identified as safe with intervention following a mental health crisis (e.g. self-harming behaviour, suicide attempt or ideation). The Panel found that in practice 'safe' often translated to a bed to sleep in and 'intervention' translated to 1:1 supervision – actions that are merely a postponement until the next crisis rather than providing meaningful supports to parents and young people that may have addressed issues and/or prevented future challenges.

As a society, we owe a duty of care to these young people; a duty of care that we suggest cannot be met by the system in its current state, despite the existence of well-intentioned workers and caregivers and the desire of many to do good work. We believe that in order to meet their needs, a reorientation of the service system – including all services to young people, their families and communities – is necessary. Ontario's current system is largely reactive, operates in siloes, and focuses on services to the individual rather than the individual and their families and communities. Ontario's most vulnerable young people, those with multiple needs in complex environments, need a system that is intentionally designed to provide wholistic, early, ongoing

and prevention-focused care and treatment that works for them, their families and their communities – and they need it now.

We believe that with intention and commitment to a core set of principles and the implementation of some targeted recommendations, change is possible. The principles we have outlined are not new; they have been asserted, endorsed and recommended by governments, service organizations, advocacy organizations, panels, commissions and bodies many times over the last 25 years, and reflect best practices. We recognize that over time changes have been made to honour them – but the Panel asserts that it has not been enough.

The attached principles arose through our discussions as essential guideposts. We believe that dedication to implementing the concepts and philosophies below in policy and in practice will lead to a wholistic system that improves outcomes for Ontario's most vulnerable people – those at highest risk, and in greatest need.

The recommendations have been developed with a view to practical and implementable changes that would make a fundamental difference to Ontario's young people – both now, and over the longer-term. While there is some work happening, we are in agreement that it is not nearly enough – and not nearly soon enough – to effectively safeguard the young people in Ontario's care.

Change is necessary, and the need is urgent. We ask that those in positions of power and influence, who are responsible for the functioning of the systems, be accountable for fixing them; that they take the lessons learned from the deaths of these young people and utilize them to ensure meaningful change. To that end, we ask you to use your power and influence to ensure that these recommendations do not go ignored, and that those in positions to make change are accountable to the public, and to young people, for their actions in response to these recommendations.

Once again, thank you for the opportunity.

Signed,

The Expert Panel on the Deaths of Children and Youth in Residential Placements:

Ms. Helen Cromarty
Ms. Sherry Copenace
Dr. Aryeh Gitterman
Ms. Joanne Lowe
Dr. Nathan Scharf
Ms. Stella Schimmens
Dr. Kim Snow

Executive Summary

In the first six months of 2017, five young people died in residential placements. All of the young people were in the care of a Children's Aid Society or Indigenous Child Wellbeing Society (Society), and all of them struggled with mental health challenges.

The public, stakeholders and the Office of the Chief Coroner (OCC) felt that further exploration was required to determine whether this might be representative of a spike or part of a trend. To determine the answers to these questions, the OCC undertook an analysis of the data available to understand how many young people in the same circumstances had died.

The OCC identified a group of 12 deaths of young people in the care of a Children's Aid Society or Indigenous Child Wellbeing Society (Society) that occurred while they were in residential placements between January 1, 2014 and July 31, 2017¹. All of the young people had a history of mental health challenges.

To inform the investigation of the deaths and provide an opportunity for recommendations to prevent further deaths, the OCC established the Expert Panel on the Deaths of Children and Youth in Residential Placements (Panel).

The Panel was tasked with:

- reviewing and assessing the services and supports provided to the 12 young people;
- identifying any commonalities and/or trends arising out of the review and assessment of the deaths;
- identifying any systemic issues or concerns arising out of the review and assessment of the deaths;
- providing expert opinion on the extent to which current and forthcoming plans, activities, legislation, regulations, policies and practices, including the activities outlined in [Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services](#) and initiatives underway in the child welfare and children's mental health sectors address any issues or concerns identified; and
- making recommendations that may assist in preventing further deaths.

¹ Initially, 11 young people were identified. A 12th young person was identified in the course of the Panel's work and a full review of the young person was incorporated into the process.

Key Findings and Observations

Indigenous Young People, Their Families and Communities

The Panel found that despite complex histories and the high-risk nature of these young people's lives, intervention was minimal and sometimes non-existent. The environments where they were living often did not foster a continued sense of purpose or belonging. Frequently, they did not appear to be encouraged to be hopeful about their futures or to have positive aspirations – a finding that was consistent with what the Panel heard from youth with lived experience.

The identities of marginalized young people were not incorporated into service delivery or care. Indigenous, Black and LGBTQI2S young people were not consistently connected to identity-based or culture-based programs, nor was their identity incorporated into their care. There were minimal efforts made toward inclusivity.

Eight Indigenous Lives

Eight of the 12 young people were Indigenous. The Panel found that those young people, their families, and their communities were impacted by colonization, the legacy of residential schools, and intergenerational trauma. In spite of this, the Panel saw evidence that Indigenous communities continue to persevere, heal, and reclaim their culture and identity. The Indigenous young people with lived experience that provided input to the Panel demonstrated the value of this work; they highlighted the importance of connection to Elders, land-based teachings, traditional ceremonies, and wholistic care (see page 13 for more information on “wholistic care”).

The Panel found that the services provided to the eight Indigenous young people were largely unresponsive to these needs; there was a lack of culturally safe, trauma-informed approaches with a focus on prevention and family supports. It did not appear that they had a safe place to go on-reserve when it was needed and when they could not remain in their homes, they were often removed from their communities altogether. Following removal, there was minimal connection to Elders, land-based teachings, traditional ceremonies, and wholistic care.

The challenges faced by these young people were compounded by the systemic barriers and challenges faced by Indigenous peoples and their communities in Ontario including limited access to resources. There is evidence of inadequate shelter, water, and food in their communities and many of the young people that were the subject of review did not have equitable access to education, healthcare including, mental healthcare, social services, and recreational activities. In particular, Indigenous child wellbeing societies that serve people in remote First Nations communities have distinct constraints to delivering services that other societies do not; for example, large geographic areas.

Society Involvement and Placements

The Panel was struck by the lack of focus on family preservation and early intervention, and the long-term implications for the young people. All 12 of the young people reviewed by the Panel were in the care of a Children's Aid Society or Indigenous Child Wellbeing Society (Society) at the time of their death and many of them had substantial child protection involvement throughout the course of their lives.

The young people had minimal opportunity to have a voice in their care and their attempts to communicate their needs were often overlooked, ignored and characterized as "attention-seeking." They were not meaningfully engaged in services or programs in the community including, educational programs and mental health services, for significant periods of time.

"It's not about *how* to let kids share their voice, it's just about letting kids share their voice."

Many of the young people were placed far away from their home communities so it was hard for them to stay connected to their families, communities, and cultures. They experienced multiple placements in short periods of time making it difficult to build relationships and form healthy attachments with their caregivers. On average, the young people had approximately 12 placements throughout their lives.² There is currently no way to monitor and track the length of young people's placements or the number of placement transfers they have at the systemic level. Placement selection appeared to be based on what was known to be available, rather than on goodness-of-fit or the young person's needs.

One of the challenges with matching placements to the young person's needs is the lack of clarity regarding the different types of placements. Despite commonly used terms for children's residences (i.e. group home, staff-model foster home, foster care treatment, etc.), there are no clear definitions for the differences between them or the distinct services they may or may not provide. Licensing requirements and oversight are also unclear; many residences, both licensed and unlicensed, are not inspected by the Ministry of Children, Community and Social Services. This is because residences are not inspected where an operator with multiple homes is issued a license based on an inspection of 10 per cent of their homes.

While licensing may monitor compliance with operational standards in the facility, there is no process to monitor the quality of care that is being provided to young people. As there is no central database for placements, it was also clear that societies had a variable understanding of what placements were available, where they were located and the nature and quality of services they provide.

² The average number of placements is approximate because in some of the young people's case documents, there are gaps for periods of time where placement transfers cannot be confirmed.

In reviewing the placement environments where the young people lived, it became clear that their basic needs were inconsistently met. Overall, the Panel determined that many received a poor quality of care which had a profound impact on them over time. They believe that the quality of care was impacted by the capacity, lack of supervision, qualifications, training, and education of staff and caregivers. While physical restraints and 1:1 supervision models³ were commonly used interventions, there did not appear to be a shared understanding of when to use different intervention models or a consistent approach to them.

Mental Health Care

All 12 of the young people struggled with their mental health problems – many from an early age. The Panel found that most of them experienced fragmented, crisis-driven and reactionary services and, in some cases, no services at all. Many of the young people's families would have benefited from additional support services, and very few of the families were able to access them, even when they were requested. The Panel observed that many of the 12 young people faced complex circumstances in their lives and in their families of origin, which may have contributed to their mental health challenges. There were concerns regarding the availability of long term and/or intensive mental health care; particularly for latency/early teenage youth. Where young people required more intensive, residential services, there was variability in access and availability of treatment beds across the province. Where young people were connected to mental health services, there was often an absence of a team approach, a lack of service coordination and accountability, and a lack of professionals equipped with the skills to adequately respond to their mental health needs.

Service Systems

Roles, relationships and communication structures in the child protection system did not appear to be clearly defined. There was an apparent lack of transparency and information sharing between societies, placement providers and other child and family services. Specifically, there seemed to be confusion regarding the role and mandate of child welfare services in providing mental health care. There appeared to be an assumption on the part of other community service providers that the child welfare system has the mandate and capacity to provide mental health care and/or to promote young people's mental health needs being met. The distinction between child protection services and mental health services are not clearly understood by families or children and youth service sectors. Challenges between service systems extended beyond role clarity; there was also a lack of service integration at the local community level in many of the young people's communities.

System Oversight

It was difficult for the Panel to determine the specific degree and nature of service providers' involvement in many of the histories. Case files and documentation were disjointed with gaps in

³ This refers to the ratio of staff working with a child.

information, unclear service trajectories, discrepancies between agencies, and inconsistent definitions. These same challenges were felt to impact the Ministry of Children, Community and Social Services' ability to maintain meaningful oversight. If the Panel could not determine in some cases, who was providing services and what type, it was likely that the ministry was equally unable to understand the pathways through the various systems, both at the individual level and in aggregate.

The Panel also reviewed serious occurrence reports to understand the circumstances and environments in which the young people lived. They found that the information in these reports was often not substantial and, in some cases, inaccurate. From a systemic perspective, the Panel was concerned that trends in serious occurrence reports and other documentation have not historically been monitored at the provincial level to identify opportunities for improvement.

Any analysis of service systems would be incomplete without an assessment of cost versus benefit. These young people do not appear to have received significant "benefit" from the services and supports that were in place to serve them. It was clear that it is not possible to determine the overall cost to support young people in the child protection system because it is not recorded centrally. Not understanding the costs, outcomes and experiences at an aggregate level limits the ability to provide cost-effective and high quality services that offer the potential to reduce systems costs over time.

Recommendations

The Panel developed five recommendations they believe would make a fundamental difference to Ontario's young people and the overall burden on Ontario's social service system – now and over the longer-term. The recommendations follow in abbreviated form; additional context and detail can be found in the recommendations section, which begins on page 65.

To the Government of Canada and the Government of Ontario:

1. Immediately provide equitable, culturally and spiritually safe and relevant services to Indigenous young people, families and communities in Ontario.

To the Ministries of Children, Community and Social Services, Education, Health and Long-Term Care, and Indigenous Affairs:

2. Identify and provide a set of core services and support an integrated system of care for young people and their families across a wholistic continuum to every child in Ontario. Services must include health, mental health and wellbeing, education, recreation, child care, children's mental health, early intervention services, prevention services and developmental services. Service provision should be geared to the needs and intensity of needs, of each young person and family.
3. Develop a wholistic approach to the identification of, service planning for and service provision to high-risk young people (with or without child welfare involvement) that supports continuity of care to age 21 years.
4. Strengthen accountability and opportunities for continuous improvement of the systems of care through measurement, evaluation and public reporting.

To the Ministry of Children, Community and Social Services⁴:

5. Immediately enhance the quality and availability of placements for young people in care.

Principles

The Panel identified 10 principles that underpin their recommendations:

1. All young people must be involved in and at the centre of their care and be given the ability to influence their care based on their knowledge of themselves and their situations. Their voices must be heard, believed and prioritized.
2. All young people must have the opportunity to learn about, understand and experience their history, culture and its customs and teachings.
3. The care of and service provision to young people, families and communities must be holistic, prevention-focused, and driven by their needs. It must ensure that the physical, mental, emotional and spiritual needs of young people are met.
4. Indigenous communities must be enabled, supported and funded to bring forward their needs and to further develop their methods of addressing their needs.
5. Indigenous communities must be enabled, supported and funded to self-govern in a nation-to-nation relationship with Ontario.
6. Caring is an action. Care must be provided with a continued sense of purpose and a focus on the young person's future.
7. Caring is a shared responsibility that crosses organizational, sectoral, geographic and jurisdictional boundaries. Barriers between systems must be eliminated or be made unnoticeable to clients.
8. Children must be kept at home wherever possible – and when it is not possible, they must be in stable, nurturing placements for as long as required that ensure as few moves and transitions as possible.
9. Services must be provided to young people and their families where they are, wherever possible. Where it is not possible, distances should be minimized.
10. All young people must be in school or participating in equivalent learning.

⁴ Formally the Ministry of Children and Youth Services (MCYS).

Introduction

In Ontario, death investigation services are provided by the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS). Together, they form a division within the Ministry of Community Safety and Correctional Services.

The OCC derives its mandate from the Coroners Act. Under the Act, coroners are responsible for undertaking investigations pursuant to the criteria set out in section 10 of the Act and in the public interest, to enable the coroner to answer specific questions about a death, determine whether or not an inquest is necessary, and to collect and analyze information about a death in order to prevent further deaths.

The extent of a death investigation can vary, depending on the circumstances surrounding the death. Should the OCC believe that there may be systemic issues that, if addressed, could help prevent further deaths, a special review may be completed.

In the first six months of 2017, five young people died in residential placements. All of the young people were in the care of a Children's Aid Society or Indigenous Child Wellbeing Society (Society), and all of them struggled with mental health challenges.

The public, stakeholders and the Office of the Chief Coroner (OCC) felt that further exploration was required to determine whether this might be representative of a spike or part of a trend. To determine the answers to these questions, the OCC undertook an analysis of the data available to understand how many young people in the same circumstances had died.

The OCC identified a group of 12 deaths of young people in the care of a Children's Aid Society or Indigenous Child Wellbeing Society that occurred while they were in residential placements between January 1, 2014 and July 31, 2017.⁵ All of the young people had a history of mental health challenges.

A number of common issues were identified during a preliminary review of the 12 cases. The issues had been previously recognized by those involved with care in residential placements including, the Ministry of Children and Youth Services – which is now the Ministry of Children, Community and Social Services (MCCSS). Collectively, MCCSS, the Ontario Association of Children's Aid Societies, the Association of Native Child and Family Service Agencies of Ontario and Children's Mental Health Ontario were making efforts to address the challenges and identify, develop and help implement solutions to address current critical issues in residential services.⁶

The OCC established the Panel to inform the investigation of these 12 deaths and provide an opportunity for recommendations to prevent further deaths. The Panel was tasked with the following:

⁵ Initially, 11 young people were identified. A 12th young person was identified in the course of the Panel's work and a full review of the young person was incorporated into the process.

⁶ Many organizations use the language "residential services". We have used residential placements to refer broadly to the settings in which these young people were living. It is not clear at this time whether the work underway encompasses all residential placement settings that are relevant to this review.

1. Review and assess the services and supports provided to the 12 young people;
2. Identify any commonalities and/or trends arising out of the review and assessment of the deaths;
3. Identify any systemic issues or concerns arising out of the review and assessment of the deaths;
4. Provide expert opinion on the extent to which current and forthcoming plans, activities, legislation, regulations, policies and practices, including the activities outlined in [Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services](#) and activities underway in the child welfare and children's mental health sectors address any issues or concerns identified;
5. Make recommendations to the Chief Coroner, if appropriate, with a view to effective intervention and prevention strategies toward the prevention of further deaths.

The review was intended to be specific to the services and supports provided to the 12 young people that are linked by the fact that their deaths occurred in residential placements. The Panel was permitted to review and discuss the suitability of the residential placements, availability of services, and issues of service quality and oversight mechanisms. In addition, the reviewers were also permitted to consider how the determinants of health, socio-economic circumstances and the intersections between systems of care may have impacted the outcomes of these young people.

Services and service systems that were not directly linked with those provided to the 12 young people were considered out of scope and beyond the mandate of the OCC.

The OCC did not wish to “reinvent the wheel,” and therefore the Panel's terms of reference asked them to provide opinion on whether the current initiatives underway addressed any issues and concerns identified. The Panel also reviewed multiple other reports and reviews in the course of their formulation of recommendations; details on the reports reviewed can be found in the section titled Current Work Underway on page 62.

Panel Composition

To achieve the objectives above, the OCC identified members of the Panel with expertise in the following areas:

- psychiatric and/or psychological care of young people;
- community mental health care;
- services to Indigenous young people;
- residential placements in Ontario;
- the service system, including child welfare, child and youth mental health and youth justice systems; and
- government administration.

Biographies of the Panel members can be found in Appendix 1. The Panel was not intended to be representative of Ontario's population or any subgroup or the service system.

Process

The Panel were provided with a summary and analysis of the services and supports that were provided to the 12 young people. The summaries were developed based on information contained in the records of various service organizations, including societies, children's mental health agencies, health professionals including mental health professionals and institutions, educational institutions and youth justice records. In addition, the case reviewer examined the coroners' reports, post mortem reports and toxicology reports (where available).

Materials were requested from several organizations to help clarify current and forthcoming relevant policies and practices. Presenters with knowledge of the current system challenges and work underway appeared before the Panel to share information, insights and expertise.

In addition, nine of the 12 families and leadership from four Indigenous First Nation communities provided information to the panel for consideration. Their input was vital in providing the Panel with insight into the experiences of the young people, their families and their communities. We thank each person that participated in this way for sharing their thoughts and for helping us to honour the deaths of these young people. Their insights have been woven into the fabric of this report and greatly enriched the Panel's considerations.

The insights of those living and working within the system were also sought and obtained. Thirteen young people with lived experience were brought together in Kenora, Thunder Bay and Toronto. Staff of the OCC inquired about their placement histories and experiences of mental health care, and provided summaries of the information they shared to the Panel. The histories of the 12 young people that died and their thoughts, stories and suggestions were at the heart of the Panel's work and provided the lens through which the Panel's work found focus.

Throughout this report, where young people with lived experience transmitted messages relating to the findings and observations of the Panel or made suggestions to improve the experiences of young people, they are highlighted in purple. We have highlighted their input in order to elevate their voices; their messages speak volumes, and deserve to be heard.

In addition to meeting with young people with lived experience, staff of the OCC invited staff from the Children's Aid and Indigenous Child Wellbeing Societies and placement settings that had worked with the 12 young people directly to share their insights into the systems of care. Ten staff chose to participate in this process. The names of the young people and staff that participated will not be released in the interests of protecting their privacy.

Over 100,000 pages of records were reviewed and the Panel received almost 4,000 pages of summary information. While the review of records is no substitute for speaking with service users, the depth of the information available to the Panel provided sufficient information to help them understand the young peoples' varied experiences and trajectories.

Summaries of the individual experiences of the 12 young people comprise the first section of this report. Where the Panel had specific observations relating to the young person, they have been noted. The second section of the report outlines the Panel's aggregate findings and observations in four areas of focus that emerged during their discussions:

- Society Involvement and Placements;
- Mental Health Care;
- Service Systems; and
- System Oversight.

The third section of the report outlines a set of principles and recommendations for change.

A note on Wholistic care...

Wholistic care is defined by the Oxford dictionary as a philosophy characterized by the belief that the parts of something are intimately interconnected and explicable only by reference to the whole.⁷

This philosophy was introduced to the Panel by its three Indigenous Elder members who put forward the notion that all services should be provided in ways that address the continuous interaction of the physical, mental, emotional and spiritual aspects of individuals.

While this concept is age-old in Indigenous communities, it is not widely embraced in Ontario's westernized system of care. The Panel's observation was that this philosophy is of benefit to all people. Consequently, it is a philosophy that underpins all of the Panel's observations and recommendations.

Services to Children and Youth – Who Does What?

Child Welfare

Child welfare services in Ontario are provided by 38 independent Children's Aid Societies and 11 Indigenous Child Wellbeing Societies (Societies) to deliver child protection services, for a total of 49 Societies. All Societies receive provincial funding from the Ministry of Children, Community and Social Services (MCCSS). MCCSS is responsible for oversight of Societies mandated by the Child, Youth and Family Services Act (CYFSA). Two umbrella organizations, the Ontario Association of Children's Aid Societies (OACAS) and the Association of Native Child and Family Service Agencies of Ontario (ANCFSAO) provide services, supports and advocacy on behalf of member Societies.

Under the CYFSA, the functions of Children's Aid Societies and Indigenous Child Wellbeing Societies are as follows: investigate allegations or evidence that children may be in need of

⁷ "Wholistic | Definition of Wholistic in English by Oxford Dictionaries." Oxford Dictionaries | English, Oxford Dictionaries, en.oxforddictionaries.com/definition/wholistic.

protection, to protect children where necessary, to provide guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children, to provide care for children assigned to its care, to supervise children assigned to its supervision, and to place children for adoption.⁸

Other Services and Supports

Young people being served by Ontario's child welfare system may also be receiving other services and supports, such as health, mental health, prevention, and/or developmental services, and other special needs services. Societies generally do not provide these services directly to the young people they work with, but work to connect young people and families with the services and supports that they need. For example, community mental health agencies often provide counselling, treatment, family supports and prevention-focused care to young people.

Places for Young People to Live

Most young people served by the child protection system stay in their homes of origin. When young people cannot remain in their homes, they can be placed in various residential settings including group homes, foster homes and customary care homes (broadly referred to as "placements" or "placement settings" throughout this document).

Customary care is a culturally appropriate placement option for First Nations, Métis and Inuit children and youth who are in need of protection, who can't remain with their parents. In customary care arrangements, the child or youth is cared for by a person who is not the child's parent, according to the customs of the child or youth's band or First Nations, Inuit or Métis community. The model of customary care varies depending on the young person's band, First Nation, Métis, or Inuit community.

The children and youth served in residential placements come from a variety of backgrounds and may have multiple needs. Placement settings indicate that they provide a range of services from basic accommodation, care and supervision in a family home setting to specialized programs in treatment settings for children and youth with complex special needs or who are medically fragile – though the Panel found that in many cases, these services were not provided as described.

The Child, Youth and Family Services Act defines the types of environments in which children and youth that are removed from their homes can be placed in. In the Act, these environments are referred to as children's residences. Children's residences in Ontario have two different accountability relationships with MCCSS. The first is a transfer payment agency (TPA), which receives a direct transfer payment from the ministry and has a contractual agreement to provide group care or foster care to young people. The other is a private business, often referred to as an outside paid resource under contract with the placing agency. Outside paid resources do not

⁸ For complete mandated functions and standards of children's aid societies, see *Child, Youth and Family Services Act* (2018) s. 15 (3). <https://www.ontario.ca/laws/statute/90c11>

have a contractual relationship with MCCSS however; they do have a contractual relationship with Societies, and they are licensed by MCCSS, where required.

Licensing

Many placements are offered by service providers and agencies that are licensed to do so by MCCSS under the authority of the Child, Youth and Family Services Act. Providers must meet the requirements under the associated regulations and ministry policies.

MCCSS has the authority to issue a license to a staff-model children's residence where there are three or more young people residing in a home, not of common parentage; a foster-model home where there are five or more young people residing in a home, not of common parentage; and a license to provide residential care, directly or indirectly, for three or more children not of common parentage in one or more homes. For operators with multiple foster homes, a single license is issued, based on an inspection of 10 per cent of those homes. Where young people are residing in a staff-model residence with two or fewer young people, a license is not required. MCCSS reports that Agency Operated Homes (AOH) are used by licensed foster care agencies to place two or fewer children, where there are no other placement options. The licensed foster care agencies are sometimes Children's Aid Societies or Indigenous Child Wellbeing Societies. MCCSS licensors are not required to do inspections of these homes, because the agency is required to ensure that standards in the homes are being met.

Note: As of April 30, 2018, O.Reg 156/18 has expended licensing requirements to residential care homes that are not children's residences or parent model foster care, where there are fewer than three children per location but more than three children cumulatively across multiple sites (Section 117 of O.Reg. 156/18). This comes into effect July 1, 2019.



Section 1: Records Reviews

The Twelve Young People & Their Histories

All 12 young people were touched by complex and often intersecting experiences, starting at an early age. They had been removed from their families of origin and were in a placement at the time of their death, and all were high-risk. The majority of them had been removed from their home communities and were up to 1,600 kilometres from their homes of origin.

Many of the young people identified as LGBTQI2S. Eight of the young people were Indigenous. All of those young people were from First Nations communities in Northern Ontario, and the majority of those communities are remote. One of the young people was Black.

Many of these young people experienced mental health challenges, struggled with substance use, and had developmental challenges, features of fetal alcohol spectrum disorder and attachment disorders. All of the young people had histories that included self-injurious behaviors and/or suicidality.

Of the 12 young people, eight died by suicide; one by homicide; two were determined to be accidental; and one died of undetermined causes. A death is classified as undetermined when a full investigation has shown no evidence for any specific classification or there is equal evidence or a significant contest among two or more manners of death.

DANNY⁹

Danny was described as quiet and polite with a very good sense of humour. He was further described as an intelligent boy with some very significant learning disabilities in the areas of thought processing and memory.

At age six, Danny and his brothers were brought to Canada by their mother.

The Children's Aid Society became involved when Danny at the age of eight years due to inappropriate behaviour at school and concerns that he may be subject to physical abuse. Over time, concerns about mental health issues within the family, poverty, uncertain immigration status and a lack of family and community supports arose. Danny was brought into the care of the society on an emergency basis at age nine. Two years later, Danny was the subject of an order for Crown wardship (now known as extended society care).

Shortly after his admission to care, Danny began self-harming and received in-patient assessment in three children's mental health facilities. Over the next few years he was diagnosed as having an adjustment disorder with anxious features, possible attention deficit hyperactivity disorder and a learning disability. There was recognition of severe psychosocial stressors, academic difficulties and bullying. Danny required accommodations that were identified to be needed but were not provided for a long period of time. For example, he required eye glasses and a laptop for educational purposes – both were provided after a long delay. Medication was prescribed to address distorted thinking, perceptual distortion, sleep disturbance, fear and anxiety. Later in his life, Danny was diagnosed as having complex traumatic syndrome with severe features of anxiety and intermittent psychotic symptoms, a motor tic disorder, dysthymia and early signs of affective psychotic syndrome. It was noted that Danny's learning disability would be a barrier for most therapeutic processes.

Danny lived in 10 placements in his six and a half years in care. Initially, Danny was placed with his brothers in his home community, in a foster care home operated by an agency. At Danny's request, he moved to a group home without his brothers approximately a year later. He remained in this group home for three years, until his death.

For a period of time in Danny's last placement, he attended a section 23 classroom,¹⁰ where he reportedly did well academically. After progressing significantly, he was reintegrated into a community school for high school, where he did not appear to have been connected with school activities or staff.

The recommendations outlined in assessments for therapeutic intervention and a structured and supportive living environment were not identifiable in this placement. A request by the Society to connect Danny to community based mental health services did not occur and the reasons were not clearly documented.

⁹ Some names have been changed to protect the privacy of the individual and/or their family.

¹⁰ Section 23 classrooms provide educational services to students in care, treatment, or correctional settings. The programs are designed to meet the individual cognitive, social, emotional, and physical needs of young people.

As he aged, Danny became quieter and continued to be introverted with fewer outbursts of aggression or negative emotion. Over his final three years, Danny transitioned from being afraid to leave the group home and unwilling to participate in community activities to being generally absent from the group home and spending his time with friends in the community. Danny had minimal contact with the staff and there are no indications in the records that the staff was aware of how he was doing. In the year prior to his death, Danny chose to discontinue art therapy and refused all medication. As Danny did not engage in the type of behaviour that required an immediate response (for example, aggressing against staff), there were few reports of any incidents. Danny does not appear to have been engaged with staff in the last year of his life. In the months leading up to his death, Danny's school attendance began to decrease.

On the morning of his death, at the age of 16, Danny went to his first class and then left the school. His body was found the next day in a park. The manner of death was found to be suicide by hanging.

ANAYA *

Described as an outgoing likeable child, Anaya was reported to have sought out opportunities to participate in her Indigenous culture, especially by dancing. She loved attending Pow Wows. She also enjoyed swimming and ice hockey as recreational activities.

Anaya was the youngest of four daughters born to her mother. All three of Anaya's siblings were reported to struggle with addictions and mental health challenges. Approximately seven months apart, two of Anaya's sisters died by suicide in the time immediately preceding Anaya's death. No information is available about her father.

For the first few months of her life, Anaya and her sisters lived with their grandmother until she was no longer able to care for them. The Society had been involved with the family prior to Anaya's birth and became re-involved at this point. Anaya lived with an aunt and her family from the time she was seven months old until she was nine years old under a customary care agreement. Anaya's mother had sporadic contact with her children over the years, and it is reported that her mother stated that she did not wish to regain custody.

After eight years in this placement, Anaya disclosed physical abuse. The subsequent investigation did not verify the allegation. Nevertheless, Anaya moved to a nearby community and lived with her grandfather and one of her sisters under a customary care agreement. The allegation of abuse was later recanted by Anaya and she repeatedly asked the Society to return her to her aunt's home.

Anaya remained with her grandfather and developed a close bond with him. The Society maintained involvement as there was documentation of concerns about the level of supervision in this placement. Offers of assistance to address this issue were declined. Anaya was continually left in the care of family members who were reported to be emotionally abusive. It was noted that mandatory standards related to visits and documentation were not followed in either of the customary care placements.

As a young child, Anaya was assessed as having an executive function disability and had significant cognitive delays. She was never formally diagnosed with fetal alcohol spectrum disorder or any other mental health condition, although this was suspected by health professionals. No medication for behavioural or mental health concerns was prescribed.

Anaya's attendance at school appears to have been regular throughout her life. In the seven months prior to her death she was absent from school for 26.5 days.

Beginning at six years old, concerns were noted about Anaya's precocious sexualized behaviour. Two years later, Anaya reported that she was using alcohol. She experienced at least two incidents of sexual abuse, and other instances were suspected. Anaya later became involved in solvent use and was reported to experience frequent and recurring episodes of suicidal ideation and self-harm. Concerns were raised by family members and school personnel and some sporadic counselling was provided to Anaya and her family.

At age 11, Anaya spent three weeks in an assessment home. Shortly thereafter, she spent 10 weeks in a residential treatment program designed for Indigenous youth. Anaya made attempts to die by suicide while in the residential treatment centre. The centre was noted to be designed for older youth whose cognitive abilities were greater than those of Anaya. Although efforts were made to modify the program to meet Anaya's needs, it was reported that she was not able to understand the concept of treatment. Anaya left the program unexpectedly following the suicide of her second sister. A safety plan was developed and she was released into the care of her remaining sister to return to her grandfather's home to grieve with the family. Three weeks later, Anaya sent a letter to a relative stating her intention to die by suicide. She had previously sent similar letters to friends. A few days later, Anaya left school to go to her grandfather's home for lunch and did not return for the afternoon. Her body was found in the home later that day. The cause of death was hanging and the manner of death was suicide.

JAZMINE *

As a younger child, Jazmine was described as pleasant and polite. She did very well in school and was well-liked by her peers. Later on in her life little was documented about other aspects of her strengths or interests in her early life.

Jazmine lived in a Northern Ontario city with her biological parents and two younger brothers until her parents separated when she was nine years old. The Society became involved as a result of a concern that Jazmine was anxious and wanted to hurt herself. Instances of intimate partner violence and substance use were reported to have occurred in Jazmine's family. The Society verified concerns about the caregiver's ability to care for the children. At that time, Jazmine reportedly disclosed that she wanted to die by suicide.

Shortly afterward, Jazmine and her brothers went to live with their grandmother in the family's remote First Nation community, located 500 kilometres away from the city that she had grown up in. Jazmine lived with her grandmother in a formal customary care arrangement from the time she was nine years old until her death. Two children's aid societies were involved (responsive to the location of various family members) and family reunification was seen as a preferred outcome. There is minimal evidence of collaborative or coordinated planning for the children between the two societies.

Jazmine attended two schools without any apparent disruption in her education. She was reported to have done well at both schools.

Jazmine was first assessed by a mental health professional at age 10 as a result of self-harming behaviour and suicidal ideation. Referrals were made for expressive arts therapy and counselling, however, this support was sporadic due to the challenges of providing service in the remote community.

Jazmine continued to self-harm. At age 12, she was re-assessed. The assessment concluded Jazmine was experiencing a mood disorder and problems relating to abuse and neglect. The assessment strongly reinforced the need for collaborative planning and monitoring by the societies involved; the school and the family. Immediate and intensive intervention was indicated as necessary; however, it appears from the records that this did not occur. Records were incomplete and confusing, making it difficult to understand the supports provided.

Over the next seven months, some inconsistent and limited counselling was provided. Jazmine was not prescribed any medication. While she continued to exhibit signs of significant depression, she received no further help, despite documented concern that her needs seemed to be beyond her grandmother's ability to cope.

On the night of her death at the age of 12, Jazmine visited with her grandmother and then had dinner at the home of other relatives. Later in the evening, Jazmine's body was found by one of her siblings. The cause of death was hanging and the manner of death was determined to be suicide.

TYRA

Tyra was described as an excellent student and a committed athlete who was consistently noted as having a lot of potential. Her intention was to attend university away from her home community and she had identified an interest in working in the corrections field. She was described as having a big heart.

Early in her life, Tyra's parents separated and she lived with her mother and two siblings. For a period, their mother's new partner lived with them. Child protection concerns related to parental supervision and instances of the children being in the home during parties involving substance use, where adults unknown to them were present.

The Society was involved with the family during Tyra's early years and verified that the children's basic needs were not being met. Family support was provided in the home. When Tyra became an adolescent, she requested that she be taken into the care of the Society. She reported feeling depressed and had begun self-harming. Tyra disclosed that she was the victim of sexual abuse early in her life and that she experienced further victimization in adolescence. Her parents agreed to a temporary care agreement and she lived under the care of the Society for the rest of her life.

With the support of experienced foster parents, Tyra was provided with significant trauma-informed counselling and intensive support from her school community. Despite this, she continued to be unsettled. Approximately a year after coming into care, Tyra was admitted to the children's psychiatric unit of the local hospital as a result of suicide ideation. She was diagnosed with depression and post-traumatic stress disorder and placed on medication.

A series of suicide attempts in the following months led to two additional in-patient admissions to the children's psychiatric unit of a local hospital. A move to a residential treatment program operated by a children's mental health centre was seen to be better able to respond to Tyra's needs. While at the program she was able to stabilize and return to school. Tyra continued to self-harm, including multiple suicide attempts.

Tyra was reported to have been an excellent student throughout elementary school and high school. With the exception of time Tyra spent hospitalized in relation to her mental health, her school attendance was not interrupted.

Tyra was surrounded by a group of helping professionals from the Society, school and children's mental health sector who maintained extremely close contact with her and communicated with one another on a very regular basis regarding her welfare.

On the day of her death at the age of 18, Tyra left school in the afternoon. Her body was later found hanging from a tree in a wooded area off a recreation trail. Tyra's cause of death was hanging and the manner of death was suicide.

JUSTIN

Justin was described as a sensitive and likeable young man who loved nature and particularly, fishing and walking in the forest. Justin enjoyed watching movies, playing board games and making arts and craft projects that he frequently gifted to others.

At two years of age, Justin was assessed by a paediatric development clinic due to concerns related to his inattention and behaviour. Early intervention services were subsequently provided. Over the course of his life, Justin was diagnosed as having a developmental disability and mental health challenges. Additionally, he was diagnosed with attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder, alcohol related neurodevelopmental disorder and significant learning disabilities. Justin was prescribed medication as a young child to respond to the ADHD symptoms, and additional medication in response to anxiety and escalating aggression was prescribed as he aged.

The Society became involved with the family prior to Justin's birth and remained involved throughout his life. Justin lived with his mother, father and two older siblings for the first two years of his life, until his parents separated. He continued living with his mother until the age of eight, when his grandparents began caring for him in a kinship care arrangement following concerns that his needs were not being adequately met. There were reports of Justin's escalating aggression towards peers and school personnel at this time.

After almost two years, this arrangement was no longer viable as his grandparents struggled to manage Justin's increasingly challenging behaviour. Justin came into the care of the Society where he remained for the rest of his life. He lived in four different foster homes with each placement breaking down due to his escalating behaviour.

At age 10, Justin became a Crown ward (now known as extended society care) and just prior to his 12th birthday, he moved to an unlicensed group home 550 kilometres from his home. Records indicate that an appropriate placement was not available closer to home. From this time, Justin lived in four different group homes before his fifth and final placement, where he lived until his death at age 17.

Due to an enrollment issue, Justin's education was disrupted for a few months following a placement transfer. During this time, he was reportedly home schooled and attended a day treatment program on the premises of the group home.

It appears that minimal effort was made to provide mental health services or developmental services to Justin. Although he was going to transition to the adult developmental services sector, he had no contact with the developmental services agencies in the community.

At the time of his death, Justin was living in an unlicensed arrangement where staff supported him in his separate living unit within a triplex, with two other clients in separate units. Up to two staff supported him at a time.

Five days prior to his death at the age of 17, Justin was placed in a restraint following behavioral escalation that resulted from a disagreement with staff over whether he could ride his bicycle. Justin lost consciousness during the restraint. He was transported to hospital but did not regain consciousness and remained on life support. His cause of death was determined to be a result of Anoxic Encephalopathy due to Desmoglein-2 mutation-related cardiac arrest, with contributing factor of struggle/restraint. The manner of death was undetermined.

AZRAYA

Azraya was described as having a good sense of humour and an interest in fashion. She was one of three children born to her parents, an older brother and a twin brother. The family of five lived together throughout most of Azraya's life in their Indigenous community in Northern Ontario, surrounded by grandparents and other relatives who were involved in the family's life.

The Society was involved with the family prior to her birth and throughout most of her life as a result of concerns related to inadequate supervision, domestic violence and alcohol use. The Society provided some ongoing family supports and apprehended the children on several occasions.

Azraya's parents struggled to provide care to the three children, including her older brother, who suffered from a progressive neurological disorder until the time of his death, when Azraya was twelve years of age.

Following her brother's death, the family made arrangements for Azraya to move to a nearby city and live with a relative while she was attending school. Four months after her brother's death, Azraya was admitted to the local hospital as a result of suicidal ideation. The Society sought and was granted a protection order, following which Azraya lived in a Society operated residence for a short time before returning to her parent's home.

A few weeks later, Azraya was re-admitted to the adolescent psychiatric unit of the hospital following a suicide attempt. An assessment identified that little was known about Azraya's early life, cognitive abilities or intellectual functioning that could impact on her ability to benefit from therapy. Following discharge, she was placed in three short-term placements while awaiting admission to a treatment foster home in Southern Ontario, where she subsequently lived for five months with 1:1 supervision.

Initially, it was reported that Azraya settled well into this placement however; following a visit from her family, her behaviour was reported to have become more challenging. Azraya expressed suicide ideation and was admitted to the psychiatric units of two local hospitals during this time. It was brought to the attention of the Society that the placement was unable to manage her behaviour, nor was the placement able to provide the supports and services that were thought to be in place.

While the Society began looking for an alternative placement, Azraya's parents asserted their desire to bring her home. It was determined that she would go home under a supervision order with terms and conditions, which included attending mental health services.

For the next six months, Azraya lived primarily at home. During this time the environment was reported to be unstable. She came into care on a few occasions following incidents of substance use or violence when she would reach out to the Society and ask for intervention. It appears that Azraya was not receiving mental health supports at this time.

The Society had set up an intake appointment for a residential treatment program designed for Indigenous youth. The appointment did not occur as Azraya died prior to the appointment date. Two weeks before her death, she indicated that she wished to come back into the care of the Society due to escalating challenges at home. On a temporary basis, Azraya was placed in a Society operated home, where she was housed in an apartment (without other young people) and supported by casual, relief staff. Azraya was known to be at high risk of self-harm and had constant supervision by a 1:1 worker. This was discontinued in the days prior to her death. No rationale for discontinuing the 1:1 supervision was found in the documentation reviewed.

Azraya did not attend school for the last year of her life. During this time she was hospitalized, in treatment foster care, in Society operated homes for short periods, or in the care of her parents under a supervision order. In the four months she was in treatment foster care, she was registered in two different schools, but only attended school for one day.

On the night of her death at the age of 14, Azraya missed her curfew and was known to be attending a house party. The police attended the party and brought her to the emergency department of the local hospital. The staff of the society operated home attended the hospital at which point the police left. A short time later, Azraya left the hospital and a search was immediately launched. Two days later, she was found in a forest adjacent to the hospital. The cause of death was hanging and the manner of death was suicide.

KANINA

From an early age Kanina was described as active socially and physically. She enjoyed school, particularly math and science. Kanina provided support to her older sister and was called Kookoomes by one of her foster parents.

Kanina was a young person from a remote First Nation. She lived with her biological parents and five siblings until she and her sister came into care under a customary care agreement when Kanina was two years of age. She was admitted to care ten times over the course of her life, generally for six month periods. The goal of family reunification remained throughout her time in care. Instances of intimate partner violence and substance use were reported to have occurred in the family home throughout Kanina's life. There was a significant history of deaths by suicide in Kanina's family. Her parents twice successfully completed family treatment programs, which included some or all of the children.

Kanina was referred for counselling at the age of seven following the death of her aunt by suicide. Counselling at that time and in the months prior to her death at age 15, focused on her grief at the loss of relationships. Kanina did not receive a psychiatric diagnosis and was not on any medication.

In the final year of her life, Kanina had a number of placement changes, which often followed incidents of self-harm, suicidal ideation and attempts. Following a placement transfer, Kanina was not attending school for a period of time. From the documentation, it is unclear what the reason for this disruption in her education was, or how long she was not attending school.

In the four months prior to her death she was placed in an Indigenous youth healing centre. She was medically evacuated out twice in response to self-harming behaviour and suicide attempts. The most recent visit to hospital occurred five days prior to her death.

While residing in the healing centre, Kanina began a relationship with another female resident. This female resident, Jolynn, is also the subject of review by the Panel. In the weeks and days prior to her death, the two were together on a number of occasions. Although this relationship is referred to in various documents, there was no evidence of supportive discussions around Kanina's sexual identity. Additionally, it appears that staff indicated to her that she could be arrested for engaging in a sexual relationship with Jolynn, as a result of Jolynn's age. While this is accurate from a legal perspective, this position does not demonstrate responsiveness or recognition of the needs Kanina was endeavouring to meet.

Kanina was in her final placement for less than three days prior to her death. The placement was a staff-model foster home operated by the Indigenous Child Wellbeing Society.

At the age of 15, Kanina died by suicide at her foster home. She recorded her suicide on her iPad. Suicide notes were left for various family members and Jolynn. The autopsy indicated significant evidence of self-harm over time on various parts of Kanina's body.

JOLYNN

Jolynn was an Indigenous young person born in Northern Ontario. She was described as quiet. She liked to draw and sketch.

Jolynn lived with her biological mother prior to her admission to care at two years of age. Her mother had a history of transience and substance use reported to have occurred during Jolynn's early years. Her biological father was not known to her until the last year of her life.

Shortly after her admission to care, Jolynn was placed in a customary care home operated by the Indigenous Child Wellbeing Society. After seven years in this placement, Jolynn was discharged from the care of the society into the care of the same caregiver, through a private arrangement. She remained with this caregiver and their family until the age of eleven.

Following the breakdown of this placement, Jolynn had 20 placements in an 18 month period. Placement changes often occurred on an unplanned basis following a behavioural incident. Jolynn's education was described in a social history in her file as "interrupted" by multiple placement changes. During some placements, she was not enrolled in school. The last grade Jolynn completed was grade six – she would have been in grade seven, had she been enrolled at the time of her death.

In the six months prior to her death, Jolynn was placed at a youth healing centre on two occasions. While at the centre, Jolynn began a relationship with another female resident. This resident, Kanina, is also the subject of review by the Panel. Kanina left the centre and Jolynn was later medically evacuated from the centre following a suicide attempt. While away from the healing centre, in the days prior to Kanina's death the two were together on a number of occasions. Within days, Jolynn learned that Kanina had died by suicide.

Following this, Jolynn was admitted to the child and adolescent mental health unit of a hospital for 17 days. Except for a period of time during this hospital admission, Jolynn was not prescribed any medication at any point in her life.

While placed in the hospital, Jolynn spoke to staff about her relationship with Kanina and her feelings about this loss. There were no records suggesting that Jolynn's sexual identity was ever discussed with her while in hospital or by staff of other organizations including the Indigenous Child Wellbeing Society.

On discharge from hospital, no children's mental health treatment bed was available. Consequently, Jolynn was discharged to an extended home visit at her father's home pending the availability of a treatment bed. A safety plan was agreed to by the hospital, the Indigenous Child Wellbeing Society, the family and Jolynn. There was, however, no evidence of active therapeutic intervention during the seven weeks she was in her father's home.

At the age of 12, Jolynn died by suicide in her father's home. Kanina's death by suicide is felt to have been an influencing factor in Jolynn's suicide. The autopsy indicated significant evidence of self-harm on various parts of Jolynn's body.

KASSANDRA

Kassandra was described as an intelligent, energetic and pleasant youth who loved to dance, sing and do gymnastics.

Kassandra lived with her biological parents and one older brother until her admission to care at age 12. Instances of intimate partner violence and substance use were reported to have occurred during her early years.

Over the course of her life, Kassandra was diagnosed with attention deficit hyperactivity disorder (ADHD), mood dysregulation disorder, and generalized anxiety disorder. She was on various medications beginning at age 11 and continuing until the time of her death at age 14, including, at various times, stimulant medication for ADHD, antipsychotics and antidepressants.

Kassandra's behavior was reportedly challenging from very early in her life. Reports outline increasing instances of violence, aggression and behavioral disturbances between age two and age seven. At age seven, the Society became involved on an ongoing basis and in-home family intervention was put in place along with access to a parenting program. Kassandra's mother is reported to have requested assistance on multiple occasions, but was unable to obtain the type of help she felt was necessary to cope with her daughter's behaviour.

At age seven, Kassandra's mother requested her to be placed in a residential treatment facility. Community service providers were not in agreement and placement did not occur. Children's mental health services were initiated and a period of tenuous stability in the home was noted. As Kassandra aged, there were repeated incidents requiring crisis intervention of police and hospital based mental health services. Kassandra's behaviour was noted to have interfered with her ability to attend and succeed at school. At age 13, Kassandra moved to the first of four section 23 classrooms operated by residential providers or community agencies under a provision of the Education Act. Just before her 12th birthday, Kassandra was admitted to residential treatment. In the two and a half years between her admission to residential care and her death, Kassandra lived in seven different placements, with six months being the longest period in any one home. Her service providers were working toward a goal of family reunification; efforts were made to continue family therapy and Kassandra continued to have regular access to her family. In 2014, Kassandra came into extended society care with continued access with her mother.

Some mental health services were provided while Kassandra was in residential care, but she continued to struggle to benefit from these services. She was noted to have difficulty engaging with peers, staff or family in positive ways. Kassandra was self-harming and was placed in vulnerable situations with people she met over social media.

Kassandra was in her final placement for four months prior to her death. The placement was a staff-model foster home with two other residents. Available records did not provide details of the circumstances or needs of the other young people in the home; however, there are indications that the needs of the residents varied considerably and questions arose regarding the capacity of staff to meet the wide range of needs present in the home.

At the age of 14, Kassandra died from smoke inhalation in a fire at her foster home. The manner of death was determined by the coroner to be a homicide. The incident was precipitated by escalating behavior of another young person in the home, in response to which Kassandra and two staff removed themselves and locked themselves in a second-floor bedroom. A fire began on the first floor and they were unable to exit. Resuscitation attempts were unsuccessful.

AMY

Amy was described as a friendly but cautious person. She took pride in her appearance and showed interest in her Indigenous community and culture. When given the opportunity, she enjoyed learning birch bark construction and beading using traditional designs and methods. She liked to sketch and journal, and was interested in gymnastics.

The Society was involved with Amy's family prior to her birth and throughout most of her life as a result of concerns related to inadequate supervision, parental substance use, domestic violence and one parent's mental health. Amy and her siblings were apprehended by the Society on many occasions but returned shortly thereafter to the family with safety plans developed. The Panel identified more than eight referrals regarding child protection concerns in Amy's family throughout her life. Over time the Society continued to respond to a very high volume of protection concerns and placements became more difficult to arrange.

Amy began engaging in high risk behaviour (cutting, as well as solvent and alcohol use) very early in her life. Amy witnessed family violence, suicide attempts and deaths in the community. She disclosed repeated instances of sexual assault that were reported to occur throughout her childhood.

Amy remained close to her sisters and was at times placed with them in foster care. Amy and one sister were part of a suicide pact with other youth, and there were multiple incidents of self-harm involving Amy and her sister. On many occasions, Amy was medically evacuated out of the community for medical attention following significant instances of self-harm.

Amy did not receive a formal assessment of her needs until near the end of her life. Prior to this, she primarily received mental health supports on an emergency basis following instances of self-harm and suicide attempts. Although fetal alcohol spectrum disorder was suspected, further investigation was not done. She was formally diagnosed with an adjustment disorder and Depression just prior to her death. Counselling was sporadic throughout her life, without the benefit of a consistent therapist or a coordinated approach.

From an early age, Amy did not attend school regularly. While she was in care there were periods of time where her attendance was more regular and she did well in school. However, during her last placement she was not enrolled in school due to administrative delays in retrieving documents from her previous placement.

At age 10, Amy came into the care of the Society and remained in their care for 15 months. Initially, she was placed in four short term foster homes and then moved to a residential program in Southern Ontario where she remained for 12 months prior to returning to her parent's care. Amy returned home, where her behaviour escalated to include significant vandalism, alcohol and solvent use, suicide attempts and property damage that resulted in her being removed from the community and coming back into the care of the Society.

Amy was re-admitted to the same residential program. At the time of her return, the local Society was in the process of an institutional protection investigation of the children's residence, which resulted in verification of several child protection concerns. Amy remained in the home following the investigation. After three months, Amy was involved in an altercation with staff and was immediately moved to another residential program nearby.

While in the new residential program, Amy continued to struggle with self-harm and aggressive behaviour that led to hospitalizations and physical restraints. Amy was seeing a crisis counsellor at a community agency, however, it did not appear that this was a regular occurrence. It was known that Amy was part of a suicide pact, and two other youth in this pact had died by suicide. Amy also disclosed a past history of sexual abuse, as well as a more recent incident of sexual assault that was reported to have occurred during one of the times she left the residence without permission and was missing overnight.

As a result of self-harm, Amy was seen in urgent care and the emergency department of the local hospital on multiple occasions in the six months leading up to her death. Amy was admitted to hospital on two occasions, the last being for four days, approximately two weeks before her death. From her discharge to the day of her death, she was brought to the emergency department on three additional occasions related to self-harm and suicide ideation or attempt.

On the day of Amy's death at the age of 13, staff at the residential program checked on her regularly as she was in her bedroom alone. Twenty minutes after the previous check, staff returned to her room with a snack for her and found her hanging by the cord from the window blind. Resuscitation attempts were unsuccessful. The cause of death was hanging and the manner of death was suicide.

BROOKLYN *

Brooklyn was described as a polite and friendly young person. She was of Indigenous heritage and was reported to enjoy participating in ceremonies and learning about her culture. She enjoyed a variety of sports. She enjoyed horseback riding, art, cooking and gardening.

Brooklyn lived with her parents for the first year of her life and for another period of eight months as a young child. She had five siblings and her early years reflect the challenges faced by her First Nation community including, poverty, substance use, minimal community supports and intermittent access to education. Brooklyn was apprehended at just under a year old. She maintained some contact with her parents and siblings on and off throughout her life. Brooklyn was consistently placed in the same home as her younger sister and they maintained a lifelong connection.

Brooklyn was diagnosed with fetal alcohol spectrum disorder, a mild developmental disability, a reactive attachment disorder, learning disabilities and developmental trauma disorder. As early as age four, a psychiatric assessment stressed the importance of permanency planning and warned of issues with attachment. Medication was prescribed to address symptoms of sleep disruption, attention, impulsivity and anger management. Brooklyn was twice admitted to in-patient children's mental health units as a young adolescent, following outbursts of aggression, and received some counselling and art therapy while in her placements.

Efforts to find a stable kin or customary care living arrangement for Brooklyn closer to home were attempted throughout her life, but were unsuccessful. By the age of six, she had lived in 17 foster homes in Northern Ontario, almost all of which were located in First Nations communities.

At age six, Brooklyn and her sister moved to a foster home 800 kilometers from home, which was operated by an outside paid resource agency. Brooklyn had minimal English language skills at that time and had not attended school regularly. She and her younger sister lived with this foster family for six years, and this was by far the most permanency she experienced. The end of this foster placement was abrupt and the reasons appear to be unrelated to the children. Minimal support was provided to Brooklyn to process her feelings about this transition and the resulting change of foster parents, community, school and therapists.

Following two foster placements within the next year operated by a different outside paid resource agency, Brooklyn experienced eight additional placements operated by multiple OPR agencies between the ages of 13 and her death three years later. The longest duration of stay was seven months in one group home. From the age of 14, school attendance was disrupted and Brooklyn exhibited challenging behaviours that were anticipated in early assessments. Brooklyn had a history of fire setting behavior.

At the time of her death, Brooklyn had been living in a staff model foster home for ten weeks following an emergency placement with minimal transition planning. Brooklyn was not attending school nor was she involved in any community activities.

Following a series of departures from the group home without permission to meet individuals thought to be involved with illegal activities that took advantage of vulnerable youth, a screw was inserted into Brooklyn's bedroom window to prevent it from opening fully. This occurred with the intention of preventing Brooklyn from using the window to depart the residence. No other safeguards and supports intended to mitigate the various concerns were evident.

Attempts to limit access to social media created significant contention, and Brooklyn would isolate herself in her bedroom, at times barricading herself in the room by pushing furniture against the door. On the day of her death at the age of 16, she became upset with staff when her internet access was withdrawn. She pushed her mattress against her bedroom door and set fire to it. The mattress blocked her exit and prevented staff from entering the room, as did the screw in the window. Her death was determined to be accidental as a result of smoke inhalation.

ASHLEY *

Ashley was described as a bright young person who had musical talent. She expressed her creativity through sketching and drawing and liked to play cards and electronic games. She was known to have had remarkably good insight into the issues she experienced in her life, and had detailed discussions with physicians and psychiatrists about the effects that prescribed medications had on her.

When Ashley was abandoned at birth, her grandmother became her caregiver through an informal arrangement. They lived together for the next fifteen years in their First Nation community and her mother would visit sporadically.

As a child and young adolescent, Ashley witnessed domestic violence between extended family members and suicide attempts within the family. She experienced sexual abuse and bullying. Ashley engaged in substance use and vandalized communal property. She witnessed at least two incidents resulting in death or serious injury of another child in her early life.

Ashley's frequent suicide attempts resulted in repeated medical evacuation to the children's in-patient psychiatric unit of a local hospital. Her grandmother's ability to care for Ashley became compromised as a result of her advancing age, challenging life circumstances and her own medical and mental health challenges.

At age 15, following eight instances of suicidal ideation and attempts, Ashley was brought into care under a customary care agreement and the Indigenous Child Wellbeing Society. This supported Ashley's wish to enter a residential treatment program. Following this, her extensive background of psychiatric, psychological and behavioural problems resulted in six hospitalizations (two of which were approximately five months in duration) and 10 suicide attempts. She lived in 18 different placements, including treatment foster programs, three treatment programs operated by First Nations communities in Northern Ontario and on one occasion, secure treatment. Ashley moved 23 times, including four instances when she returned to her grandmother's home when no alternative was available and five one-night placements on a crisis basis.

Over time, diagnoses included cannabis abuse, conduct disorder, post-traumatic stress disorder (PTSD), dissociative identity disorder, and complex trauma response including dissociation, intrusive recall and borderline organization. Ashley was reported to have used cannabis daily since the age of 11. Medication was prescribed and frequently adjusted as the efficacy of these medications was seen to be questionable. In particular, medication was used to prohibit the nighttime recall associated with the PTSD.

The possibility that Ashley was transgender was noted in the file but not addressed directly by any service provider.

Two months prior to her death, Ashley moved to a therapeutic foster program located close to her home community. At the time of her placement, an institutional child protection investigation of the children's residence was underway and verified a number of child protection concerns.

Although Ashley was to have 1:1 staff supervision while in this placement, she was regularly allowed to leave the home unaccompanied by staff. She was not attending school or receiving any therapeutic intervention. Despite this, her behaviour seemed to stabilize and there were no suicide attempts while in this placement.

The evening preceding Ashley's death, she was dropped off by staff of the foster home at a location where relatives from her home community were staying. Ashley was expected back at the foster home by 11 p.m. Ashley and three other young people went to a secluded area of a local park. The youth later confirmed that they had consumed alcohol, smoked marijuana and left Ashley in the park as she was unable to be roused.

When Ashley had not arrived at the foster home by 12:30 a.m., police were called and a missing person was reported. Ashley's body was found in the park at approximately 8 p.m. that evening. It was determined that the death was accidental and the result of drowning in a young person with acute ethanol intoxication.



Section 2: Findings & Observations

Indigenous Young People, Their Families and Communities

Overall, there were many similarities in the histories of the 12 young people, their families, and communities, and in their experiences of care.

Key findings

- Despite complex, traumatic histories and the high-risk nature of these young people's lives that was evident early-on, intervention and prevention was minimal, and sometimes non-existent despite having been identified early. Responses to young people and their families was largely crisis oriented.
- The identities of the young people were not incorporated into service delivery or care. Indigenous, Black and LGBTQI2S young people were not consistently connected to identity-based or culture-based programs, nor was their identity incorporated into their care. There was a lack of attention paid to their identities, and minimal efforts toward inclusivity.
- Young people were often not living in environments that fostered a continued sense of purpose, belonging or healthy, long-term attachment to any adult in their lives. They frequently did not appear to have been encouraged to be hopeful about their futures or to have positive aspirations or engage in activities to promote their capacities.

Summary of Observations

The experience of complex, multiple traumas was determined to be common to each of the young people. Many of them also came from families that would be assessed as high-risk. Indications of intergenerational trauma were evident in the stories of the eight Indigenous histories reviewed.¹¹ Some of the families questioned whether caregivers in the placements provided adequate support for young people experiencing trauma, grief, loss of loved ones, and who had experienced sexual assault or abuse.

The challenges faced by these young people seemed to be compounded on entry into care. During the Panel's meetings, one of the Indigenous Elders shared a story about a community ceremony that takes place early in life that provides children with a name, a clan, free will, and a purpose. The Panel reflected that the ceremony encompasses many of the fundamental components that were observed to have been missing from the experiences of the 12 young people - identity; relations, connections and belonging; roles and responsibilities; empowerment to choose their own path; and purpose.

The Panel observed that there was a lack of attention and responsiveness to young people's identities. Indigenous, Black and LGBTQI2S young people who faced marginalization were not consistently connected to identity-based or culture-based programs, nor did it appear that their identity was considered when determining services during their time in care.

¹¹ See page 40, Eight Indigenous Lives for additional content relating to intergenerational trauma.

Young people, families and Society workers all identified significant challenges for young people in care in connecting with others.

Young people with lived experience frequently describe social isolation and a lack of meaningful connection. They reflected on the trauma of being removed from families and communities and of having no one they were comfortable talking with or an emotional outlet. Young people described “desperately” needing a bond, and someone to guide them.

Some of the young people described being in a group home as being equivalent to living alone. They reported a lack of supervision, an ability to come and go from placements at will, not enough security, and no counselling or people to talk to.

Some families reported that they believed their children had limited contact with them while in care. One parent reported that their child had to ‘sneak’ calls to their family and consistently expressed loneliness and a desire to go home. Another parent explained that it was difficult for their children to spend holidays away from their community.

The Society workers and staff from placements spoke about the importance of having a goal of reunification with biological families, and noted that placing young people as close to home as possible supports this goal. Connection to families, community and culture were identified as being integral to young people’s sense of identity and belonging.

Specific Opportunities for Improvement

- Prioritize keeping children with their families of origin for as long as possible.
- Provide biological parents and children with supports early in the intervention process, so that young people do not have to experience a removal from their homes and communities.
- Consider removing parents from their communities for treatment and support, rather than apprehending young people.
- Have staff in placements, Society workers, and caregivers who accept, support, and/or reflect various identities, including those that identify as LGBTQI2S and Indigenous.
- Connect young people to others with lived experience of the child welfare system and with mental health challenges so that they will not feel alone in their experiences.
- Caregivers should operate with the assumption that young people have experienced trauma, understand the impacts of trauma on brain development and employ a trauma-informed approach.

Eight Indigenous Lives

Eight of the young people who were subject of the expert panel review were Indigenous and from First Nations communities in Northern Ontario. The Panel took care to acknowledge the uniqueness of these young people, their families of origin and their communities in a way that acknowledged and honored the differences in their lives, experiences and needs. The majority of those communities are remote.

Key Findings

- The young people, their families and their communities were impacted by colonization, the legacy of residential schools and intergenerational trauma.
- There were significant structural barriers, a severe inequity for family and child services and limited access to specialized resources in the young people's home communities.
- Inadequate shelter, water and food in the young people's home communities was a striking feature of the young people from remote communities. Many of the young people did not have equitable access to education, healthcare, including mental health care, social services and recreational activities.
- There was a lack of culturally safe, trauma-informed approaches with a focus on early intervention, prevention and family supports.
- It did not appear that young people had a safe place to go on-reserve, when it was needed.
- Particularly after removal from home communities, young people were placed in environments with minimal connection to Elders, land-based teachings, traditional ceremonies and wholistic care, and their placements did not appear to acknowledge and/or provide for their cultural needs.
- Indigenous Child Wellbeing societies that serve young people and families in remote First Nations communities have distinct restraints to delivering services that other societies do not (e.g. large geographic areas, limited resources).
- Despite historical and current impacts of colonization, the legacy of residential schools and intergenerational trauma, Indigenous communities continue to persevere, to heal and to reclaim their culture and identity.

Summary of Observations

It was overwhelmingly clear to the Panel that there were significant structural barriers and limited access to resources in the young people's home communities. The Panel heard from Chief and Council in two communities that a lack of sustainable funding is a challenge. In particular, funding to support cultural healing programs was referenced. The inequitable access to resources has contributed to inadequate shelter, water and food. Many of the young people did not have regular access to education, healthcare, including mental health care, social services and recreational activities.

Indigenous young people with lived experience explained that their home communities are often without clean drinking water and fresh fruit and vegetables, resulting in a reliance on less expensive processed foods. They described over-crowded housing units without electricity and running water.

They talked about having no leisure activities available to them, and related this to young people's mental health and increased substance use. They noted that they need something to do to stay occupied; mentioning that their communities try to have activities available, but often, these are only available on special occasions.

Indigenous young people also described many positive attributes of their home communities - large extended families that they were close with, a sense of home and community, and the opportunity to learn their own culture, customs and language.

Similarly, the Elder panel members spoke of the importance of extended family and connectedness to family and culture. They observed a lack of culturally safe, trauma-informed approaches with a focus on parenting and family supports. The leadership in one of the communities discussed the intergenerational impact of residential schools in their community and familial sexual abuse. They indicated that in order to respond to intergenerational trauma, systemic barriers must be addressed and resources must be sustainable.

Overall, the young people, their families, and their communities were observed to have been impacted by colonization, the legacy of residential schools, and intergenerational trauma.

Indigenous young people reiterated this when they spoke of intergenerational trauma resulting from their family members growing up in residential schools. They explained that because their communities have a recent history of growing up without parents (in residential schools), they do not have any parenting skills. They described a lack of parenting supports and classes in, and appropriate to, their home communities. They talked about westernized parenting classes as "forcing a foreign model onto a culture." They suggested that a model where families heal together would be a better fit in their communities.

They talked about a community raising a child and noted that the nuclear family model is not in practice in most Indigenous communities. They also noted that parents are often told that they will get their children back when child protection services apprehend but they don't, contributing to mistrust of the societies in the communities.

The Chief and Council in three of the communities maintained that there needs to be structured, sustainable support on-reserve so that young people do not have to leave for services and if they do, they are supported in their transition home. Prevention services and family supports were rarely available, and it did not appear that young people had a safe place to go on-reserve, when it was needed.

Indigenous young people indicated that where there are prevention services in their communities, when families try to access those services it frequently results in an apprehension, which discourages involvement.

The Panel saw very little effort to provide wholistic care or to prioritize spiritual needs. When the Indigenous young people were removed from their homes, many of them were placed far

away from their home communities. Indigenous families and leadership from three communities spoke of the need to keep young people in their communities, or as close to home as possible. The Panel observed minimal connection to Elders, land-based teachings, and traditional ceremonies, particularly after removal from their home communities.

Indigenous young people spoke of the importance of connection to the land. They described wanting opportunities to go out on the land, and to hunt and fish, when they were away from their home communities. They described this as an important part of their culture and spiritual practices that were often missing when placed outside of their communities.

Indigenous young people described the culture shock that they experienced when they were removed from their communities – being expected to use transit systems, to adapt to the ways of urban life, and increased availability of alcohol.

The young people also describe facing racism in urban settings – having things thrown at them, being bullied, and being subject to negative comments in person and on social media often on a daily basis. They spoke about the use of alcohol to escape – they indicated that many young people “go out, get drunk and get lost” in the city.

The Panel acknowledged that Indigenous Child Wellbeing Societies that serve young people and families in remote First Nations communities have distinct challenges in delivering services that other societies do not. For example, the geographic jurisdiction of their caseload may be far larger and the resources in the communities far fewer.

Leadership in two communities and young people with lived experience explained that there are challenges related to confidentiality in small communities.

Young people described the close relationships between Society workers and mental health workers in their communities and the families they serve; indicating that in some cases it was felt that these relationships compromised the integrity of child protection investigations and decision-making.

The Panel suggested that funding to Indigenous communities should be based on the needs of each community and that programs and services should be designed, developed, and delivered by Indigenous communities so that they are more relevant and effective in serving young people and their families. Young people wondered whether a Gladue approach¹² could be applied to young people that come into care and whether a restorative justice approach could be taken to child protection within Indigenous communities.

¹² In Canadian sentencing laws, Gladue refers to the requirement that a judge pay particular attention to the circumstances of Indigenous offenders and to consider reasonable alternatives to imprisonment.

The Panel acknowledged the resilience of the Indigenous young people, their families and communities that were subject of the review; highlighting that despite historical and current impacts of colonization, the legacy of residential schools, and intergenerational trauma, their communities continue to persevere, heal and reclaim their culture and identity.

Specific Opportunities for Improvement

- Indigenous young people suggested that it might be better to remove parents from their communities for treatment and support, rather than apprehending young people.
- Indigenous young people should be taught about the history of residential schools, colonization, and patriarchy.
- In the event that it is not possible to place Indigenous children in their home communities, Indigenous language classes should be offered.
- The leadership in two of the communities indicated that there should be group homes in First Nations communities and there should be professionals who stay in the community, rather than coming in for a crisis and then leaving. They proposed that it would be beneficial to have a community liaison who knows how to navigate mental health systems.
- The leadership in two of the young people's communities noted that Jordan's Principle should always be applied; a concept with which the Panel agreed. Jordan's Principle is a child-first principle that aims to resolve jurisdictional disputes regarding payment for services between provincial/territorial and federal governments in a timely manner, so that services to First Nations young people are not delayed or interrupted.¹³
- The leadership in one Indigenous community maintained that community engagement is very important and communities should determine their own specific needs when funding is available. They should design, develop and deliver their own services to their home community.

**"I was always ashamed of being a Native person.
After learning about our ancestors I feel
empowered."**

Society Involvement & Placements

The Panel identified many commonalities in the young people's residential placements including: the distance of placements from their home communities, frequent placement transfers, and common practices and approaches when working with young people.

¹³Government of Canada (2018). *Definition of Jordan's Principle from the Canadian Human Rights Tribunal*. <https://www.canada.ca/en/indigenous-services-canada/services/jordans-principle/definition-jordans-principle-canadian-human-rights-tribunal.html>

Key Findings

- Many of the young people were placed far away from their home communities, making it difficult to stay connected to their families, communities, and cultures.
- Multiple placements negatively impacted young people's ability to build relationships and form healthy attachments with their caregivers, teachers, or any other adults.
- Multiple placements impacted young people's access to a meaningful education. Their absence from school environments contributed to social isolation and gaps in life skills development.
- Physical restraints and 1:1 supervision models are commonly used interventions in residential placements. There does not appear to be a shared understanding of the different intervention models, or a standard or consistent approach to them.
- The implementation of 1:1 supervision models appeared to be used in response to an immediate safety need and did not incorporate meaningful engagement and relationship building with young people.
- The value of 1:1 supervision to support young people beyond a short-term crisis is unclear, but many of the young people were subject to 1:1 supervision for long periods of time.
- There is no minimum standard for capacity, supervision, qualification, training and education for staff and caregivers.
- There is a need to better understand the risk factors, indicators and effective interventions for human trafficking.
- The youth voice is fundamental to the wellbeing of young people. Young people had minimal opportunity to have a voice in their care, their voices were not prioritized, and their attempts to communicate their needs were often overlooked, ignored and characterized as "attention-seeking."
- The basic needs of young people were inconsistently met.
- The poor quality of the care that the young people experienced throughout their lives had a profound impact on them.
- Young people were not meaningfully engaged in services or programs in the community, including educational programs and mental health services, for significant periods of time – they were often in their placements all day, with very little to do. There were indications to suggest that several of the 12 young people were at risk of and/or engaged in human trafficking.

Summary of Observations

Many of the 12 young people were placed far away from their home communities with the longest distance up to 1,600 kilometers.

Young people with lived experience described placements that were far away from their home communities. They spoke of seeking connection – to land, family (including siblings), community and language. They reflected on their desire to return to their home communities at the earliest possible opportunity; for many, this was age 16, when they left care because they wanted to return to their home community.

The Panel noted that when young people are no longer connected to their cultures, families, communities, education, and social supports, they are stripped of one of their strongest

safeguards – natural advocates. The Panel suggested that the further the young people were moved from their home communities, the more difficult it would have been for them to maintain connection to the people in their broader communities that cared and advocated for them, if they could not do so for themselves.

In addition, most of the young people had multiple placement transfers. The moves were often unplanned, resulting in emergency placement at the first available location. Sometimes multiple placement transfers occurred in a short period of time. For example, one young person was transferred 18 times in a 20 month period. The Panel and workers noted the challenges to providing quality care, building relationships, maintaining education, and forming healthy attachments with caregivers when young people are transferred so frequently. Society workers and staff from placements described apprehension from families and the trauma experienced by young people being transferred to a new placement.

Young people reiterated this sentiment and spoke of transferring placements with their belongings placed in garbage bags, describing this as a dehumanizing experience.

In addition to multiple placement transfers, young people talked about placement selection, noting that the children's aid society or Indigenous Child Wellbeing Societies "try to find a place to stuff kids." They described placement selections as being determined based on where there are residences, rather than on fit, and a lack of compatibility between placements and their needs – language, culture, and personality. They reflected on times when they felt they were not welcomed or accepted in already established families, and often felt treated as "a paycheck."

The Panel found that there were common approaches to interventions and practices in residential placements. One of these practices is to implement a 1:1 supervision model when a young person is considered to be at risk of harming themselves. The Panel observed that across residential placements, it did not appear that there was a shared understanding of how 1:1 supervision models are operationalized in residential placements. The staff from placements explained that typically, a 1:1 refers to a staff member providing constant eyesight supervision to a young person, until they are determined to be at a lower risk level. It was explained that the implementation of this practice requires extra staff to be working. This can present challenges when there is not enough staff available during a shift and it can interfere with the care of the other young people in a residence.

While the Panel recognized that there are circumstances where 1:1 supervision models are required to ensure immediate safety, it appeared that this was often the extent of the intervention. The Panel noted that at times, constant eyesight supervision can serve an immediate safety need however; to promote positive wellbeing and create an enriched environment for young people, the staff from placements and caregivers must also engage young people and build meaningful relationships with them. This does not appear to be part of the current approach to 1:1 supervision. The Panel also observed variance in the

implementation and cessation of 1:1 supervision models, noting that some of the staff making decisions regarding 1:1 supervision may not have had adequate training in this area.

Another common intervention in residential placements was the use of physical restraints. The frequency of physical restraints in the young people's residential placements was notably high and was the most common serious occurrence reported in a six month period. The Panel observed that there was inconsistency in the type of physical restraints used and the length of restraint with the longest restraint to a young person lasting up to two hours. According to the MCCSS Guidelines for Serious Occurrence Reporting, any restraint must be reported as a serious occurrence. As part of the report, the less intrusive measures that were used before the restraint must be described. The Panel found that there was variability in the interpretation and/or application of less intrusive measures and in the approaches to de-escalation before the use of a physical restraint.

The Panel, families, Society workers, staff from placements and young people with lived experience all spoke of staff and caregiver capacity in residential placements. Everyone acknowledged the level of skill, expertise, attention, and care that is required to support young people and the significant impact they can have on a young person's life; whether positive or negative.

The Panel observed that there was an absence of quality care in residential placements. The Panel noted that quality of care is influenced by staff and caregiver training, qualifications, education, compensation and a supportive workplace environment. In particular, the Panel observed that staff from placements, Society workers, and caregivers were not always prepared or enabled to support young people with mental health challenges, substance use, concurrent disorders, fetal alcohol spectrum disorder and/or complex trauma. The Panel also noted that there was significant variability in caregiver capacity. Society workers noted that staff working in residential placements often lack formal qualifications and frequently work part-time in multiple places to make ends meet given the low rates of pay.

Young people described staff in residential placements as lacking adequate training and that there are inconsistencies in group home standards for their staff (e.g. qualifications, education and training). They explained that specific skills are needed to support children and youth, and that staff capacity is an issue stating that, 'it can't be just anyone doing the job.' For example, a young person described that a group home may have multiple youth living with different diagnoses (e.g. oppositional defiant disorder, fetal alcohol syndrome, attention deficit disorder, anxiety, depression etc.). The young person explained that if there is only two to three staff working to support multiple youth with high needs, they are unable to provide adequate support.

Young people also explained that staff from placements have demanding jobs, leading to high burnout rates and staff turnover. They suggested that if efforts were made to make work less demanding, there would be more opportunity to be meaningfully engaged with young people.

There were indications to suggest that several of the 12 young people were at risk of and/or engaged in human trafficking when they were in a residential placement. The Panel recognized that this risk increases when youth do not have a solid and consistent support network. They indicated that human trafficking is largely misunderstood and that it would be beneficial for staff from placements, Society workers, caregivers and police to understand risk factors, indicators and effective interventions if they suspect a young person is being victimized. In

particular, the use of the internet and social media in luring young people into human trafficking must be explored.

Youth Experiences in Placements

The experiences of young people, while influenced by their identities, histories and where they come from, were also significantly impacted by their interactions with systems of care that were intended to serve them. The following details some of what Panel learned about their experiences in residential placements.

Many of the 12 young people did not appear to have had an opportunity to meaningfully provide input regarding their needs, desires and overall care. In some cases, it was apparent that they were explicitly exercising their voice and they were ignored. For example, there was written evidence of a young person explaining their trauma, struggles and perceived barriers to improving their circumstance. This person was doing everything within their power to have a voice, ask for help and articulate what they needed – both from individuals, and from the systems. The Panel observed that the adults within their sphere of care did not prioritize the young person's voice and did not adequately respond to their pleas for help.

While there was evidence of young people asserting their voice explicitly, the Panel also observed that there were numerous examples of their needs being communicated indirectly and being overlooked by Society workers, staff from placements, or caregivers. At multiple points in their lives, the young people communicated by 'raising flags' like self-harming, acting aggressively, or running away. Rather than interpreting these behaviours as communicating a deeper need and responding in-kind, it was, too often, responded to with a punitive approach, dismissed as 'attention-seeking' or, with a visit to the emergency department, or a transfer to a new placement.

Young people with lived experience identified many commonalities related to their placement experiences and the quality of care they received. Several of the young people in one geographic area shared experiences of sexual, spiritual and physical abuse at the hands of caregivers, as well as neglect.¹⁴

The young people indicated that they reported this abuse to their workers, only to have their workers be spontaneously changed without follow up. They indicated that the workers never acted upon their reports and concerns, which fostered a lack of confidence and trust. One of them said "I didn't know who to trust with my words after that." Another said, "No one comes at the end of the day for kids who cry abuse in the system." After disclosing abuse, the young people described a lack of documentation of their disclosures, which in turn led to an inability for them to pursue recourse through the judicial system. They described significant impacts of this abuse including, ongoing post-traumatic stress related to their placements, as well as night

¹⁴ Note that as these experiences were all reported in one geographic area, the former Ministry of Children and Youth was advised. As the incidents were historical and information regarding the caregivers' identities was not provided to the Office of the Chief Coroner, the incidents were not reported to a children's aid society.

terrors and other trauma-associated impacts, including an inability to accept or express compassion, or to “learn emotions.”

Young people also spoke of a general lack of thoughtful, attentive and intentional care. Workers, staff and caregivers were described as making young people feel like “just another paycheque.” They described being in care as living out of a suitcase, without a proper address and often being transferred to new placements. They spoke of group homes with “two to three people watching the house, smoking inside and inviting their friends over” (referring to caregivers) and of not being allowed to use the phone, or access anyone outside of the care setting for help. Young people referred to extended society care (formerly known as Crown wardship) as a primarily financial agreement; indicating that not all of their fundamental needs can be met with money.

Several of the young people’s families reported that they did not feel that their children’s placements were supportive, positive environments where they were really listened to. Some questioned whether Society workers prioritized the perspectives of placement caregivers over the perspectives of their kin when making decisions about their care.

A parent described their child to have been unhappy in their residential placement and to have been ‘just living there.’ A number of families reported that their children told them they were forcibly restrained whenever they were angry, that caregivers were ‘not nice’ or that they were threatened by their caregiver.

The Panel observed that young people’s basic needs were not always met. There were young people who were largely absent from the homes they were placed in, and it did not appear, based on available information, that anyone was aware of or concerned about how their time was being spent. The Panel observed that many of them were not meaningfully engaged in services or programs in their placements or in the community. There was little connection to day programs, youth centres, recreational and leisure activities and many instances with no access to education for significant periods of time.

Specific Opportunities for Improvement:

- The youth voice should be considered, valued and respected at all times.
- Young people should be placed as close to their home communities as possible, wherever this does not pose a safety risk.
- Priority should be placed on promoting long-term placements for young people where there are opportunities to form healthy, long-term attachments to adults.
- Society workers and staff from placements should take care to reduce the trauma of apprehension and placement moves as much as possible.
- More research is needed to understand the most appropriate use of physical restraints with young people.
- Staff from placements and caregivers should receive mandatory training in human trafficking, mental health challenges, substance use, concurrent disorders, fetal alcohol spectrum disorder, LGBTQI2S issues, Indigenous culture and culturally appropriate service delivery, and complex trauma for young people.
- Youth should be provided with opportunities to articulate their own needs and for those needs to be taken seriously. Children and youth should be informed of all processes and interventions concerning them.

- No young person should have to move with their belongings in a garbage bag.
- Through a screening process, it should be made clear what the expectations of foster parents are, and what the child or youth's expectations are. They should be matched accordingly.
- Young people should be grouped and housed according to their needs.
- Efforts should be made to make work less demanding for staff in children's residences, so that there are lower burnout rates, less staff turnover and there is more opportunity to be spent meaningfully engaged young people.

"I have always wanted to ask my workers, "What if you were in my shoes?"

"You can't just give someone a cheque and expect them to raise a child – it's more complicated than that."

Mental Health Care

All 12 young people that were subject of the expert panel review struggled with mental health challenges. The following section outlines the Panel's findings and observations of the mental health services provided to the young people.

Key Findings:

- Mental health care was fragmented, crisis-driven, reactionary, and in many cases, non-existent.
- There were concerns regarding the availability of long term and intensive mental health care; particularly for latency/early teenage youth.
- There is a need for wholistic, prevention-focused assessment and intervention that is delivered early-on. When a young person was experiencing mental health challenges, there appeared to be a tendency to connect them to hospital emergency departments or psychiatric services (where they are connected at all), without exploring or leveraging the availability of other services that could be beneficial to their mental health and wellbeing.
- There are striking inequities in mental health care availability in northern First Nations communities.
- There seems to be an assumption that the child protection system has the mandate and capacity to provide mental health care and/or to promote young people's mental health needs being met. The distinction between child protection services and mental health care are not clearly understood by families, children and youth serving sectors.

Summary of Observations:

The Panel found that there were commonalities in the young people's interactions with mental health care services. It was notable that the degree to which the young people and their families had access to mental health care varied considerably depending on their geographic location. This variability was also apparent with the experiences of the young people with lived experience and information received from families and Society workers.

Regardless of location, the Panel observed a lack of comprehensive, prevention-focused mental health care in all 12 of the histories reviewed. Throughout these young people's lives, there were identifiable points where early assessment and intervention may have prevented declining mental health and possibly, apprehension by a Children's Aid Society or Indigenous Child Wellbeing Society. Some of the young people's families reported requesting support for their children's mental health very early in their lives and noted that they were not able to receive what they needed. For those that received mental health care, it was often fragmented and short-term, though based on available information, longer-term may have been more beneficial.

Young people, families and Society workers identified lengthy waitlists to be a barrier to accessing mental health care. Multiple hospital visits prior to receiving care, or multiple hospital visits without any additional care, seemed to be a common experience for many of the young people whose histories were reviewed, in addition to those with lived experience.

Indigenous young people and the leadership in three of the young people's communities noted that counselling in remote First Nation reserve communities is complicated because of the small size of the population; workers are often community or extended family members acquainted with the young people and their families, causing concerns about confidentiality within the community and creating a barrier to accessing mental health services.

The Panel observed examples of young people who were involved with child welfare not because of child protection concerns, but because all mental health or developmental service options in their communities had been exhausted and families were not able to cope or meet the mental health needs of their children. Families reflected on their belief that the child protection system would be a pathway to mental health care for their children.

A young person explained that they went into care because of mental health challenges, after their parent contacted the Children's Aid Society numerous times to ask for support and to be connected to resources. This young person feels that if they had been able to get into supportive mental health programs early, it may have been possible to continue living with their parent.

In the histories of the young people reviewed, the Panel found examples of young people who appeared to have a developmental disability and did not receive an official diagnosis, despite descriptions of symptoms in the documentation. In other examples, young people were likely experiencing a developmental disability, and were being assessed as having mental health challenges, and treated as such. In particular, the Panel noted that there seemed to be a lack of understanding about the most effective treatment options and support for young people living with fetal alcohol spectrum disorder.

Both staff from placements and Society workers reported that when young people have involvement with child protection, parents and community service providers such as teachers, school boards, nurses, doctors, assume that their mental health needs will be met. They also expect streamlined access to mental health resources by virtue of this involvement. Each group explained that these are unrealistic expectations of the child protection system, and that consequently, young people's mental health needs are not being met.

Similarly, staff from placements and Society workers explained that in a crisis, young people are often discharged from hospitals because they are not considered at risk of suicide in that moment. For example, a young person who is consistently self-harming by cutting will be discharged because the doctor says 'cutting is rarely successful (in dying by suicide)' or they are dismissed as 'attention-seeking.' Staff from placements and Society workers described young people routinely being discharged without a safety plan. When a safety plan was recommended, it was usually to implement 1:1 supervision. Staff from placements noted that the implementation of this type of recommendation requires additional staff and approval from the Society that cannot be secured immediately, resulting in a gap in the safety of the young person. The workers and staff articulated the challenges this represents to providing sustainable responses and to preventing further mental health crises by securing long-term treatment for young people. The Panel observed that 1:1 supervision was often insufficient to keep young people safe, and provided no support to the young people in improving their mental health or wellbeing, calling into question the effectiveness of 1:1 supervision overall.

The Panel observed that all of the 12 young people should have had mental health assessments early-on and on a routine basis thereafter, however; many of them did not. Staff from placements explained that when young people are in crisis and are taken to the hospital, the degree and nature of assessment is reported to vary considerably, even where self-harm and suicide ideation are present. In some cases, the staff from placements reported that there are young people who are 'blacklisted' (a term reportedly used by hospital staff) from admission to the hospital. Placement staff members were of the impression that this meant young people would not be admitted or appropriately assessed when they presented in hospital in some circumstances. When asked, hospital staff did not confirm the use of the term, but explained that some young people do not benefit from hospitalization, and that the hospital often assumes that young people are receiving the support they need in their placements and/or through the child protection system. There was no information available to guide this determination.

While the Panel observed fragmented and reactive mental health care for some young people; they found a complete lack of mental health care for others. In particular, the Panel observed inequities in mental health care in northern First Nations communities. In some cases, there was no access to a doctor or a mental health worker in the community. In the event of a mental health crisis, young people would be taken to a nursing station. If young people were determined to need more care and support, they would be transported to the nearest city,

which was often a considerable distance away. Families and the leadership of one of the communities described the need for young people to receive culturally appropriate services. They also explained that when young people are removed from their communities for care, they struggle to maintain progress when they return to the same environment.

Young people explained that sometimes there are mental health workers in First Nations communities who are not formally trained, but can take young people out on the land, which can be of significant benefit to their mental health.

The Panel observed that where psychiatric services were unavailable in First Nations communities, young people were sometimes connected to psychiatric services through telepsychiatry. The Panel acknowledged that while this model can bridge immediate service gaps, without understanding the context of the community, it is challenging to make realistic, culturally appropriate and sustainable recommendations to support young people's mental health.

Indigenous young people from Northern Ontario candidly described suicide attempts, self-harming behaviours, and friends who had died by suicide. When asked about mental health supports, many of the young people were unable to articulate having ever been offered any form of mental health support. They described talking to their workers and being told to "get over it." They described foster parents that did not report suicide attempts to children's aid societies or others for months, because of concerns that the child would be removed from their care (which would have consequential impacts on the financial supports they receive). One young person described a suicide attempt by overdosing on medications; they indicated that they were mistaken for being intoxicated on alcohol and "thrown in the drunk tank overnight."

The Panel felt that the 12 young people subject of this review were often considered in isolation of their families, communities, environments and broader social structures surrounding them. It was suggested that wholistic, team-based mental health care, including assessments and treatment that consider the whole child (i.e. physical, emotional, spiritual, and mental) in relation to their environment could have benefited the 12 young people immensely. The Panel also felt that innovative therapies should be explored, and that in particular, innovative and original Indigenous ways should be supported and validated. With a wholistic approach to mental health, the impacts of intergenerational trauma, systemic racism, or socio-economic and structural barriers are less likely to be interpreted as mental health challenges that are particular to the individual young person.

The Panel and families discussed the need to better understand young people's use of the internet and social media and its relationship with their mental health. There were concerns about the internet being used to facilitate suicide pacts and incidents of cyberbullying. The Panel and families also recognized that while the internet sometimes presents safety concerns, there could be opportunities to better support young people through the internet and social media.

Specific Opportunities for Improvement:

- Wholistic, team-based and preventative screening and assessment tools should be developed at the local community level to enhance relevance, cultural appropriateness and effectiveness.
- Prevention of mental health challenges requires going beyond typical mental health care to include access to basic needs, education, recreation and community programs.
- Mental health care should consider the whole child (i.e. physical, emotional, spiritual and mental) in relation to their environment (family, extended community, etc.).
- More research and training with regard to opportunities and risk factors of young people's internet use. In particular, suicide pacts and cyber bullying.
- Some families identified the need for mental health care that is targeted towards young people who are survivors of sexual abuse.
- Mental health services should include traditional ceremonies appropriate to the community such as the use of feathers, sacred circle meetings and pipe ceremonies.
- When medication is used to treat mental health, it should be coupled with additional therapeutic supports.
- There should be a phased approach to transitioning out of mental health services.
- There should be more basic training for workers and caregivers to understand mental health so that it is not misinterpreted as behavioural challenges (e.g. anger).
- Out-patient treatment should be prioritized, wherever possible.
- Counsellors and workers should avoid having young people retell traumatic stories, wherever possible.
- Staff from placements suggested that extra support is required from hospitals to de-escalate and ensure appropriate follow-up care when a young person is in crisis, even if the young person does not need to be admitted to the hospital.

"I wasn't mad at the system, I was mad at the fact that I wasn't safe while I was in the system."

Service Systems

The interactions that the 12 young people and their families had with service systems greatly influenced their wellbeing. The following section will consider those service systems, how they intersected, and their impact on young people and families.

Key Findings:

- Young people did not receive enriched, meaningful or quality care with a focus on family preservation.
- Roles, relationships and communication structures in the child protection system are not clearly defined.
- There was an apparent lack of transparency and information sharing between Children's Aid Societies or Indigenous Child Wellbeing Societies, children's residences, and other child and family services.

- There was a lack of service integration at the local community level (e.g. schools, cultural programs, community recreation, and local supports and treatment).
- There is variability in access and availability of children's residential beds and treatment beds, and a lack of clarity regarding the meaning of a 'treatment bed'
- The overall cost to support young people in the child protection system cannot be ascertained and is not recorded in one consolidated place.
- The service systems the young people were involved with did not focus on family preservation.

Summary of Observations:

Service System Integration

The Panel found that the roles, relationships, and communication structures between the various serving organizations, and types of serving organizations (i.e. child protection and community mental health) were not clearly defined.

Oversight structures were also unclear. Staff from placements and Society workers seemed to have limited understanding of initiatives underway by MCCSS.

There appeared to be a lack of transparency and information sharing between societies and those providing care to young people in homes or residences, in particular Outside Paid Resources (many of which are for profit operators). Society workers and staff from placements explained that because there is no formal process for information sharing between societies and placements, important information about young people such as information from assessments and their historical and social context does not always make it to the frontline staff who support young people, creating a gap in their ability to provide quality care. The Panel noted that information sharing about placement availability and quality was limited and societies had variable access to residential and treatment beds. While interagency service protocols do exist, information sharing and communication still appeared to be an issue where multiple societies were involved with the same children and families.

The Panel noted that in some cases, jurisdictional issues between societies and other child and youth serving agencies caused a barrier to young people accessing the services they needed, or to accessing quality care. The Panel asserted that Jordan's Principle should be applied in all circumstances where jurisdictional boundaries cause delay in service delivery or impact a young person's care.

Many societies were perceived by other agencies in the community as having capacity to provide prevention services, protection services, and care to young people and their families. In some cases, societies endeavoured to provide a spectrum of services beyond child protection (i.e. prevention services), while others did not. Some societies formally deliver a continuum of services; these societies are referred to as 'multi-service agencies'. The Panel felt that one service agency should not be in a position to solely deliver both prevention and protection services however; the child and family services within many communities were fragmented thereby making an integrated service response challenging and creating a gap that some societies endeavour to fill.

There appeared to be a lack of clarity regarding the role of child protection, hospitals, community mental health, and secure treatment; and how they intersect when servicing the same young people and families. There was also an apparent lack of service integration at the local community level (e.g. schools, police, recreational programs, cultural programs, and local treatment). An example of service integration could be a cross-disciplinary team that meets to discuss the intersection of services for an individual, family, or community.

While there was a lack of integrated services in some of the communities, many remote First Nations communities had no access to resources and services. The Panel noted that when societies are the only service providers available in a community, families seeking support often come to their attention. The Panel felt that the absence of additional service providers in these communities likely contributes to the overrepresentation of Indigenous young people in the child protection system.

The cost to support young people in the child protection system and in particular, placements in outside paid resources is not recorded in any one consolidated place. The Panel proposed that recording this information would allow for a cost analysis to compare the current model with a wholistic, community-based wrap around service model. This would include the per diem rates for each young person, Special Rate Agreements, and the amount of hours each staff is working.

Experiences of Service Systems

The Panel observed that the young people did not receive quality care from the service systems they interacted with. There were examples of thoughtless and inattentive care from hospitals, schools, child protection workers, caregivers, and staff. The Panel felt that many of the young people were not consistently treated with dignity and respect and did not receive a basic level of care from many of the care providers they interacted with. Young people went months without education, were shuffled through placements without apparent thought to appropriateness, and were not engaged in enriched and meaningful environments.

Young people described their care as having a 'punishment-focus' rather than a 'correction-focus' that emphasizes strengths, solutions, and progress. They felt that services and supports were not personalized to focus on their individual needs and instead, they described being treated the same as any other young person with a similar family history or diagnosis. Young people reflected on having very few opportunities for positive activities to look forward to while they were in care (e.g. music events, sports events, etc.).

Staff from placements suggested that there should be more supports for young people who are transitioning out of care to independent living or adult services. Staff from placements spoke of the need for a phased approach that would require collaboration between the children's sector and the adult sector.

Young people echoed this sentiment when they reflected on their own transitions out of care. A young person talked about suddenly being in 'semi-independent' living because of their age, but not yet feeling ready for that level of independence. Following discharge from care, young people reported that there were no more casework visits and no follow up. Some of the Indigenous young people described their discharges from care as "being sent home", and noted that they give you a clothing allowance and other things when you're in care, but when you reach 16 "they throw you out."

The Panel found that in the 12 young people's cases, there did not appear to be a focus on family preservation in the service systems they interacted with. Families rarely received supports before their child was removed from the home, and the documentation did not suggest that Society workers, staff from placements, and caregivers facilitated or encouraged communication between young people and their families following apprehension. Many of the families described their communication with children's aid societies or Indigenous child wellbeing societies to have been sporadic; explaining that they were not informed of their children's care plans or of their overall wellbeing. Community representatives in four of the young people's communities identified the need for structured and sustainable support for families and communities both before apprehending and when young people return home.

Young people also described poor communication between children's aid societies or Indigenous child wellbeing societies and their parents/families. They felt that biological parents should get more visits with their children. Young people described that often parents are told that they will get their children back, but then they don't.

Indigenous young people from Northern Ontario explained that family service systems do not meet the needs of the families in their communities and suggested that traditional ways would be more effective. One participant noted, "We know that when people are connected to their communities they do better."

The young people articulated that there needs to be a process to help Indigenous young people based on traditional ways and said, “Don’t colonize the process, don’t colonize the solutions.” They also noted that government or any other social service should engage young people when their work impacts their communities. Engagement should start at the development and planning stage and follow through to implementation.

Specific Opportunities for Improvement:

- There should be increased coordination and information sharing between MCCSS, children’s aid societies or Indigenous child wellbeing societies, and placements.
- Systems at the local community level should be integrated, and should include health, mental health and wellbeing, education, recreation, child care, children’s mental health, early intervention services, prevention services, developmental services and other special needs services. This type of integration could involve a cross-disciplinary team with an identified lead.
- Jordan’s Principle should be applied in all circumstances where jurisdictional boundaries cause a delay in service delivery or impact a young person’s care.
- Integrated and community-based wrap around services with a focus on prevention and family preservation should be provided to children and their families.
- There should be resources available to young people as they age out of care.
- Traditional Indigenous approaches should be incorporated into child and family services because they are more effective in meeting the needs of Indigenous families in Ontario.
- When government or social services undertake initiatives with Indigenous communities, Indigenous young people should be involved from the beginning to the end. Once Indigenous young people have been engaged and have provided insight into an initiative, they should be regularly updated on the progress and the status of that initiative.
- Young people should be provided with more positive opportunities (e.g. music events, sporting events, etc.) while they are in care.
- Services and supports to young people should be personalized based on the individual young person’s strengths and needs.

“When kids get out (of the child protection system), there are suicides and drugs ...It’s not the kids, it’s not the staff; it’s the system that is failing us.”

System Oversight

The following section provides a summary of the Panel's findings with regard to oversight and accountability of the care provided to the 12 young people.

Key Findings:

- There are young people placed in residences that are not inspected by MCCSS.
- Despite commonly used terms for placement environments (i.e. group home, staff-model foster home, foster care treatment, etc.), there are no clear definitions for the differences between them or the distinct services that they may or may not provide.
- While licensing may monitor compliance with operational standards in the facility, there is no process to monitor the quality of care that is being provided to young people.
- There are no minimum educational standards or pre-service qualifications for staff working in children's residences.
- Training for foster parents and caregivers does not appear to be consistently updated to reflect the current needs of young people in care (e.g. mental health, substance use, developmental challenges, fetal alcohol spectrum disorder, human trafficking, and social media and internet use for young people).
- There are no mechanisms to monitor and track the length of young people's placements or the number of placement transfers they have incurred.
- Case files and documentation were disjointed with gaps in information, unclear service trajectories, discrepancies between agencies, and inconsistent definitions.
- Trends in serious occurrence reports and other documentation have not historically been monitored at the provincial level to identify opportunities for improvement.
- Documentation did not appear to focus on the young person's strengths or provide a sense of who the young person is.

Summary of Observations:

The Panel found that many residences, both licensed and unlicensed may not have been inspected by the MCCSS. This is because operators were issued a license based on 10 per cent of their homes. Of the young people subject of the expert panel review, two were residing in family homes under a customary care agreement; three were residing in agency operated homes that were not inspected by MCCSS licensors, one was residing in an unlicensed staff-model home, and six were residing in licensed homes, including group homes, residential treatment, and staff model foster homes.

The names used for different types of placements varied considerably and led to substantial confusion. The Panel observed terms such as group home, parent-model foster home, staff-model foster home, agency operated home, and foster care treatment are commonly used in child protection and children's residential services. Both the Panel and Society workers determined these terms to be misleading, because the constellations of the homes may or may not be materially different. For example, 'staff-model foster homes' and 'group homes' both have staff on rotating shifts supporting young people. Society workers, who are responsible for placing young people, explained that because of misleading terms, they do not always have a

full understanding of where they are placing young people, what the differences are between different types of environments, and whether certain types of placements are licensed or unlicensed. For example, if it is a treatment foster home operated by a Society that only has two beds, many workers will assume it is licensed when it is not. Agency operated homes caused particular confusion; workers did not understand licensing requirements, and when the Panel sought clarification from MCCSS as to the licensing of these environments, the response was also unclear—leading the Panel to the observation that agency operated homes exist in a grey space where no one is clear about licensing or accountability requirements. The Panel was not able to ascertain what the licensing process is for children's aid societies or Indigenous Child Wellbeing Societies, if any.

Where environments were licensed, the implications of licensing reviews and outcomes were not well understood by workers. Society workers explained that when a residence is provided with a 'provisional license' from the ministry, they are unaware of what the non-compliance issues were that prohibited the issuance of a full license. They explained that this creates challenges in matching young people based on their individual needs, noting that they would benefit from more transparency in the licensing process. Through a review of licensing documents, the Panel found that with the issuance of a 'provisional license', a children's residence may or may not have remaining issues pertaining to the safety of young people or the quality of their care.

Some of the residential staff expressed concerns regarding MCCSS' approach to licensing. They explained that the approach to licensing should be collaborative and supportive rather than punitive and compliance-focused. When MCCSS employees visit a children's residence for a licensing inspection, they are required to interview the young people residing there. Residential staff were concerned about the skill sets of the MCCSS employees that speak with children and youth. It was suggested that they should be required to have trauma-informed and child development training before interviewing young people.

The Panel found that while the current licensing model may promote compliance with operational facility standards, there are no systems in place to monitor and ensure that young people are receiving quality care in an enriched environment. Society workers and staff from placements felt that standards in children's residences need to be raised and need to be consistent. They took care to note that the standards should allow for the diversity in resources and practices across the province. The Panel felt that quality of-care standards were necessary as well.

The Panel observed that there are no minimum educational qualifications for staff in children's residences and inconsistent training for foster parents and caregivers to support the current and complex needs of young people (including mental health, substance use, developmental challenges, fetal alcohol spectrum disorder, human trafficking, social media and internet use).

The Panel also observed that there is no process to monitor the length of young people's placements or the number of placement transfers they have, which could serve as indicators of a young person's experience and wellbeing.

The Panel noted that every young person in care deserves the same level of review and accountability from oversight bodies. An extended society care review (formerly a Crown ward review) was referenced as an opportunity to monitor quality, however, the Panel observed examples of the reviews failing to identify challenges with young people's care. Since not all of the 12 young people were in extended society care (i.e. were not Crown wards), the Panel was

not privy to the same level of documentation for each young person that an extended care review can sometimes offer. Additionally, young people in long-term customary care are not subject to these types of reviews, which was seen as a missed opportunity to monitor quality for Indigenous young people specifically.

The Panel also indicated that there is a need for culturally appropriate oversight that is developed by Indigenous communities and takes into consideration structural barriers (e.g. lack of funding and resources, inadequate housing and infrastructure).

As part of the Panel's work, an extensive review of the documentation surrounding the 12 young people was completed. The Panel questioned what the intended purpose of some of this documentation (e.g. serious occurrence reports, incident reports) was and whether it was being used effectively. It was apparent that MCCSS has not historically tracked trends in serious occurrences at the provincial level, which offers the potential to indicate challenges in care and areas for improvement. There is work underway, however, to assess risk based on data in serious occurrence reports.

The Panel observed that documentation was disjointed with gaps in information, unclear service trajectories, inconsistent definitions and discrepancies of information between agencies. The approach to documenting incidents and serious occurrences was often inconsistent and occasionally careless. There were examples of sections that were copied and pasted, sometimes not even pertaining to the subject young person. In other cases, there was a complete lack of documentation, making it difficult to fully appreciate the young person's circumstances or their wellbeing.

Young people spoke of a lack of documentation, which in turn led to a perceived (and potentially actual) inability to report challenges with their care. For foster care operators with multiple residences, the operators often completed the report and the main office was recorded as the address, leaving the reader without any understanding of where the young person was actually residing. Unlicensed residences, including agency operated homes, are not required to submit serious occurrence reports to MCCSS. The Panel also noted that much of the case files and documentation do not give the reader any sense that staff or operators are taking a strengths based approach when working with young people and instead, the young person is often presented as difficult. Young people reiterated this perspective when they explained that serious occurrence reports created an opportunity for negative perceptions of young people to be fostered amongst staff.

The young people suggested that new staff in group homes should not read about serious occurrences until they have spent time with each young person, so that they can form their own opinions, instead of 'reading about us through someone else's eyes.' It was proposed that until new staff members have spent time with young people, they should only be informed of safety concerns. It was also noted that serious occurrence reports are one-sided and that they are written to show that staff did everything they could, sometimes missing context about the young person.

Specific Opportunities for Improvement:

- New staff in children's residences should not read serious occurrence reports until they have spent time with each young person, so that they can form their own opinions of them. New staff should only be provided with information that is necessary to ensure their personal safety, the safety of the young person and others.
- All young people should have an equitable review of their care and should receive equitable accountability from oversight bodies.
- There is a need for culturally appropriate oversight structures that consider structural determinants of care and where applied in Indigenous homes, should be developed by Indigenous communities.
- Measurable standards should be implemented in children's residences so that staff, operators and oversight bodies are able to understand what is expected of them and whether the standards are being met.
- Society workers suggested that the minimum standards in children's residences should be raised, however; they should allow for diversity in resources and practices across the province.
- Society workers suggested that there should be more transparency in licensing so that when placing young people, they have access to the areas of non-compliance in a children's residence's licensing reviews.
- Residential staff suggested that ministry representatives who are responsible for conducting licensing interviews with young people should be trained in child development and trauma-informed approaches.

"I was traumatized in the system – who is accountable for that?"



Section 3: Work Underway

Current Work Underway

The Panel was tasked with providing expert opinion on the extent to which current and forthcoming plans, activities, legislation, regulations, policies and practices, including the activities outlined in [Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services](#) and activities underway in the child welfare and children's mental health sectors address any issues or concerns identified here.

To support the Panel's understanding of current and forthcoming work, materials were requested from several organizations such as relevant policies and practices. Presenters with knowledge of the current system challenges and work underway appeared before the Panel to share information, insights and expertise. Presenters to the Panel included:

- Ontario Association of Children's Aid Societies
- Association of Native Child and Family Service Agencies of Ontario
- Ministry of Children, Community and Social Services
- Children's Mental Health Ontario
- Child Welfare Political Action Committee

In addition to these presentations and the supporting materials, the Panel also examined the activities outlined in [Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services](#) (Blueprint) in detail. While the Blueprint identifies some initiatives that are either complimentary or directly address the Panel's recommendations, the Blueprint's planned initiatives are being implemented in phases. Many initiatives are not expected to be in place until 2019-2020, and some not until 2025, which the Panel asserts is unacceptable. It is the Panel's overwhelming sense that the young people in Ontario's care are in precarious, unsafe situations now – they cannot wait another seven years for meaningful action.

Any work that is ongoing or planned for the near future was mapped against the Panel's recommendations and areas of concern. The Panel felt that the ongoing and planned work failed to adequately reflect a plan to address the major systemic issues identified during the course of their review and the recommendations being proposed.

The identified issues and the Panel's recommendations are not new; they have been asserted, endorsed and recommended by governments, service organizations, advocacy organizations, panels, commissions and bodies many times over the last 25 years and reflect best practices. Still, they have not resulted in sufficiently addressing identified challenges. Specific examples of recommendations made in the same areas can be found in:

- Because Young People Matter – Report of the Residential Services Review Panel (2016)
- Searching for Home: Reimagining Residential Care (2016)
- Doing it Right Together for Black Youth (2018)
- The Office of the Chief Coroner's Death Review of the Youth Suicides at the Pikangikum First Nation (2006-2008) (2011)
- Truth and Reconciliation: Calls to Action (2015)
- The Office of the Chief Coroner Inquest – First Nations Youth (2016)
- Report of the Royal Commission on Aboriginal Peoples (1996)

The Panel asks that those in positions of power and influence who are responsible for the functioning of the systems be accountable for fixing them; that they take the lessons learned from the deaths of these young people and utilize them to ensure timely, meaningful change.



Section 4: Recommendations

Principles

The Panel identified ten principles that underpin their recommendations:

1. All young people must be involved and at the centre of their care, and given the ability to influence their care based on their knowledge of themselves and their situations. Their voices must be heard, believed and prioritized.
2. All young people must have the opportunity to learn about, understand and experience their history, culture and its customs and teachings.
3. The care of and service provision to young people, families and communities must be wholistic, prevention-focused and driven by their needs. It must ensure that the physical, mental, emotional and spiritual needs of young people are met.
4. Indigenous communities must be enabled, supported and funded to bring forward their needs and to further develop their methods of addressing their needs.
5. Indigenous communities must be enabled, supported and funded to self-govern in a nation-to-nation relationship with Ontario.
6. Caring is an action. Care must be provided with a continued sense of purpose and a focus on the young person's future.
7. Caring is a shared responsibility that crosses organizational, sectoral, geographic and jurisdictional boundaries. Barriers between systems must be eliminated or be made unnoticeable to clients.
8. Children must be kept at home wherever possible – and when it is not possible, they must be in stable, nurturing placements for as long as required with as few moves and transitions as possible.
9. Services must be provided to young people and their families where they are, wherever possible. Where it is not possible, distances should be minimized.
10. All young people must be in school or participating in equivalent learning

Recommendations

The Panel developed five recommendations they believe would make a fundamental difference to Ontario's young people and the overall burden on Ontario's social service system – now and over the longer-term.

To the Government of Canada and the Government of Ontario:

1. Immediately provide equitable, culturally and spiritually safe and relevant services to Indigenous young people, families and communities in Ontario.

Specifically:

- a. Address structural barriers to wellbeing and ensure that every Ontarian, including those living on-reserve, has access to food, clean water, housing and education.
- b. Enhance service availability in Indigenous communities; specifically, the availability of safe placements for young people on-reserve, in environments identified by the communities.
- c. Provide equitable resources to design, develop and deliver culturally safe family care, a range of prevention and ongoing support services and to build local capacity for early response to needs.
- d. Enable Indigenous Child Wellbeing Societies to develop their own models of care while maintaining current models, and allow for transition period and supports while implementing Indigenous preferred models of care.
- e. Provide funding and programming to support family healing from intergenerational trauma in Indigenous communities.

Comments from the Panel:

Eight of the young people reviewed were Indigenous. All eight were from reserves in Northern Ontario; many of those reserves are remote. Those whose families of origin were located on-reserve were notably more disadvantaged amongst the group of young people reviewed by the Panel.

In several of the cases reviewed and in feedback received from young people with lived experience, it was clear that there are stark and startling inequities and structural barriers that limited these young people's potential. In some cases, access to food, clean drinking water, and/or adequate housing were unavailable. Likewise, access to education, recreation and healthcare was either limited or unavailable. The Panel asserts that where basic needs are unmet, the capacity of families and communities to adequately support and care for each other is severely compromised.

This capacity is further impacted by historical and current colonialism and intergenerational trauma that remains inadequately addressed in many Indigenous communities including the home communities of the young people reviewed by the Panel.

It is the assertion of the Panel that until such time as these inequities are resolved and Indigenous communities are supported and enabled to heal and implement their preferred models of care, their young people will continue to be at disproportionate risk of severe and ongoing disadvantage, harm and of admission to care.

To the Ministries of Children, Community and Social Services, Education, Health and Long-Term Care, and Indigenous Affairs:

2. Identify and provide a set of core services and support an integrated system of care for young people and their families across a wholistic continuum, to every child in Ontario. Services must include health, mental health and wellbeing, education, recreation, child care, children's mental health, early intervention services, prevention services and developmental services. Service provision should be geared to the needs, and intensity of needs, of each young person and family.

Specifically:

- a. Undertake community needs assessments to identify service gaps and opportunities for service realignment against the identified set of core services.
- b. Address systemic pressures, inequities and gaps in the availability of mental health treatment beds for young people.
- c. Define and make public standards pertaining to the geographic availability of each core service.

Comments from the Panel:

The Panel observed that none of the twelve young people, their families or communities received coordinated and integrated care from the outset of their involvement with the systems designed to protect, safeguard and help them – including child protection, children's mental health, developmental services and other service organizations. In all of the histories it was clear that service providers were not communicating with each other or taking a collective view of the young person's needs, resulting in gaps in care. Education did not appear to have been a priority focus and there was frequently a lack of detail regarding the educational experiences of young people. This made it difficult to determine the degree to which they had access to education or educational models that could meet their needs. The provision of mental health care was particularly infrequent, and in some cases, nonexistent in the face of obvious and identified needs.

Many of the young people reviewed by the Panel interacted with multiple systems of care. The services they received were fragmented and more often than not, service provision was driven by the structures and systems in place, rather than the needs of the young people, their families and communities. For example, in many cases child protection services facilitated the pathway to children's mental health services or counselling, because they were the most adequately equipped service provider in a geographic area. In other cases, there was an absence of structures in place that limited service availability so severely that young people, their families and communities did not receive, and often were not offered, the services that were necessary. This experience was most pronounced in Indigenous communities in the Far

North, but was not exclusive to those populations. The Panel observed similar limitations and barriers in Southern Ontario and non-Indigenous contexts as well.

There appeared to be minimal capacity across Ontario to respond to these 12 young people's multiple complex needs including, but not limited to their mental health needs. It is clear that some young people in Ontario require specialized mental health treatment placements. The availability of mental health treatment beds is declining in Ontario and is inconsistent across the province. Ontario should plan for and meet anticipated needs for these types of services to ensure that young people do not fall through the cracks and are not placed in inappropriate environments as a result of the lack of specialized treatment placement options.

Many of the young people reviewed did not have access to important services within a reasonable geographic distance, which resulted in frequent moves, or lack of access. While the Panel recognizes that not all core services can be provided in each community in Ontario, standards should be in place regarding maximum distances for core services. For example, schools should be available in each community in Ontario, including each First Nation.

3. Develop a wholistic approach to the identification of, service planning for and service provision to high-risk young people (with or without child welfare involvement) that supports continuity of care to age 21.

Specifically:

- a. Develop and implement wholistic, standardized screening of all young people that come into contact with child protection societies at the point of first and each subsequent involvement, to identify those who are high risk.
- b. Undertake a comprehensive assessment of the needs of the identified high-risk young person at the earliest opportunity.
- c. Provide a Navigator for each young person identified as high risk, to act as a stable relationship in the young person's life, a natural advocate, the lead amongst service providers and the person responsible for planning to enable continuity of care.
- d. Establish local transdisciplinary teams responsible for service planning for young people identified as high-risk youth, regardless of ongoing child protection involvement. Include the Navigator and Indigenous Elder(s) as part of the team.
- e. Enable information sharing amongst service providers based on mutual service provision, regardless of the presence or absence of client consent.

Comments from the Panel:

Many of the young people reviewed were undoubtedly at high risk, but did not appear to have been assessed as such. While risks to safety and harm were assessed frequently during child protection intervention using the child protection required tools, the tools were not intended to, and therefore did not, identify the constellation of factors involved in their personal circumstances as high risk; child protection interventions did not appear to consistently do so either. Many of these young people were at high risk for reasons that were not directly associated with the reasons for child protection intervention (e.g. their cognitive ability, presence of multiple complex needs, minimal supports) and may not have been best serviced

by child protection intervention – though in some cases, no other providers were actively engaged. The long-term risks to the young people’s wellbeing, and the predictable outcomes if services to address them were not provided, do not appear to have been considered in many cases.

The Panel is recommending the development and implementation of a standardized and consistent screening tool to better identify young people at high risk who may be vulnerable and/or require more intensive service provision. Many screening tools exist that could be adopted or modified for this purpose within a short time frame. In addition, options for the administration of the tools should be explored; many tools could be administered by trained people in the community, and would not have to be administered by Society employees or others with professional skill sets – an option that could reduce the overall cost and administrative burden of implementation.

Once identified, understanding the needs of young people is vital to providing services that are responsive to their needs. In the majority of the histories reviewed, there were significant and serious gaps in knowledge and understanding of their needs. In some cases, assessments were never completed or completed but not followed through.

Comprehensive assessment of young people will help ensure an ability to identify what their needs are and which service providers should be involved. The Panel felt strongly that being high risk does not automatically infer that placement is required, though this was seen to be the case in many of the histories reviewed. This model is intended to support early identification and intervention, thereby preventing risk of harm and avoiding placement outside of homes of origin whenever possible. This could take the form of ongoing, in-home family support intervention.

The establishment of a transdisciplinary team in a circle of care model will support a collective understanding of what is available, possible and feasible for the young person. It will also provide clear delineation of responsibilities based on a philosophy of shared responsibility and knowledge. Teams should support planning for young people and their families as well as service provision, and should hold each other accountable. They should be customized based on what is available in each community, but should include all core service providers (see Recommendation #2) and all other relevant service providers (e.g. educators, Elders, teachers, mental health and addictions service providers, youth justice, social work, psychology, psychiatry, etc.). Elders should be included in each community to inform service planning and provision to Indigenous young people. Participation should be mandatory and information sharing amongst team members should be enabled. Input from the young person and their caregivers should be incorporated into service planning.

The Panel found that young people did not have advocates as a result of multiple placements and their distance from their home communities and natural support systems. Consequently, the Panel recommends that where a young person identified as high risk, requires multiple services and supports and/or is experiencing frequent placements a “Navigator” should be assigned to support them until age 21. The Navigator becomes the person responsible for leading and facilitating a wholistic approach to planning and service provision. The Navigator would provide a stable relationship and would act as the point of contact as well as an advocate for the young person. They should be responsible for guiding care planning, delivery and enabling continuity of care. In order to adequately fulfil this role, Navigators should have

facilitation and case coordination skills as well as experience working with young people and families.

4. Strengthen accountability and opportunities for continuous improvement of the systems of care through measurement, evaluation and public reporting.

Specifically:

- a. Collect, link and integrate data across all children's services (whole of government approach) to facilitate accountability and enable evidence-informed treatment models to be put in place.
- b. Identify indicators and outcome measures to enable assessment of youth experience, measure and publicly report on them.
- c. Institute mandatory public reporting on placement availability and placement achievement of quality standards.
- d. Streamline documentation completed by children's aid societies and Indigenous Child Wellbeing Societies so that necessary information is recorded accurately and in a timely fashion.
- e. Fund evaluation of service delivery explicitly.

To improve the system, we must first be able to understand its' complexities.

Over the course of the Panel's work, several different pieces of data were requested from the former Ministry of Children and Youth Services (now MCCSS). Detailed review revealed that there were several challenges pertaining to data collection. Data is not collected in several areas that the Panel considers key – for example, no data is collected in a standardized way on number of placement moves or the cost of a day of care in a particular type of placement setting. It did not appear that the data collected would enable the ministry to have a sound understanding of service availability, provision or total cost in order to exercise good governance and fiscal oversight.

Furthermore, the data that is available is not linked to data from other ministries; so, for example, it is not possible to electronically determine the placement dates of stay for a child that moves between a residential placement and hospital (either inpatient, or more frequently, emergency department visits) or to align it with a child in care's educational history based on Ministry of Education's electronic records. The absence of this information, both at the individual and aggregate levels, results in serious gaps in the ability to assess outcomes, service experience, service availability, provision and total cost.

While service availability and provision are important from an accountability perspective, so too is performance. The Panel found no evidence in the material reviewed that service availability, provision or performance are well understood from a systemic perspective. Consequently, the Panel is recommending that data be collected, linked and integrated across all services to facilitate accountability and enable evidence-informed treatment models to be put in place. Furthermore, the Panel is recommending that service agencies be funded to conduct program evaluations, separate from their core funding, to help assess efficacy and inform continuous improvement.

At the core of service provision to young people is a desire to improve their wellbeing. The current system does not provide a great deal of information on how young people in the province's care are doing. Children's Aid Societies and Indigenous Child Wellbeing Societies are required to publicly report five performance indicators reflecting the safety, permanency and well-being of children and youth. Only one indicator pertains to wellbeing; the quality of the caregiver-youth relationship for children in care (the others pertain to safety and permanence). There are several limitations on the use of this indicator and the population that is measured is quite small relative to the number of children and youth that have child welfare involvement. The Panel suggests that additional indicators and outcome measures to assess youth experience are required.

In addition to how young people experience their care, it is also important to measure the quality of the care. The Panel recommends that the ministry institute mandatory public reporting on placement achievement against defined quality standards (see recommendation #5).

Independent of quantitative data that is collected, qualitative data is also routinely collected through mandatory documentation completed by Children's Aid Societies and Indigenous Child Wellbeing Societies. This documentation is meant to inform service planning and provision, as well as reporting to the ministry when serious incidents occur. In the comprehensive review of the files associated with the 12 young people, it became clear that in many instances, the documentation was completed for the sake of completion, rather than for its intended purpose. This conclusion was based on the sheer volume of repetitive entries that were seemingly cut and pasted and the presence of information that did not relate to the subject youth in a number of instances. Another issue was that the reports were often filed later than the required timeframes. The Panel recommends that the Ministry conduct a review of the documentation that is completed, and streamline it where possible so that necessary information relevant to the subject young person may be recorded in a timely fashion.

To the Ministry of Children, Community and Social Services:

5. Immediately enhance the quality and availability of placements for young people in care.

And specifically:

- a. Establish quality of care standards for all placement environments, identify clear mechanisms to achieve the standards, and measure and monitor to ensure implementation and ongoing maintenance. Standards should also apply to any auxiliary programs or services offered by the placement.
- b. Undertake a government-led planning process to plan for and implement placement availability across Ontario, based on identified need, and establish clear and transparent placement access mechanisms.
- c. Issue a Directive to Children's Aid Societies and Indigenous Child Wellbeing Societies that directs societies to place young people:
 - a. In licensed care environments only;
 - b. In the highest quality placement available;
 - c. In environments that are able to meet the identified needs of young people;

- d. With a view to stable, nurturing placements for as long as required that ensure as few moves and transitions as possible; and
- e. As close to their home communities as possible, where this does not present a safety risk.
- d. Expedite the development of a human resource strategy for the residential placement sector to address recruitment, retention and skills of caregivers. The strategy should include:
 - Pre-service educational qualifications/standards for staff of placement environments
 - Mandatory pre-placement training to foster and customary caregivers including, information on support to young people with mental health challenges, fetal alcohol spectrum disorder, developmental challenges, substance use, the impact of social media and the internet on young people, and human trafficking.
 - A northern recruitment and retention strategy across all children's services to support the development of a local, skilled workforce based on a needs assessment.

The majority of the Panel's recommendations focus on supports that optimize the potential for young people to stay at home with their families. The Panel recognizes that when safe care cannot be provided in the home, out-of-home placements are a necessity. The Panel felt strongly that safe, high quality placements that are as close to home as possible should be available for the young people who need them.

The Panel's review found that placements appeared to be selected based on availability rather than on suitability. Placement availability and access mechanisms were not well understood, their quality varied considerably, their licensing status was variable, difficult to understand and inconsistent across the Province, and those responsible for caring for children were under-skilled for the task.

The Panel does not believe that the current licensing system provides insight, monitoring, accountability for quality of care in placement environments, and notes that quality of care standards are distinct from licensing standards.

Many placements offer auxiliary programs and services in addition to being a place of residence. These sometimes include section 23 education classrooms, mental health services or other programs. Quality of care standards should also be in place, measured and monitored for these programs and services, where they are provided.

It was also clear that the current system does not direct the availability of and access to placements based on predictable need close to young people's home communities. The Panel suggests a government-led process to identify need, plan for and implement availability of licensed placements to better facilitate equitable access in a cost-efficient manner.

The Panel noted that a workforce development strategy is going to be under development by the ministry, with implementation planned for 2025. The Panel asserts that having skilled workers taking care of young people in licensed placements should be a key priority, and that work towards achieving these improvements must begin immediately in order to mitigate risk to the young people in Ontario's care.

“A lot of these recommendations seem like basic human rights.”

Youth Responses to Recommendations

Three groups of young people with lived experience were brought together in Kenora, Thunder Bay and Toronto to provide insight in support of the Panel’s work. Following the Panel’s meetings, the groups were brought back together. Staff of the OCC shared the Panel’s recommendations with them, and asked how the recommendations could impact youth experience and, if implemented, they would make things better.

Overwhelmingly, the young people were supportive of the recommendations. They felt that if implemented, the actions suggested by the Panel would have a positive impact on the wellbeing of young people in their communities.

Some of the things the young people highlighted in relation to the recommendations were:

Equal opportunities for culturally and spiritually safe, and relevant services to Indigenous young people, their families and communities.

Indigenous young people asserted that it is important that their basic needs are met. They noted that the United Nations Declaration on the Rights of Indigenous Peoples should be honored and implemented in Ontario, and these rights should be taught to Indigenous young people early in life.

They commented on the need for mental health services on-reserve to be available 24/7, and for service providers to be consistent; explaining that calling in help takes days and often times, people cannot wait that long. They also explained that communities need more education on suicide prevention.

Young people explained that services should be available in the Indigenous languages spoken by the people they serve. Service providers should be committed to long-term service provision in communities and should be culturally informed, qualified, and prepared for what living on-reserve is like. They spoke of the importance of service providers working in their communities for the ‘right reasons,’ not just to make money.

They explained that standards for Indigenous homes should be different. Extended families are important in Indigenous communities, and they could care for young people when their parents are unable to.

They asserted that non-Indigenous and Indigenous people should work together and suggested that non-Indigenous government employees should visit reserves, before making policies and programs that affect people living there.

They emphasized the need to apply Jordan's Principle, and explained that young people should be given opportunities to understand it.

Core services and an integrated system of care:

Young people highlighted the need to be connected to services before they transition out of care and suggested that an aftercare program would be helpful.

Substance use treatment services, counselling and traditional healings services for Indigenous young people were identified as particularly necessary.

Young people suggested that access to education should include access to opportunities outside of mainstream education as well.

Young people explained that mental health diagnoses should be a priority, however; young people should not be shuffled through multiple doctors because this can result in a 'sea of diagnoses,' negative labels attached to them and being heavily medicated.

Identification of, service planning for and service provision to high-risk young people:

Young people indicated that some young people are high risk because of their parents so it is important to heal both the parents and the children.

Many young people were in agreement that service providers should be able to share information about the services being provided to high risk young people. However, some had concerns about sharing confidential information provided in a counselling context amongst service providers, noting that trust is a significant issue and sharing without consent can compromise that. Young people warned that service providers would need to take care not to disclose information that young people share in confidence, unless it is for necessary for safety reasons.

Young people shared their feedback on the role of a Navigator for high risk young people. Most felt that the Navigator would be a useful resource and liked the idea of having someone "in their corner." Others asserted that if there is a Navigator, they must be 'fighting for the young person and no one else' instead of working on behalf of the foster parent, staff, or other service providers. Some young people felt that this is the role of the Society worker and worried that if there was another type of job, there would be even fewer workers available to do Society work. They felt that whether there is a Navigator or not, there needs to be work to improve Society worker turnover so that young people are able to establish relationships and build trust.

There was a suggestion that the Navigator role should also monitor medication changes in young people because they can occur frequently and are often overlooked or are not well monitored.

There was also a suggestion that there could be a partnership with the organization Big Brothers, Big Sisters in order to identify Navigators.

Strengthened accountability and opportunities for continuous improvement:

Young people with lived experience from all over Ontario need more opportunities to provide input and there should be more youth outreach. In particular, young people in foster homes should be asked how they are doing and their voices should be heard.

Some young people felt that evaluations of service delivery would not mean anything because they felt it was unlikely anything would change as a result.

Some young people were very supportive of licensors doing unannounced visits to children's residences; work to implement this type of oversight is currently underway by the MCCSS.

Enhanced quality and availability of placements:

Young people felt that the child tax benefit should stay with the child, instead of it being provided to Societies. They saw this as a violation of their rights.

Young people asserted that placements outside of home communities don't allow young people to maintain connections with their families and should be avoided. They suggested that there should be a deeper understanding of a young person's needs when they come into care so that placements can be matched accordingly and are based on need rather than availability. They highlighted that there should be a focus on the differing needs of young people in placements. For example, if one young person has higher needs than others, the staff or caregiver's attention can be occupied by supporting them at the expense of the needs of others in the residence.

If transferring placements (and it is not an emergency), the transition should be slow and thoughtful with visits to the new placement in advance. They noted that multiple placements can be 'damaging' to a young person's wellbeing, and that anything to make placements stable and long-term will be helpful.

There should be more effort in residential placements to understand the roots of a young person's behaviours instead of immediately responding with a restraint or a type of punishment. Further, there is a need to monitor the frequency of restraints used in children's residences and the effectiveness of restraints as an intervention.

Licensing all homes was viewed by all of the young people spoken to as important. In some communities, there are not enough foster homes available. If the solution is to have more group homes, all group homes should provide high quality care.

Training for caregivers was strongly supported. In particular, some young people felt that caregivers should have training to understand what considerations are needed to support LGBTQI2S young people.

**"It shouldn't take 12 deaths for somebody to care.
It's been a broken system for years."**

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Elders:

Sherry Copenace
Helen Cromarty
Stella Schimmens
Sam Achneepineskum
Gilbert Smith
Wabagoon (Patti Phipps-Walker)

Panel Members:

Sherry Copenace
Helen Cromarty
Aryeh Gitterman
Joanne Lowe
Kim Snow
Nathan Scharf
Stella Schimmens

Key Informants:

The 13 young people with lived experience
The families of nine of the 12 young people that were the subject of review
Chief and Council from four communities
Five staff from Children's Aid and Indigenous Child Wellbeing Societies
Five staff from placement settings

Facilitator:

Adair Roberts

Records Reviewers:

Janice May
Sandra Frampton

Presenters:

Amber Crowe, Dnaagdawenmag Binnoojiiyag Child and Family Services
Dr. Rebekah Jacques, Child Welfare Political Action Committee
Sally Johnson, Ontario Association of Children's Aid Societies
Mark Kartusch, Highland Shores Children's Aid Society
Jane Kovarikova, Child Welfare Political Action Committee
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Kimberley Moran, Children's Mental Health Ontario
Ragaven Sabaratnam, Ministry of Children, Community and Social Services
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Corrie Tuyl, Ontario Association of Children's Aid Societies

Supports to the Youth Advisory Groups:

Catherine Cheechoo, Nishnawbe-Aski Nation
Ruth Hislop, Ontario Child Advocate's Office
Esther McKay, Nishnawbe-Aski Nation
Abdi Mohamud, on behalf of the Ontario Child Advocate's Office
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Victoria Snowden, Office of the Chief Coroner

Appendix 1: Acronyms, Short Forms & Definitions

Agency Operated Home (AOH): A home operated by a Children's Aid Society or Indigenous Child Wellbeing Society. May be licensed or unlicensed.

Child, Youth and Family Services Act (CYFSA; the Act): The Child, Youth and Family Services Act governs many of the province's programs and services for young people, including child welfare, youth justice services, secure treatment, children's developmental services, residential services, community support services, Indigenous child and family services and adoption within Ontario.

Child Protection Services: Under the Child, Youth and Family Services Act, the functions of children's aid societies and Indigenous Child Wellbeing Societies are as follows: investigate allegations or evidence that children are in need of protection, to protect children, to provide guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children, to provide care for children assigned to its care, to supervise children assigned to its supervision, and to place children for adoption.

Customary Care Agreement: An Indigenous model of child protection services where a child is residing with someone who is not a biological parent. Customary care agreements are voluntary and involve signatures and consent from parents, Band/council members in the child's community, and the serving Society. The model of customary care varies depending on the young person's band, First Nation, Métis, or Inuit community.

Gladue: In Canadian sentencing laws, Gladue refers to the requirement that a judge pay particular attention to the circumstances of Indigenous offenders and to consider reasonable alternatives to imprisonment.

Jordan's Principle: Jordan's Principle is a child-first principle that aims to resolve jurisdictional disputes regarding payment for services between provincial/territorial and federal governments in a timely manner, so that services to First Nations young people are not delayed or interrupted.

LGBTQI2S: Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex, Two-Spirited.

Outside Paid Resource (OPR): A for-profit organization operating group and/or foster homes. Homes may be licensed or unlicensed.

Per diems: The rate per day that an operator can charge the placing Society for a child occupying a bed in a children's residence.

Society: Children's aid society or Indigenous Child Wellbeing Society designated under the Child, Youth and Family Services Act.

Special Rate Agreement (SRA): Funding provided to an operator that is above the per diem rate. Special rate agreements cover the costs of caring for a young person who requires extra supports to meet their needs.

Temporary Care Agreement: When a parent is temporarily unable to care for their child, this is an option for the serving Society and parent to enter an agreement for the Society to provide temporary care and custody to the child

Transfer Payment Agency (TPA): an agency that receives a direct transfer payment from the Ministry of Children, Community and Social Services and has a contractual agreement to provide group care or foster care to young people.

Young Person in Extended Society Care / Crown Ward: A child who has been placed in the permanent care of a Children's Aid Society or Indigenous Child Wellbeing Society.

1:1 Supervision: The ratio of staff working with a young person. Generally, a 1:1 supervision model is implemented when a young person is determined to be at risk of harming themselves or others.

Appendix 2: Expert Panel Biographies

Sherry Copenace - Niizhoosake, Saagimaakwe (Anishinaabe/Spirit Names), Atikdodem (Elk Clan), Midewin

Ms. Copenace was born and raised on the community of Ojibways of Onigaming. Ms. Copenace is firm in her ways of knowing and being Anishinaabe. Ms. Copenace speaks her original Language - Ojibway and has a great love for the Land, Waters and Peoples. Since 2011, Ms. Copenace has organized Makooskewin- Anishinaabe young women coming of age teachings and ceremonies. She is part of a Grandmothers Circle with Nanadawegamig (FMHSSM). Ms. Copenace has over 25 years' experience in Indigenous social services and has her MSW degree. She is currently employed at the University of Manitoba in the MSW-1K program.

Helen Cromarty

Ms. Cromarty is an Elder from Sachigo Lake First Nation. Ms. Cromarty began her education as a residential school student and attained her HBScN degree from Lakehead University. During her 45-year career as a nurse, she worked ICU-CCU for 23 years. Following this, Ms. Cromarty was a Health Policy Analyst/Health Liaison at Nishnawbe Aski Nation (NAN) and Special Advisor for First Nation Health at Sioux Lookout Meno Ya Win Health Centre (SLMHC). Ms. Cromarty was in many leadership roles in the development and implementation of health care programs and services delivered throughout NAN and Ontario. Ms. Cromarty has been recognized for her work in First Nations Health by the Aboriginal Nurses Association of Canada, Nishnawbe Aski Nation, and the Chiefs of Ontario. Ms. Cromarty received an Honorary Doctor of Science from Lakehead University in 2016. Ms. Cromarty is a residential school survivor, friend, sister, aunt, mother, and Kookom (grandmother). Her husband, Dennis Franklin Cromarty, passed away February 3, 1993. She is proud of their five children and a very proud Kookom of three beautiful girls.

Aryeh Gitterman, Ed.D.

Dr. Gitterman is currently a Distinguished Visiting Scholar in the School of Child and Youth Care, Faculty of Community Services at Ryerson University.

From 2007 to 2016 Dr. Gitterman was an Assistant Deputy Minister (ADM) in the Ontario Ministry of Children and Youth Services (MCYS). While at MCYS Dr. Gitterman was responsible for policies and programs for: autism, community-based mental health, child protection, special needs, residential services, and the poverty reduction strategy.

Prior to joining MCYS, Dr. Gitterman was ADM of the Instruction and Leadership Development Division, and the Business and Finance Division in the Ministry of Education. While at Education he was responsible for policies and programs for: secondary schools, teacher quality, leadership development and safe schools.

Dr. Gitterman has presented at numerous meetings and conferences regarding education and children's policies. Some examples: OECD, IMFAR (International Meeting for Autism Research), Asian Development Bank, American Educational Research Association, SickKids, World Bank, CAMH, Children's Mental Health Ontario.

Dr. Gitterman began his career at the Scarborough Board of Education teaching high school Mathematics and English. He then worked at the Halton Board of Education, as a guidance counsellor, Head of Guidance and Special Education in a Grade 7-13 school, and as a Curriculum Coordinator for the school board.

Dr. Gitterman was born in Winnipeg where he received his B.Sc. at the University of Manitoba. He moved to Toronto where he completed his B.Ed., M.Ed. and his Doctor of Education in Counselling Psychology at the University of Toronto.

Joanne Lowe

Ms. Lowe is currently the Executive Director with the Youth Services Bureau of Ottawa (YSB). YSB is one of the largest youth serving organizations in Ontario impacting the lives of 12,000 youth, their families and caregivers each year. More than 350 staff at YSB serve clients through four service areas that include youth justice, mental health, health, housing and employment services across 22 sites in Ottawa.

Ms. Lowe joined YSB six years ago following nine years with the Children's Hospital of Eastern Ontario where she was the Manager, Community Division for the then Specialized Psychiatric and Mental Health Services (SPMHS) – now known as "Young Minds" which is a partnership between CHEO and The Royal created following recommendations from the Health Services Restructuring Commission. Previously, she was the Executive Director of the Canadian Mental Health Association, Ottawa Branch from 1994 to 2003. Previous to CMHA, Joanne was the Executive Director with Regeneration House, a supportive housing agency in central Toronto.

Ms. Lowe has participated and provided leadership in several local, provincial and national networks, coalitions, committees and working groups that include co-chairing the Cross-Sectoral Committee in mental health and education, United Way Partner Agencies Network, CMHA Executive Directors Network and the founding Co-Chair of the Alliance to End Homelessness.

More recently, Ms. Lowe has and continues to be involved in the Provincial Framework Advisory Committee for Child and Youth Mental Health; the Provincial Partnership Table for Moving on Mental Health and the Provincial Youth Addiction Advisory Committee. As one of first of 33 appointed Lead Agencies for Child and Youth Mental Health, Ms. Lowe has provided leadership in the development of the Lead Agency Consortium as its inaugural Co-Chair.

Ms. Lowe has been the Co-Chair the Ottawa Suicide Prevention Network for the past six years with more than 50 members working collaboratively to prevent youth suicide.

Nathan Scharf, MD FRCP(C)

Dr. Scharf was born in Montreal in 1958 and has resided in Toronto since 1984. He attended McGill Medical School, graduating in 1982. After several years of Residency in Internal Medicine, he switched to Psychiatry, where he developed a particular interest in psychiatric service delivery systems after travelling several times to Baffin Island with the Centre for Addiction and Mental Health Psychiatric Consultation Group. Dr. Scharf chose to pursue subspecialty in child psychiatry in part because of an interest in the complexity of service and support systems inherent in the subspecialty, where parents, caregivers and children together and separately navigate systems involving physical and mental health education, child welfare and protection and youth justice. This interest has been pursued through involvement in transdisciplinary consultative teams and in the development of various consultative and treatment programs at the Youthdale Treatment Centre in Toronto. In the last several years, he has been involved in the development of inpatient and outpatient psychiatric services at Youthdale for Transitional Age Youth. He is currently writing a book for parents, caregivers and service providers on issues relevant to psychiatric service provision with high risk youth.

In regard to psychiatric patient care, Dr. Scharf's specialty area of work is with "high risk" youth in inpatient, outpatient and residential settings and in outpatient consultation with children with neurodevelopmental disorders, complex psychopharmacologic concerns or with youth justice involvement.

Stella Schimmens

Ms. Schimmens is a council member of the Moose Cree First Nation. In that role, Ms. Schimmens is able to advocate while sitting on various portfolios, including Health, Education and Resource Development. Early in her career, Ms. Schimmens worked at the local Children's Aid Society.

Later, while working at Medical Services, Health Canada, Ms. Schimmens advocated for patients and their families to ensure that they received optimum medical benefits in terms of transportation, medical supplies and the referral process. Medical Services transferred Health Care Delivery to Weeneebayko Regional Health Authority (WAHA), where Ms. Schimmens continued with patient advocacy and worked to develop the WAHA/Traditional Healing program using traditional practices, restoring historical knowledge and beliefs.

More recently, Ms. Schimmens was part of a team of culture support workers that accompanied the Truth and Reconciliation Commission (TRC) across Canada and provided supports at TRC events.

One of the highlights of Ms. Schimmens career was travelling with Centre for Addiction and Mental Health to Peru, where she had the opportunity to meet with a group of international Elders and witness the work they do combining modern and traditional methods for addictions.

Ms. Schimmens is a proud mother of four, a very proud Gookum (grandmother) of 11 and a Jaban (great-grandmother) of one.

Kim Snow, PhD.

Dr. Snow began her career in residential services in the children's mental health sector, and while there earned her Child Care Worker Diploma. Dr. Snow then practiced in an intensive psychiatric day hospital working on outpatient assessment teams. In 1990, Dr. Snow established a private practice providing assessment and treatment for children and families with complex mental health needs. For a period time she served as a Child Advocate at the Office of Child and Family Services Advocacy. Most recently, Dr. Snow has been working as an Associate Professor in the School of Child and Youth Care at Ryerson University. She has a focus on safeguards for children and youth in care and the meaningful participation of young people in their care. She leads The Voyager Project, a social innovation strategy to redress educational disruption and disadvantage faced by children in care. Dr. Snow also engages in Participatory Action Research with remote First Nations communities and youth groups. She has published extensively in the areas of child and youth care and youth in care.