STRENGTHENING FOUNDATIONS:

ASSESSMENT, INFORMATION-SHARING AND COLLABORATION

AN INVESTIGATIVE REVIEW

2-YEAR-OLD WHITNEY | 4-YEAR-OLD JOSH | 6-YEAR-OLD GREG

8-YEAR-OLD CAMDEN | 15-YEAR-OLD CHARA

16-YEAR-OLD MARINO | 19-YEAR-OLD SKYE

20-YEAR-OLD NATALIE | 20-YEAR-OLD TREVOR

ocya
OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

September 2021

Message from the Advocate

Under my authority and duty as identified in the *Child and Youth Advocate Act* (*CYAA*), I am providing the following investigative review regarding the deaths of nine young people who died over a 14-month period in 2018–2019. I am reviewing the circumstances and experiences of Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor as part of a broader collective review.

These nine young people's circumstances were similar. Each required thorough assessments to understand their needs, along with better information-sharing and collaboration among the professionals involved in supporting them. Trevor was receiving child intervention services when he passed away; the other eight young people had received child intervention services within two years of their deaths.

In accordance with the *CYAA*, investigative reviews must be non-identifying. Therefore, the names used in this report are pseudonyms (false names). Finding an appropriate pseudonym can be difficult; however, it is a requirement that my office takes seriously and respectfully. Where possible, names for these young people were chosen in consultation with family members.

As with any investigative review, focused and dedicated attention was given to each young person's circumstance. Although my staff has taken great care to protect the privacy of these young people and their families, I cannot guarantee that interested parties will not be able to identify them. Accordingly, I would request that readers and interested parties, including the media, respect this privacy and not focus on identifying the individuals and locations involved.

This review identifies opportunities for child-serving systems to strengthen how they support children and families. I hope that the recommendations arising from this report, along with other relevant recommendations, will be acted on to improve services for Alberta's vulnerable children and youth.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

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Introduction

The Office of the Child and Youth Advocate

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act* (*CYAA*).

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act* (the *Enhancement Act*), the *Protection of Sexually Exploited Children Act* (*PSECA*), or the youth justice system.

Investigative Reviews

The *CYAA* provides the Advocate with the authority to conduct investigative reviews. The Advocate may investigate systemic issues arising from the death of a child who was receiving child intervention services or had received such services within two years of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Upon completion of an investigative review, the Advocate releases a public report. The purpose is to comment on findings, make observations and identify recommendations to improve services for young people and their families.

An investigative review does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an investigative review is not to find fault with specific individuals, but to identify key issues and meaningful findings, observations, and/or recommendations that: address systemic issues; are specific enough that progress made on recommendations can be evaluated; and are not so prescriptive as to direct the practice of Alberta government ministries.

It is expected that government will take careful consideration of the recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children receiving designated services. Fundamentally, an investigative review is about learning lessons and making recommendations that, when acted upon, result in systemic improvements for young people.

Executive Summary

The Advocate learned of the passing of nine young people (Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor) who died over a 14-month period in 2018–2019 and had experienced similar challenges with service provision. During the investigative review process, it was determined that it would be beneficial to examine their circumstances in a collective report. Service delivery for these nine young people was impacted by limited assessments, information-sharing, and collaboration among service providers.

Since 2015, the Advocate has made 27 recommendations to Child Intervention Services to build capacity in their workforce so that the needs of young people and their families are adequately assessed and supported. Over the same period, the Advocate made 9 recommendations to address gaps in information-sharing and collaboration among service providers.[1] Furthermore, 17 requests for internal reviews were made to address gaps in service delivery related to these concerns. Actions have been taken to address these recommendations through policy and procedure changes, and implementation of practice tools and models, yet these challenges continue.

To promote well-being and effect meaningful change, supports must be equitable. Seven of these nine young people (Whitney, Josh, Greg, Camden, Chara, Skye, and Trevor) were Indigenous, highlighting the disproportionate number of Indigenous young people who come to the attention of child-serving systems. The Advocate has spoken many times about this over-representation, and the need for all levels of government to respond.[2] Over the past 25 years, there have been many recommendations made through legal or political actions or commissions to various levels of government to address the inequities experienced by Indigenous people.[3] Yet, there has been limited progress. In this time of renewed awareness of Indigenous experiences resulting from colonization, it is critical that progress is made towards meaningful reconciliation.

1 Recommendations and responses can be found at: https://www.ocya.alberta.ca/adult/publications/recommendations/

2 Ibid.

3 See Appendix 2

Whitney, Josh, and Greg

Whitney, Josh, and Greg were young First Nation children. Whitney was a curious toddler. Josh was a busy, talkative preschooler, and Greg was a shy and soft-spoken kindergartener who was learning to read. They lived with their maternal grandparents, who had obtained guardianship.

These three children were exposed to parental substance use and family violence, and they experienced housing instability, food insecurity, and a lack of adequate medical care. Staff from child-serving systems (Alberta Health Services and Child Intervention Services) supported the family. Greg and Josh also received services from school staff. When Whitney was two years old, Josh was four years old, and Greg was six years old, they passed away in an accidental house fire.

Camden

Camden was a First Nation child who had a great sense of humour and liked to tease others. He was a gentle soul. Camden loved science and art activities and was popular with his peers at school. He was the youngest of four siblings and lived with his paternal aunt, who was his guardian.

Camden was born with a heart condition and diagnosed with fetal alcohol spectrum disorder. He was exposed to family violence and caregiver substance use, and he had irregular school attendance. Staff from numerous child-serving systems (education, Alberta Health Services, and Child Intervention Services) supported Camden and his family. Camden was eight years old when he passed away from sepsis.

Chara

Chara was a shy First Nation teenager. She often found it difficult to ask for help, and she moved frequently between her mother's and grandmother's homes.

Chara had severe asthma and frequently had to go to the hospital. She was exposed to family violence and parental substance use, and she was sexually abused. She experienced housing instability and did not receive adequate medical care. Her school attendance was irregular. Staff from numerous child-serving systems (education, youth justice, Alberta Health Services, and Child Intervention Services) supported Chara and her family. Chara was 15 years old when she passed away from drug toxicity.

Marino

Marino was a shy, quiet, and kind young man. For most of his childhood, he was involved in sports, particularly hockey. When he was a teenager, Marino and his friends were active members of a Dungeons and Dragons fantasy role playing group. He lived with his mother until the last two months of his life, when he moved in with his older sister.

Marino often missed school, was exposed to family violence, and was prescribed antidepressants. Staff from numerous child-serving systems (education, Alberta Health Services, and Child Intervention Services) supported Marino and his family. Marino was 16 years old when he passed away from suspected drug toxicity.

Skye

Skye was an artistic, caring, and resourceful First Nation young woman. She was easygoing and formed connections with those who supported her. She was actively involved in her culture and smudged daily.

Skye was exposed to family violence and parental mental illness, and she frequently experienced housing instability. She used substances, self-harmed, and attempted suicide. Staff from numerous child-serving systems (community-based supports, education, Alberta Health Services, and Child Intervention Services) supported Skye and her family. Skye was 19 years old when she passed away from drug toxicity.

Natalie

Natalie was a young woman with freckles and a friendly smile that lit up her face. She wanted to be independent and live a healthy lifestyle, but struggled to do so.

Natalie was exposed to family violence, parental substance use, and drug trafficking. She used substances and was sexually exploited. Staff from numerous child-serving systems (education, youth justice, Alberta Health Services, and Child Intervention Services) supported Natalie and her family. Natalie was 20 years old when she passed away from sepsis.

Trevor

Trevor was a sweet, quiet, and polite First Nation young man. He wanted to graduate from high school and own a roofing and drywall company, but his frequent moves impacted his education.

Trevor was exposed to parental substance use, family violence, housing instability, gangs, and drug trafficking. Staff from numerous child-serving systems (education, youth and adult justice, Alberta Health Services, and Child Intervention Services) supported Trevor and his family. Trevor was 20 years old when he was a victim of homicide.

The Advocate is making two recommendations:

Recommendation 1

The Ministries of Children's Services, Health, Education, Justice and Solicitor General, and Community and Social Services should review and adjust their quality assurance processes to include both qualitative and quantitative measures that regularly evaluate service delivery within their systems.

Recommendation 2

The Ministries of Children's Services, Health, Education, Justice and Solicitor General, and Community and Social Services should collaborate and coordinate with Service Alberta to regularly communicate where to access reference and training materials to those responsible for providing services under the *Children First Act*. Furthermore, these ministries should offer service providers opportunities for ongoing, interactive, cross-systems training on the act.

About this Review

The Advocate learned of the passing of nine young people (Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor) who died over a 14-month period in 2018–2019. During the investigative review process, it became apparent that they faced similar issues in service provision, so it was decided that their circumstances would be examined in a collective investigative review.

Trevor was receiving child intervention services when he passed away; the other eight young people had received such services within two years of their deaths. These nine young people lived in different communities across the province and received services from various child intervention offices, including Delegated First Nation Agencies and Children's Services regions.

While reviewing the individual circumstances of Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor, common themes emerged. Assessments did not appear to consistently consider parental capacity or the trauma history of the young person and their family. Interventions were limited to addressing the presenting concerns. Furthermore, assessments appeared to be impacted by a lack of information-sharing and collaboration among service providers.

In preparing this report, we thoroughly reviewed each young person's information from child-serving ministries. We spoke to young people's relatives, caregivers, and close contacts, as well as caseworkers and other professionals. We held town hall meetings with practitioners from all child-serving systems. They provided insights into what is working well and identified some of the barriers they experience when working with families. We also held meetings with our staff and the OCYA Youth Council to understand some of the concerns young people have with the services they receive.

A preliminary report was presented to a committee of subject matter experts, including Elders and professionals in the areas of mental health, parental capacity assessments, child intervention best practice, information-sharing best practice, family violence, and support of people facing social issues. Committee members provided advice related to this report's findings and recommendations.

A glossary of terms is provided in Appendix 1; terms in **bold font** are defined in the glossary. External recommendations to address inequities for Indigenous people are provided in Appendix 2. A list of experts and Elders consulted is provided in Appendix 3, and the town hall questions and feedback themes are provided in Appendix 4. The terms of reference is provided in Appendix 5, and the bibliography is provided in Appendix 6.

Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor depended on their caregivers to meet their needs and make sure they were safe. When their caregivers were unable to do so, the professionals involved with these families had to provide appropriate services and supports to meet their needs. In the circumstances of all nine of these young people, service delivery was impacted by limited assessments, information-sharing and collaboration among service providers. Despite previous recommendations and efforts to build capacity in assessments, information-sharing and collaboration, these areas of concern persist, and the experiences of Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor highlight these gaps.

Systems Change

Service providers regularly review their own performance to determine resource allocation, account for the use of public funds, and identify areas of need for service delivery.[4] Despite various shifts in policy, legislation, practice frameworks, and training activities, service delivery challenges persist—an indicator that service providers should reconsider how performance and outcomes are evaluated.

Service providers must be cognizant of their organizational vision and mission and consider how these concepts translate into service delivery that promotes desired outcomes for children and families. Measuring outcomes is complicated, and government services have typically relied on evaluating activities or milestones. Social outcomes are challenging to meaningfully measure because they are often intangible and long-term.[5] However, a fundamental change in the approach to measurement is needed to shift mindsets from "hitting targets."[6] For a system to best support children and families, a balance between **quantitative measures** and **qualitative measures** is needed for evaluation. This may reveal where services are working well and where there are opportunities for learning and improvement.

> "The undue importance given to performance indicators and targets … puts so much emphasis on procedures and recording that insufficient attention is given to developing and supporting the expertise to work effectively with children, young people and families."
>
> **Munro (2011)**

> "Adults will know all is good if I'm thriving versus surviving—not just doing okay, but excelling in one thing: music, a school subject, or a sport, because that shows I feel comfortable."
>
> **OCYA Youth Council member**

What we found

Across child-serving systems, service delivery is evaluated by measures such as frequency of supervision, consultation processes for decision-making, and procedures for evaluating employee performance. The focus of publicly reported **quality assurance**

4 Patton (2008)

5 Organisation for Economic Co-operation and Development (2020)

6 Government of Canada (2021a)

"Policy evaluation is critical to ensure that policies are actually improving outcomes by bringing an understanding of what works, why, for whom, and under what circumstances."

Organisation for Economic Co-operation and Development (2020)

measures appears to be primarily quantitative: meeting timelines, readmission rates, recidivism rates, caseload volumes, and rates of staff training.[7] [8] [9] [10] These measures evaluate the occurrence and completion of tasks, rather than demonstrating improvements to the overall quality of care young people and their families receive.

Targets, such as meeting legislated or policy timelines, indicate that an activity has occurred, but provide limited insight into whether interventions were successful in achieving the desired social outcomes.

- One of Children's Services' key targets is reducing the number of Indigenous children in care, but a reduction in numbers alone does not address the intended outcome, which is an overall improvement in social circumstances and well-being for Indigenous young people.
- One of the principles of the *Youth Criminal Justice Act* is to promote the rehabilitation and reintegration of young people.[11] Measures that rely on program implementation, court and sentencing rates, and referrals to alternative justice programs do not tell us if service delivery is improving the circumstances that lead to young people's involvement with the justice system.

Since 2015, we have requested that Children's Services conduct 17 internal reviews related to concerns with service delivery. These reviews have been completed through a qualitative analysis of practice and have identified similar gaps in assessment activities, information-sharing and collaboration:

- **Assessment**: There is a need to strengthen risk assessment, address inconsistent practices, strengthen evaluation of parental/caregiver capacity and engagement, implement family systems approaches, and increase consideration of history. Safety planning must be collaborative, have realistic goals, be detailed, and be understood by all parties; plans must be confirmed and tested. There must be a shift from short-term analysis to addressing longer-term needs.
- **Information-sharing/Collaboration**: Improved documentation and clearer procedures when multiple systems are involved, or cases are being transferred, will enhance information-sharing. Collaboration across systems, and with community and natural supports, improves information-sharing, supports decision-making and richer assessments, and ensures appropriate services are provided. Increased collaboration is needed, especially in rural areas where services may be limited.

7 Alberta Justice and Solicitor General (2020)

8 Alberta Health Services (2020b)

9 Alberta Children's Services, personal communication, May 27, 2021

10 Government of Alberta (2021a)

11 Department of Justice Canada (2017)

What needs to happen

One way to address complex problems is through **systems thinking**,[12] which gives "attention to exploring the relationships, boundaries and perspectives in a system. It is a mental framework that helps us to become better problem solvers."[13] By using both quantitative and qualitative measurements, service providers can get a clearer picture of which interventions are leading to desired outcomes, who is benefiting, and where more work is needed.[14]

Quality assurance measures that strike a balance between quantitative and qualitative evaluation could lead to increased understanding about where resources would be most effective, and how to improve outcomes for those being served.[15] Quality assurance needs to be an ongoing priority and adequately resourced to be done well.[16]

Recommendation 1

The Ministries of Children's Services, Health, Education, Justice and Solicitor General, and Community and Social Services should review and adjust their quality assurance processes to include both qualitative and quantitative measures that regularly evaluate service delivery within their systems.

Further Comments

The quality assurance measures should:

- be based on the organization's principles and be culturally inclusive so evaluation tools and measures are meaningful and appropriate to meet the needs of Alberta's diverse populations
- evaluate the quality of interactions and inform how services are being delivered
- result in improved decision-making, as well as overall improvement in the lives of young people and their families

12 Finegood (2021)

13 The Australian Prevention Partnership Centre (n.d.)

14 Noyes et al. (2019)

15 Watt (2014)

16 Hughes (2008)

Each ministry is responsible for reporting its own public accountability activities and outcomes, which should:

- be publicly available at regular intervals
- be reported in clear, simple language
- include thorough input and feedback from service delivery staff and clients who received services

Expected Outcomes

- Child-serving ministries will have balanced quality assurance processes that evaluate both qualitative and quantitative measures, which will indicate if knowledge, critical thinking, analysis, and intervention used in service delivery for young people is improving
- Child-serving ministries will utilize evaluation results to inform program improvements, staff training, and development strategies so services are being provided to children and families as intended

Assessment and Systems Change

Gathering adequate information about the effectiveness of services should better position service providers to identify and respond to gaps and barriers. The circumstances of Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor highlight barriers practitioners face related to information-sharing and collaboration, which can contribute to gaps in assessment activities. As long as these gaps persist, young people and their families are likely to struggle with their well-being.

There is no consensus around the definition of well-being.[17] 'Well-being' is often used interchangeably with the following terms: quality of life, life satisfaction, good physical and mental health, economic security, personal fulfilment, and "goodness."[18] It can also be defined "in terms of one's context (standard of living), absence of well-being (depression), or in a collective manner (shared understanding)"[19] and includes physical, cognitive, social, emotional and spiritual health.[20]

"*Care* is a very generic, subjective word. I think the better term is *attend to the social, emotional, and physical needs to maintain well-being*, which is the platform needed to allow a child to thrive, not just survive. In the past, *care for a child* seemed to just be correlated to *providing the necessities of life.* It should be *providing the necessities to live*. To live is more than merely to be alive."

OCYA Youth Council member

17 Centers for Disease Control and Prevention (2018)

18 Teghe & Rendell (2005)

19 Pollard & Lee (2003)

20 Alberta Children's Services (2019a)

Research highlights the importance of the relationship between well-being and social connection.[21] Well-being encompasses factors such as safety and security, supportive and nurturing relationships, and a sense of purpose and belonging within a family and a community. "Well-being is achieved when infants, children and youth are physically and emotionally safe, have secure, healthy relationships, have connection to culture and community and have opportunities to grow and develop to their full potential." [22]

Trevor, Natalie, Skye, Marino, Chara and the education system

These young people faced personal life challenges and had attendance issues when they were in or close to starting junior high school. It did not appear that the underlying causes of absenteeism were explored and used to inform interventions. It was not evident what strategies were used to meaningfully re-engage these young people in their education.

Trevor, Natalie, Skye, Marino and the child intervention system

These young people had repeated child intervention involvement through intakes and assessments. It did not appear that decision-making was informed by historical information, interprovincial information and other systems' involvement.

Chara and the health system

Chara was assessed in emergency departments on multiple occasions and was discharged when her presenting concern was managed. Discharge plans did not appear to include follow-up calls to ensure her caregivers connected Chara to the referred services.

Trevor and the justice system

There appeared to be limited collaboration between youth and adult justice systems involved with Trevor. Continuity of care was disrupted between periods of incarceration and times when he was in the community. As a result, the services he needed could not be put in place.

What we found

When reviewing the circumstances of Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor, the focus of service delivery appeared to be on addressing the presenting concerns. It did not appear that the underlying causes, such as the effects of past trauma on these young people and their families, were addressed in service delivery.

Natalie's circumstances escalated from being exposed to substance use and violence to participating in drug dealing and being the victim of sexual exploitation. Whitney, Josh, and Greg were repeatedly left in situations where exposure to family violence affected their physical and emotional well-being.

Efforts were made to keep these young people with their families. However, there appeared to be an over-reliance on using families as support networks. There did not appear to be adequate assessments of their ability or capacity to provide care, or the supports they needed to do so. Developing support networks is one way to increase child safety; however, a false sense of security can come from an over-reliance on safety planning. There must be ongoing assessment of supports and testing and adjustment of the safety plan.[23]

During the town hall meetings, we heard that "the symbols of achievement—checking boxes that an assessment is done—sometimes sideline or displace what is actually supposed to be achieved."

21 Seppala et al. (2013)

22 Alberta Children's Services (2019a)

23 Information gathered through the town hall meetings.

All child-serving ministries have policies, procedures, practice models and tools to promote best practice. In 2019, the Ministry of Children's Services released the *Well-Being and Resiliency Framework*,[24] along with an accompanying evaluation framework[25] and an Indigenous resource (the *miyo Resource*)[26] designed to incorporate Indigenous worldviews. This framework "outlines the importance of policies, services, and programs that prevent or aim to reduce the impacts of early adversity by promoting the development of well-being and resiliency." The evaluation framework demonstrates methods to monitor progress and understand outcomes. The data collection process quantifies program delivery and measures program and client outcomes through client baseline data, self-assessment, surveys, and other reporting tools, including Indigenous-specific indicators. Since its release, there have been no public updates or outcomes reported.

The interviews we conducted for this report, and the feedback we received from the town hall meetings, did not indicate that frontline staff were aware of this framework. While the **COVID-19** pandemic restrictions have impacted government services and initiatives, we strongly encourage Children's Services staff to be trained in the framework and continue their work towards positive outcomes for young people and their families.

What needs to happen

Information that is collected must be analyzed to inform interventions. Along with the use of practice tools, systems also need to promote critical thinking among service providers. Children's Services policy on intake and assessment[27] speaks to applying critical thinking to information and decision-making. Critical thinking processes must be demonstrated in summary and analysis documents. Although this is outlined as an assessment activity, the concept of critical thinking is broad[28] and is not defined in policy. A policy scan of other child-serving ministries did not indicate that they explicitly speak to critical thinking as part of their information-gathering and analysis activities.

What we have said in the past

Since 2015, we have made 27 recommendations related to promoting critical thinking to inform services. Responses from ministries have included the ongoing implementation of, and training towards, practice models, policy changes, strategies, cross-ministry protocols, working groups, memorandums of understanding between ministries, and proposals for legislative changes.[29]

24 Alberta Children's Services (2019a)

25 Alberta Children's Services (2019b)

26 Alberta Children's Services (2019c)

27 Alberta Children's Services (2021)

28 Watson (n.d.)

29 Recommendations and responses can be found at: https://www.ocya.alberta.ca/adult/publications/recommendations/

Comprehensive assessments rely on the knowledge, skills, and abilities of frontline practitioners. In September 2019, we made the following recommendation:

> **Children's Services should ensure that there is a process for ongoing evaluation of how policy changes, assessment tools and practice frameworks are being integrated into day-to-day casework practice.**

The expected outcomes were:

- Child Intervention Services will have a process that evaluates the capacity of frontline staff and measures if their knowledge, critical thinking, analysis, and intervention with young people is improving
- Child Intervention Services will utilize evaluation results to inform program improvements, staff training, and development strategies to ensure caseworkers provide services to children and families as intended[30]

The Ministry of Children's Services has undertaken reviews on young people in permanent care and those transitioning out of care to gather evidence related to the supports they need to be successful.

Evaluation of how effectively policy changes, assessment tools, and practice frameworks integrate into day-to-day casework practice has been slow. We urge all child-serving ministries to consider this recommendation and evaluate whether their policies, practice tools and practice frameworks are achieving the intended outcomes.

Information-Sharing, Collaboration and Systems Change

Well-being is achieved through physical and emotional safety, secure healthy relationships, connection to culture and community, and opportunities to grow.[31] Information-sharing and collaboration is vital to safeguarding and promoting young people's well-being[32] and should result in children and families receiving the right services at the right time. To make sure that a young person's overall well-being is addressed through the interventions provided, it is imperative to gather information from, and collaborate with, the service providers involved. When young people have connections, there is a greater possibility of positive outcomes.

30 *17-Year-Old Whitebird: Mandatory Review* (September 2019)

31 Alberta Children's Services (2019a)

32 Centre of Excellence for Information Sharing (2016)

What we found

> "There is room to find and define processes that will help us know when and how we can best share information in the interest of the young person."
>
> **Town hall participant**

Information-sharing is complex; service providers are governed by overarching privacy legislation, as well as policies and guidance documents at the agency, organizational, and regulatory body levels. Information-sharing decisions are rarely black and white, but require sound judgment, knowledge and understanding of the situation and the individual.[33] Information-sharing is easier when there are open lines of communication, with all parties kept up-to-date and informed.[34] Collaboration requires the exchange of information. Child welfare experts are increasingly aware of the importance of cross-system collaborative partnerships to achieve safety, permanency, and well-being for children, youth, and families.[35]

In Alberta, there are several different legislations and initiatives that guide how information is shared. These include, but are not limited to, the *Freedom of Information and Protection of Privacy Act* (*FOIP*), the *Personal Information Protection Act* (*PIPA*), the *Health Information Act* (*HIA*), the *Children First Act* (*CFA*), and the government's *Information Sharing Strategy*. In addition to existing legislations and initiatives, each ministry is governed by their own policy and legislation.

There are additional challenges and some confusion about information-sharing when a young person is over the age of 18, or when a parent's information is needed to inform decision-making and planning. The lack of common language across service providers is a barrier, as is a lack of understanding of each other's mandates. There are additional challenges when staff from municipal districts and First Nations work together. The quality of information-sharing impacts the level of collaboration that occurs between systems.[36]

The circumstances of Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor highlight the barriers in information-sharing and collaboration among service providers. Camden was part of a collaborative school-based initiative that included staff from multiple ministries and community-based service providers. Skye was involved with multiple systems throughout her life. Marino was involved with multiple systems and received services in another province. Despite the various professionals providing services to these young people and their families, each involvement appeared to be viewed as a singular event, outside of the context of their whole history. Interventions did not appear to be holistic and appeared to be focused on the mandate of each service provider. At times, the physical, emotional, and mental health needs of these nine young people did not appear to be met.

33 Canadian Mental Health Association & Government of British Columbia (2016)

34 Price-Robinson et al. (2020)

35 Capacity Building Center for States (2017)

36 Information gathered from town hall meetings.

There are many avenues that allow professionals to share information, and in some cases require them to, but we continue to hear about barriers to information-sharing and collaboration. To inform this report, we held town hall meetings with service providers from all child-serving ministries, our staff, and the OCYA Youth Council. We heard that the boundaries of confidentiality are not well understood. Timely and effective interagency collaboration can have many benefits for both clients and workers. However, it is still common to see limited consultation or collaboration.[37]

"Because families at risk of child abuse or neglect often face challenges in other areas of their lives, effective collaboration with other service providers and systems is essential to supporting families' many unique needs."

Child Welfare Information Gateway

What needs to happen

A **"warm handoff"** is a key component of collaboration in child-centred practice. It is an approach used to transfer care from one service provider to another, with the goal of reducing issues and increasing comfort for the client. The transfer of care should:

- include introducing the person to the new provider or service directly (face-to-face or by phone)
- include the person and their family in communication between service providers and allow them to hear what is said
- provide the person with opportunity to clarify or correct information and ask questions about their care[38]

Warm handoffs can strengthen relationships among practitioners, young people, and families. The *Children First Act* (*CFA*) enables information-sharing when it is in the "best interests of the child," providing a more holistic and yet simplified approach to sharing information in a timely and effective manner.[39]

The *CFA* states that:

> "programs and services for children are most effective when they are provided through a collaborative and multi-disciplinary approach, and appropriate sharing of information between individuals and organizations planning or providing programs and services for children is critical to ensuring successful outcomes for children and families."[40]

"It is one thing to give a referral versus a warm handoff to the referral. A number to a call centre is not what is needed. Sometimes quiet kids don't get what they actually need."

OCYA Youth Council member

"Something that's missing is having a common training so we can all have a common understanding of what the *Children First Act* is."

Town hall participant

37 Darlington et al. (2005)

38 Alberta Health Services (2020a)

39 Government of Alberta (2014)

40 Government of Alberta (2014)

Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor all had multi-system involvement. The *CFA* did not appear to be applied in service delivery. In the town hall meetings, we learned that service providers had limited knowledge about how to implement the legislation. Most service providers deferred to their own legislation and policies when there was uncertainty about sharing information or the *CFA*.

What we have said in the past

Since 2015, we have made nine recommendations related to information-sharing and collaboration between service providers. Ministries have responded to these recommendations through the ongoing implementation of practice strategies, policy changes, cross-ministry protocols, and complex care resolution processes.[41] Although these approaches are good steps towards ensuring children and families receive services, challenges persist in the awareness, understanding and application of policies and legislation that enhance information-sharing and collaboration among service providers.

Children's Services is responsible for maintaining the *Childrens First Act (CFA)*. The online learning resources specific to the *CFA* are included under Information Sharing Education and Resources within Service Alberta.[42] This ministry is not tasked with ensuring that child-serving staff understand the *CFA* or how to apply it in practice. Through the interviews regarding each young person in this review, along with feedback received in the town hall meetings, we learned that frontline service providers do not appear to be aware of these resources. Making these resources accessible and easily understandable is critical for their utilization. Cross-systems training is also vital for learning and enhanced collaboration.

Recommendation 2

The Ministries of Children's Services, Health, Education, Justice and Solicitor General, and Community and Social Services should collaborate and coordinate with Service Alberta to regularly communicate where to access reference and training materials to those responsible for providing services under the *Children First Act*. Furthermore, these ministries should offer service providers opportunities for ongoing, interactive, cross-systems training on the act.

41 Recommendations and responses can be found at: https://www.ocya.alberta.ca/adult/publications/recommendations/

42 Service Alberta (n.d.)

Further Comments

Communication about the *Children First Act* should:

- be targeted towards service providers who promote well-being, safety and security of children and families
- occur at regular intervals
- be relayed using various platforms, such as public awareness campaigns, emails, hard copy marketing materials, and so on

The training should:

- be specific to information-sharing
- provide professionals who deliver services to children and families an understanding of the *Children First Act* (*CFA*) and how it fits within their ministry's legislation, policies, procedures and practice frameworks
- provide all participants with resource materials to refer to when applying the *CFA*
- be ongoing, so service providers' knowledge and resources are current
- address service providers' concerns about what information they are able to share, and when, with cross-ministry partners
- provide a dispute resolution process that can be accessed by service providers when there is disagreement about information-sharing

The language in the *Children First Act* related to "best interests of the child" should:

- be clearly defined to help reduce confusion and improve consistency when applying the legislation

Each ministry is responsible for reporting its own public accountability activities and outcomes, which should:

- be publicly available and updated at regular intervals
- be reported in clear, simple language

Expected Outcome

Children and families will receive holistic services resulting from cross-ministry information-sharing and collaboration among frontline practitioners, which will improve outcomes for Alberta's families.

THE YOUNG PEOPLE

2-Year-Old Whitney

4-Year-Old Josh

6-Year-Old Greg

About Whitney, Josh, Greg, and Their Family

Whitney,[43] Josh, and Greg were young First Nation children. Greg was a shy and soft-spoken kindergartener who was learning to read. Josh was a busy, talkative preschooler, and Whitney was a curious toddler.

Greg and Whitney had health concerns when they were born. Child Intervention Services was involved with their family multiple times through **intakes** and **assessments** for concerns related to parental substance use, parental capacity and family violence.

When Whitney was two years old, Josh was four years old, and Greg was six years old, they passed away in an accidental house fire. They had received child intervention services within two years of their deaths through an assessment.

Summary of Government Systems Involvement

Greg from birth to 2 years old

After he was born, Greg spent approximately two weeks in the **neonatal intensive care unit** to address withdrawal symptoms and **hypoglycemia**. Child Intervention Services received a report that his parents, Mary and Layton, had limited income and did not have stable housing or transportation. After Greg was discharged from the hospital, his family moved, and caseworkers were unable to locate them. Child intervention involvement ended. Approximately five months later, caseworkers located Greg and Mary, who were living with Mary's parents, Jamie and Walt. Greg appeared healthy, his immunizations were up to date, and Mary had met with **public health nurses**. Child intervention involvement ended.

When Greg was almost two years old, Child Intervention Services received a report that Mary had used substances while eight months pregnant with her second child, Josh. When Layton learned about the concerns, he returned home, and child intervention involvement ended.

Greg from 3 to 4 years old
Josh from 1 to 3 years old
Whitney from birth to 11 months old

The following year, Child Intervention Services received a report that three-year-old Greg and one-year-old Josh were being exposed to family violence and parental substance use. Mary had given birth prematurely to a daughter who passed away in hospital. Mary said she had used **methamphetamine** to help her cope with the loss, but had since stopped. Caseworkers provided short-term financial aid, and child intervention involvement ended. It did not appear that the family received supports to address the family violence and substance use concerns.

43 All names in this review are pseudonyms.

Approximately 11 months later, Whitney was born prematurely and placed in the neonatal intensive care unit. Child Intervention Services received a report related to Mary and Layton's ability to care for Whitney. Her parents had not followed up with the medical team regarding her care, and Mary said she had used substances throughout her pregnancy. There were further concerns that Mary and Layton were under the influence when Whitney was ready to be discharged. Medical staff referred the family to a First Nation health nurse, and caseworkers visited the home twice and provided formula, bottles, and diapers. Child intervention involvement ended.

Two months later, Child Intervention Services received a report that Whitney had not received medical follow-up, and Mary and Layton appeared to be under the influence of substances. Child intervention involvement ended after Whitney was taken to see her doctor. It was unclear how concerns were addressed regarding parental substance use and Mary's and Layton's ability to meet Whitney's ongoing medical needs.

Child Intervention Services received a report approximately two months later that Layton had assaulted Mary and four-year-old Greg. Whitney and Josh witnessed the assaults. Layton was charged and incarcerated. Mary and her children went to live with her parents in another community. The police completed an **integrated threat and risk assessment**, which concluded that Layton was at high risk for continued violence towards his family. Child intervention involvement ended.

When Layton was released from jail, Mary returned to live with him. Caseworkers believed the conditions of Layton's **probation order** were sufficient to keep the family safe. Mary's parents disagreed and obtained guardianship of 5-year-old Greg, 3-year-old Josh, and 11-month-old Whitney. Caseworkers were not required to complete a **home assessment** for Jamie and Walt's guardianship application, as the arrangement was private. Child intervention involvement ended.

Greg from 5 to 6 years old
Josh from 3 to 4 years old
Whitney from 1 to 2 years old

Approximately seven months after the **guardianship order** was granted, Child Intervention Services received a report that five-year-old Greg and his siblings were observed to be aggressive with each other, and their immunizations were not up to date. Josh was referred to resources for his speech, and the family was connected to a **Parent Link Centre**. Their grandparents felt that they did not need further supports and that they were financially able to care for their grandchildren. Child intervention involvement ended.

Circumstances Surrounding Greg, Josh, and Whitney's Deaths

Approximately six months after child intervention involvement ended, there was an accidental house fire. Greg, Josh, and Whitney, along with their grandparents, passed away in the fire. The Office of the Chief Medical Examiner concluded that the children passed away from smoke inhalation. A funeral was held in Jamie and Walt's community. Friends and family continue to mourn and deeply miss Greg, Josh, Whitney, and their grandparents, Jamie and Walt.

8-Year-Old Camden

About Camden and His Family

Camden[44] was a First Nation child who had a great sense of humour and liked to tease others. He was a gentle soul, popular with his peers at school, and he loved science and art activities. He was the youngest of four siblings.

Camden was born with a congenital heart condition, and he had multiple surgeries and medical interventions to address his health concerns. He was diagnosed with **fetal alcohol spectrum disorder** (**FASD**) when he was two years old.

Camden's mother, Lois, died when he was a year old. His father, Carl, was unable to care for him. Camden's maternal aunt and uncle, Anne and Jimmy, obtained **private guardianship** of Camden when he was four years old.

Camden was eight years old when he passed away from **sepsis**. He had received child intervention services within two years of his death through an **assessment**.

Summary of Government Systems Involvement

Camden from birth to 2 years old

Camden was born with a congenital heart condition, and during the first year of his life, he had four surgeries to repair his heart, trachea, and larynx. Child Intervention Services received a report regarding Carl's substance use. Camden's parents entered into three consecutive **family enhancement agreements** to address Carl's substance use so that Camden's medical needs were met. Camden was referred to a developmental clinic to help him reach his milestones.

Anne and Jimmy took over day-to-day care of one-year-old Camden after Lois died by suicide. Camden was eligible for **Non-Insured Health Benefits**, but because he was not registered with his First Nation, he did not receive coverage. Anne had not pursued guardianship because she hoped Camden could return to live with his father, but this meant she was unable to apply for his treaty status. Child intervention involvement ended because Camden lived with his aunt full-time.

Camden was 15 months old when he had another heart surgery. When Camden was two years old, his aunt and uncle moved to an urban centre to be closer to services. He was seen at the developmental clinic until he was four years old. He was referred to an FASD clinic and to the **Family Support for Children with Disabilities** (**FSCD**) program; however, the referrals were not followed up on. Camden began an early intervention program, and the hospital social worker encouraged Anne to apply for guardianship and his treaty status. Anne had her own health concerns and needed help applying for financial supports.

44 All names in this review are pseudonyms.

Camden from 3 to 5 years old

Child Intervention Services received a report that Camden was not going to his cardiology appointments, and he was often absent from his preschool program. When he went, he was disheveled and unclean. Anne asked caseworkers to stay involved until she could obtain medical coverage for Camden. She entered into six consecutive family enhancement agreements.

Anne obtained private guardianship of four-year-old Camden shortly before another surgery to repair his heart. Her daughter subsequently passed away, and she separated from Jimmy because of family violence. Anne had financial supports in place, and child intervention involvement ended. Two months later, Camden received treaty status.

Camden from 6 to 8 years old

Camden began kindergarten at a school that helped families through coordinated multi-agency services, and Camden and Anne were supported by a community-based family support worker. Child Intervention Services received a report that six-year-old Camden was often late or absent from school. Anne said her own health concerns prevented her from meeting his educational needs. Anne and Jimmy had reunited. Community-based supports were in place to assist Anne, and child intervention involvement ended.

Approximately one year later, Child Intervention Services received a report that Camden was exposed to ongoing family violence. Police had responded to his home multiple times over a few months. Anne and Jimmy separated, and child intervention involvement ended.

When Camden was in Grade 3, school staff noticed that Anne withdrew from supports and there was a significant drop in Camden's attendance. When he was at school, he was lethargic and pale. School staff worried about Camden and Anne's health, and about her ability to meet his needs. The multi-agency school support team also expressed concerns about Camden's poor school attendance and Anne's ability to meet his ongoing medical needs. Caseworkers said that school attendance was not within their mandate and did not become involved with the family. It was unclear how concerns related to Camden's medical needs were addressed.

Circumstances Surrounding Camden's Death

Approximately two weeks later, Anne found Camden unresponsive in his room. Emergency medical services took him to the hospital, where he passed away. The Office of the Chief Medical Examiner concluded that Camden passed away from sepsis due to a **streptococcus** infection. Camden is missed by those who loved and cared for him.

15-Year-Old Chara

About Chara and Her Family

Chara[45] was a shy First Nation teenager. She had severe **asthma** and often had to go the hospital. Chara's parents, Sonya and Shane, had four children. Chara also had five half-siblings. Shane died from complications of suspected substance use when Chara was 13 years old.

Chara was 15 years old when she passed away from **drug toxicity**. She had received child intervention services within two years of her death through an **assessment**.

Summary of Government Systems Involvement

Chara from birth to 5 years old

Chara appeared to be a healthy child. During her first five years, Child Intervention Services received eleven reports at four different child intervention offices. Concerns were related to family violence, neglect and a lack of housing. During one involvement, the family was referred to family enhancement services, and child intervention involvement ended. It was unclear why family enhancement services were not provided.

Chara from 6 to 10 years old

Shortly before Chara turned six years old, Child Intervention Services received a report that Sonya often left her children home alone, sometimes overnight. Caseworkers obtained a six-month **supervision order**. Sonya worked with an in-home support worker, completed a family violence program, and underwent a **psychological parenting assessment**. Child intervention involvement ended, indicating the terms of the order were met.

Child Intervention Services did not have involvement with Chara and her family for the following four years. During this time, Chara's school attendance was sporadic. When she went, **individualized program plans** were completed in order to access speech and language supports. She was also connected to her culture through Elders, and she took part in ceremonies and teachings to support her learning and success at school.

Chara from 11 to 15 years old

Child Intervention Services received a report that 11-year-old Chara had been sexually abused. Sonya said she would ensure that Chara received counselling, and she worked with police after learning of the assault. Child intervention involvement ended. Eight months later, relatives agreed to care for Chara and her siblings after Child Intervention Services received a report that Sonya had left her children home alone. She was also arrested for assaulting Chara's older sister. The following year, Chara's maternal grandmother, Alice, obtained guardianship of 12-year-old Chara, although she frequently stayed with her mother. Child Intervention Services received a report

45 All names in this review are pseudonyms.

after Chara disclosed that she had been sexually abused while living with her mother. Charges were laid against the offender. Child intervention involvement ended after Alice committed to keeping Chara safe.

Approximately two weeks before her 13th birthday, Chara was taken to the hospital because she heard voices and saw "black figures." Doctors believed the hallucinations were her way of coping with the trauma and stress at home. She was diagnosed with unspecified **psychotic disorder** and unspecified **anxiety disorder**. After three weeks, she was discharged to Sonya's care with a plan to follow up with their family physician and a child abuse clinic. Chara's father passed away 10 weeks later from complications of suspected substance use.

Over the next two years, Chara was taken 15 times to multiple medical facilities by her mother and grandmother for asthma-related issues and mental health concerns. She heard voices and saw shadows. She began using substances and, at times, was suicidal. Chara was diagnosed with **major depressive disorder** and prescribed antidepressant and antipsychotic medications, but her prescriptions were not always filled. Chara was referred to community-based medical supports, including follow-up with a pediatrician, whom she saw once. On two occasions, she had asthma-related concerns. Medical staff referred Chara's family to community-based supports following two admissions under the ***Mental Health Act***. During these admissions, she was diagnosed with **borderline personality disorder** traits, **post-traumatic stress disorder** traits, and unspecified anxiety disorder. She was prescribed medications. There did not appear to be a discharge plan in place, and Chara's family did not appear to access community-based supports.

When Chara was 15 years old, Child Intervention Services received a report that she had been hospitalized because of an asthma attack brought on by substance use. The discharge plan included an appointment at the asthma clinic and a follow-up with her family doctor. Chara was also encouraged to take her medication consistently. Child intervention involvement ended when Sonya and Alice agreed to take Chara to medical appointments and address Chara's substance use.

Circumstances Surrounding Chara's Death

Approximately three months after child intervention involvement ended, Chara was found deceased at a relative's home. The Office of the Chief Medical Examiner concluded that Chara passed away from drug toxicity. A wake was held at a family member's home, followed by a funeral. Chara is missed greatly by those who loved her.

16-Year-Old Marino

About Marino and His Family

Marino[46] was a shy, quiet, and kind young man. He was involved in sports, particularly hockey. When he was a teenager, Marino and his friends were active members of a Dungeons and Dragons fantasy role playing group. Marino was the second of four siblings. His family lived between two provinces and was involved with Child Intervention Services in both provinces. He was an infant when his parents, Carman and Murray, separated.

Marino was 16 years old when he passed away from **drug toxicity**. He had received child intervention services within two years of his death through an **assessment**.

Summary of Government Systems Involvement

Marino from birth to 6 years old

When Marino was an infant, his family lived in another province. Child Intervention Services received two reports regarding physical abuse. His family was referred to community-based supports and child intervention involvement ended. By the time Marino was three years old, his family had moved to Alberta. Over a period of four months, Child Intervention Services received three reports regarding poor school attendance for his older siblings and physical abuse of his younger brother, Bobby. Child intervention involvement ended when Carman sent her children to live with their father in another province. Within three years, Marino and his siblings moved back to Alberta to live with their mother.

Marino from 7 to 10 years old

When Marino was seven years old, Child Intervention Services received a report that he was displaying aggressive behaviours at school, and that Bobby was being physically abused. Carman was overwhelmed after her partner died in a workplace accident, and she entered into a **family enhancement agreement**. The family went to grief counselling, and an in-home support worker coached Carman on positive parenting strategies. Over the summer, Marino and his siblings went to visit their father. When they returned, Carman cancelled the family enhancement agreement. She said that she felt less stress, and her children were doing well. Child intervention involvement ended.

Child Intervention Services was not involved with Marino and his family for the following four years. During this time, his school attendance was poor. Marino and his family did not appear to receive supports to address his absenteeism.

Marino from 11 to 14 Years Old

When Marino was 11 years old, Child Intervention Services received three reports that Carman was physically abusing her children. Each time, child intervention involvement

46 All names in this review are pseudonyms.

ended after Carman said she would access community-based supports. The following year, Child Intervention Services received several reports for the same concerns. Marino and his siblings denied being physically abused by their mother. Carman said that she would connect her children to counselling services, and child intervention involvement ended.

Child Intervention Services was not involved with Marino and his family for the following three years. During this time, Marino's family doctor prescribed him antidepressants to address concerns for his mental health. School staff did not note any concerns related to his well-being; their only concern was his irregular school attendance.

Marino from 15 to 16 years old

When Marino was 15 years old, Child Intervention Services received a report that he had stolen his mother's prescription medication. He denied the allegations, but said he struggled with **anxiety** and **depression** and was seeing a counsellor. There was ongoing conflict in his home, and once Carman took him to a youth shelter. Shelter staff described Marino as a polite young man who interacted well with his peers and took his medication. When Marino returned home, caseworkers confirmed with his counsellor that she had met with Marino three times, and child intervention involvement ended.

Approximately one month later, Child Intervention Services received a report that Carman had been charged with assaulting her daughter, who subsequently left Alberta to live with Murray. Marino denied conflict with his mother, but confirmed there was conflict between his mother and sister. He did not consistently take his prescribed medication for depression. A short time later, Marino was examined and released from the hospital after he took **Ativan** that was not prescribed to him. He declined counselling supports.

Approximately three weeks after the hospital visit, Marino moved in with his 19-year-old sister, Sandra, who lived in a different community. Carman believed this would be better for his mental health; Marino planned to complete his schooling online, and caseworkers felt that Sandra would be a good support to him. Bobby remained with his mother, and child intervention involvement ended.

Circumstances Surrounding Marino's Death

Almost two months after moving in with his sister, 16-year-old Marino was found deceased in Sandra's home. The Office of the Chief Medical Examiner concluded that Marino passed away from drug toxicity. A funeral was held for Marino. In his memory, his family asked that donations be made to a children's charity. Marino is greatly missed by those who knew and loved him.

19-Year-Old Skye

About Skye and Her Family

Skye[47] was an artistic, caring, and resourceful First Nation young woman. She was easygoing and formed connections with those who supported her. She was actively involved in her culture and smudged daily.

Skye's parents, Jacob and Janet, separated when she was a baby, and she spent most of her first six years with her father. When he became ill and was unable to care for her, she went to live with her mother. Throughout her life, Skye moved often because of family violence and parental mental health and substance use concerns. She spent a significant amount of time living with relatives or in shelters with her mother.

Skye was 19 years old when she passed away from **drug toxicity**. She had received child intervention services within two years of her death through an **intake**.

Summary of Government Systems Involvement

Skye from birth to 8 years old

When Skye was 16 months old, Child Intervention Services received two reports regarding lack of supervision, neglect, and Janet's substance use. Skye went to live with Jacob, and child intervention involvement ended. Child Intervention Services was not involved with Skye for approximately four years. During this time, Skye was returned to Janet's care.

When Skye was six years old, Child Intervention Services received a report that she was being exposed to family violence. Janet said she was unable to care for Skye because of her own substance use and mental health concerns. The safety plan was for Janet and Skye to move to a shelter, and child intervention involvement ended. It did not appear that supports were provided to address Janet's substance use and mental health concerns. Shortly afterward, Skye was returned to Jacob's care.

Skye from 9 to 13 years old

Child Intervention Services received multiple reports that nine-year-old Skye was being exposed to family violence and that she had threatened suicide. Janet took Skye to the local hospital, where Janet also presented with mental health concerns. The family was connected to community-based mental health supports and a family wellness worker, and Skye was connected to an Indigenous worker through her school. Child intervention involvement ended. Within weeks, a report was received that Janet had not taken Skye to her mental health appointments. Skye went to live with her grandmother, who caseworkers felt could care for her, and child intervention involvement ended. She was subsequently returned to her mother's care.

47 All names in this review are pseudonyms.

Over the next two years, Child Intervention Services received two reports regarding Janet's deteriorating mental health and Skye's self-harming behaviours. Janet entered into several **family enhancement agreements** and was supported by a community-based mental health therapist. During the second involvement, Janet entered into a **custody agreement** and Skye was placed in foster care. Skye attempted suicide. She was hospitalized and received mental health supports. When she was discharged, she returned to her foster home and was connected to community-based mental health supports. When the custody agreement ended, Janet declined further supports. Skye and her mother moved, and their child intervention matter was transferred to their new community.

Child Intervention Services received two subsequent reports about Skye missing school, using substances, and being exposed to family violence and physical and emotional abuse. She was referred to the school liaison worker and Janet was referred to community-based mental health supports. Her family was also accepted into a **second-stage shelter program** because they did not have stable housing. Child intervention involvement ended.

Skye from 14 to 19 years old

Skye was 14 years old when she disclosed that she had been sexually assaulted and had attempted suicide. Janet entered into a custody agreement and Skye was placed in a residential treatment program. Skye responded well to the routine, stability, and safety of the program; she went to school and followed expectations. Janet did not participate in the family portion of the program, and staff noticed that the conflict in their relationship had a negative impact on Skye. When Janet found a place to live, Skye was returned to her care. Child intervention involvement ended.

Within weeks, Child Intervention Services received a report that 15-year-old Skye was in the hospital. She had self-harmed and used substances. Janet entered into a family enhancement agreement and Skye was confined in **secure services** for 30 days. Although her assessment noted she needed a structured home environment, Skye was returned to her mother's care upon discharge, and they moved to a shelter. They were referred to community-based supports for therapy and treatment, and child intervention involvement ended. Shortly after, Skye was involved in a car accident and sustained a hand injury. She was prescribed opioid medication, which she admitted to misusing and sharing with others. Her substance use escalated when she began an unhealthy relationship with a man who was involved in criminal activity.

Skye was 16 years old when she was hospitalized for an overdose. While Child Intervention Services completed their assessment, she was hospitalized again for self-harming behaviours. Skye entered into an **enhancement agreement with youth** and began seeing a psychiatrist and family counsellor; however, she did not go regularly. She lived in a shelter with Janet and was often left alone for weeks at a time. She said her substance use had decreased, and she did not want further child intervention involvement.

Approximately three months later, 17-year-old Skye attempted suicide after she was assaulted by her boyfriend. She was referred to community-based supports, which she did not access. Skye asked Child Intervention Services for help because she and her mother lost their placement at the shelter. They did not meet with caseworkers because they moved often, and child intervention involvement ended.

At 18 years old, Skye was admitted to the hospital several times because of her substance use, self-harming behaviours, and suicide attempts. She was prescribed medication and referred to a rehabilitation treatment program and support groups. Although Skye had difficulty managing day-to-day activities, she began an outreach high school program where she was also connected to her culture. She had strong relationships with school staff, who noted her difficulties and arranged for her to receive an educational assessment. The assessment indicated she had weak academic skills and required long-term supports. School staff helped Skye apply for financial supports. She was also connected to a community-based agency whose focus was crime prevention and restorative justice because she had close relationships with peers who were involved in criminal activity. Program staff worked collaboratively to help her find stable housing. Skye thrived with the structure and with having a stable home.

Circumstances Surrounding Skye's Death

Approximately one month after her 19th birthday, Skye was found deceased in her home. The Office of the Chief Medical Examiner concluded that she passed away from drug toxicity. Skye had a traditional service and burial. She is greatly missed by those who knew her and loved her.

20-Year-Old Natalie

About Natalie and Her Family

Natalie[48] was a young woman with freckles and a friendly smile that lit up her face. She wanted to be independent and live a healthy lifestyle, but struggled to do so.

Natalie was Paula's and Douglas's only child. They separated before she was born, and Natalie never met her father. Two years later, Paula had Siobhan, Natalie's half-sister. Paula later married Jason and they raised Natalie and Siobhan together.

Natalie was 20 years old when she passed away from **sepsis**. She had received child intervention services within two years of her death through a **support and financial assistance agreement**.

Summary of Government Systems Involvement

Natalie from birth to 13 years old

For her first 13 years, Natalie lived in another province. Child Intervention Services in that province had extensive involvement with her family because of neglect, physical injury, exposure to violence and drug trafficking. She and her sister went to live with their grandmother for approximately three years until Paula was able to care for them. Paula subsequently met and married Jason, who was involved in the drug trade.

Child Intervention Services received a report that Paula had assaulted 12-year-old Natalie and 10-year-old Siobhan. She gave them her prescription medication, and both children tested positive for **OxyContin**. They were taken into care and placed in a foster home. Nine months later, Natalie and her sister were returned to Paula's care, and child intervention involvement ended. Child Intervention Services received further reports that Paula and Jason used substances and misused prescription medication. It was reported that 13-year-old Natalie used substances and that she and her sister were selling OxyContin for their parents. During this involvement, the family moved and their whereabouts were unknown.

Natalie from 14 to 18 years old

By the time Natalie was 14 years old, her family had relocated to Alberta. Paula asked Child Intervention Services for help to address Natalie's **anxiety** and self-harming behaviours. Paula also wanted help to address her own mental health concerns. She was referred to community-based supports. Child intervention involvement ended.

During the next two years, Child Intervention Services received several reports about parental substance use, neglect, Natalie trafficking and using substances, and her school absenteeism. Although caseworkers had previously referred the family to community-based supports, they had not followed through. Caseworkers helped

48 All names in this review are pseudonyms.

Paula and Jason access mental health supports for their children and informed them about addictions services in their community. Child Intervention Services history from the other province was gathered, but did not appear to inform service delivery. Child Intervention Services did not become involved regarding school absenteeism because it was determined that attendance did not meet their mandate. Natalie went before the **Attendance Board** and the judge made counselling a condition of her attendance order.

When Natalie was 16 years old, Child Intervention Services received a report that police had twice found her in a known drug house. Paula and Jason were given information about applying for an order under the ***Protection of Children Abusing Drugs Act*** (***PChAD***). They said they would follow up with a residential youth treatment centre and community-based mental health supports. Child intervention involvement ended. Five months later, Child Intervention Services received a report that Paula and Jason were using and selling substances while 17-year-old Natalie and 15-year-old Siobhan were present. There was drug paraphernalia, dog feces, and garbage throughout their home. Caseworkers offered the family information on *PChAD*, community-based mental health supports, and addictions resources; however, they declined services. Child intervention involvement ended.

Days before her 18th birthday, Child Intervention Services received two reports that Natalie had been sexually abused and also needed urgent dental and medical care. She said that she had been sexually exploited since she was 16 years old. The man was a known sex offender and there was an existing protection order between Natalie and him because of a previous assault. Natalie was confined under the ***Protection of Sexually Exploited Children Act*** (***PSECA***) and placed in a safe house. While there, she told staff she was suicidal and planned to overdose on fentanyl. After five days, Natalie was discharged back to her parents' care. She entered into an **enhancement agreement with youth** for three days until her 18th birthday.

Natalie from 18 to 20 years old

On her 18th birthday, Natalie entered into the first of three consecutive support and financial assistance agreements. She was expected to be in school, maintain her home, and address her substance use. After years of substance use and trauma, staying sober was challenging for Natalie. She said she was afraid to change because she feared she would lose her family and friends.

Natalie continued to be sexually exploited and involved in unhealthy relationships. Her health declined because of substance use and she needed emergency medical services several times. Medical staff attempted to provide ongoing medical, addictions, and mental health resources, but Natalie left the hospital before this could happen. Her support and financial assistance agreement ended because she was unable to meet the expectations of the agreement. She continued to ask caseworkers for help with food. Natalie's health deteriorated and she was hospitalized for **pneumonia** and sepsis. She left the hospital against medical advice so she could be with her family.

At 20 years old, Natalie was hospitalized several times because of severe infections from substance use, which had damaged her heart and lungs. She could not have surgery because she was severely underweight. She required **tube feeding** and was placed on a ventilator. She needed a pacemaker. While in the hospital, she was diagnosed with generalized **anxiety disorder**, **depression**, and **polysubstance use**. She repeatedly left the hospital against medical advice. Doctors did not believe they had the grounds to involuntarily admit her.

Two months after Natalie's hospitalization, her mother passed away from complications due to suspected substance use. Family members told caseworkers that Natalie had overdosed, and it took several doses of **naloxone** to revive her. They worried that without help, she would not live long. Caseworkers said that because of Natalie's age, she needed to reach out to Child Intervention Services directly to receive support.

Circumstances Surrounding Natalie's Death

Three days later, Natalie was found unresponsive at a relative's home. Emergency medical services responded but could not revive her, and she passed away. The Office of the Chief Medical Examiner concluded that Natalie died from sepsis due to an infection in her heart valves. Natalie is deeply missed by those who knew and loved her.

20-Year-Old Trevor

About Trevor and His Family

Trevor[49] was a sweet, quiet, and polite First Nation young man. He wanted to graduate from high school and own a roofing and drywall company, but his frequent moves affected his education. Trevor's parents, Crystal and Gordon, had two children, Trevor and Skylar.

Trevor was 20 years old when he was a victim of homicide. The circumstances of Trevor's death are still being investigated by police and the Office of the Chief Medical Examiner. At the time of his death, Trevor was receiving child intervention services through a **support and financial assistance agreement**.

Summary of Government Systems Involvement

Trevor from birth to 5 years old

Child Intervention Services received a report when Trevor was born. Crystal was 15 years old, used substances, and did not have housing or healthy supports. She entered into several **family enhancement agreements**. At three months old, Trevor was removed from his mother's care and placed in a foster home. He was returned to Crystal's care under a supervision order. When the order expired, Crystal entered into a family enhancement agreement. She worked with parenting and counselling supports, and when the agreement expired, child intervention involvement ended.

Crystal was 17 years old when she had Skylar. Over the next four years, Child Intervention Services received nine reports regarding Crystal's substance use and her ability to care for her children. Child intervention involvement ended each time after Crystal agreed to go to an addictions treatment program. She agreed to not have known drug associates in her home and moved with four-year-old Trevor and his two-year-old brother to her mother, Millie's, and her stepfather, Henry's, home. Millie had a history of substance use and housing instability. Crystal did not go to treatment and it is unclear what supports Millie received to address her substance use and housing instability.

Trevor from 6 to 10 years old

When Trevor was six years old, Millie and Henry obtained **private guardianship** of him and Skylar. Shortly afterward, Child Intervention Services received a report regarding Millie's gambling and the children's exposure to family violence and verbal abuse. Trevor told caseworkers he was scared of being physically disciplined and of the violence in his home. Millie and Henry entered into two consecutive family enhancement agreements. When the last agreement expired, child intervention involvement ended.

49 All names in this review are pseudonyms.

Over the next two years, Child Intervention Services received three reports about family violence, Millie's and Henry's gambling, and Trevor's sexual abuse by an unknown adult. Each time, child intervention involvement ended at **intake**.

Child Intervention Services received a report that 10-year-old Trevor and his brother were in their mother's care. Crystal continued to use substances and was involved in criminal activity. Trevor and Skylar were removed from Crystal's care and Trevor was placed in a group home for approximately one year under a **temporary guardianship order**. During this time, he saw his mother sporadically, had suicidal thoughts, felt unwanted, was quick to anger, and was hard to calm down. He was aggressive towards school and group home staff and towards his peers. A therapist and youth worker supported Trevor, and his behaviours and reading skills improved.

Trevor from 11 to 15 years old

Over the next three years, Trevor had several placements. His caseworker felt it was best for him to live with family and moved him to live with his aunt. While in her care, he did well in school. Trevor was moved to Skylar's foster home after being exposed to family violence in his aunt's home. He began to use substances, but still did well in school. Millie completed an addictions treatment program and parenting courses. Trevor and Skylar were returned to her care under a six-month **supervision order**.

When the supervision order expired, Millie entered into a series of family enhancement agreements, worked with a support worker to learn parenting strategies, and received counselling supports for both her and her grandsons. Over the next two years, Millie had difficulty managing Trevor's behaviours. He was often sent back and forth between two provinces to live with relatives. While with family in the other province, he was exposed to violence and drug trafficking. When he was in Alberta, he was suspended for bringing weapons and drugs to school. Trevor began to self-harm and school staff attempted to connect him with an Indigenous liaison worker, but he did not regularly go to school. He told caseworkers that he had been inappropriately touched by another child while in foster care.

When the family enhancement agreement expired, Millie declined further supports and child intervention involvement ended. Shortly afterward, Child Intervention Services received a report that Trevor carried a weapon, used substances, and had attempted suicide. Millie said she could not care for him because she did not feel safe. Attempts were made to place Trevor in a stable placement, but he insisted on living with Crystal. During the next two years, Crystal entered into six consecutive family enhancement agreements. She had difficulty managing Trevor's behaviours. He could become violent towards himself and others, and police were often involved. Trevor and his brother said they were gang members, and a short time later, Trevor was stabbed. He was briefly supported by a youth intervention program to address concerns of suicide and violence.

During this time, Trevor's cousin died by suicide, which had a profound impact on him. Referrals were made for a youth worker, an Elder, and an outreach school program, but he did not meet with his supports or go to school consistently. At 15 years old, Trevor was charged with assaulting a community member. He attempted suicide twice and was confined under the ***Mental Health Act*** and then under the ***Protection of Children Abusing Drugs Act*** (***PChAD***). Trevor was diagnosed with **depressive mood**, **substance use disorder**, and **oppositional defiance disorder** features. After he was released, further criminal charges were laid against him, and his substance use increased. Trevor declined supports for his mental health concerns and past trauma.

Trevor from 16 to 20 years old

At 16 years old, Trevor entered into two consecutive **enhancement agreements with youth**, and he lived independently. Caseworkers arranged for counselling supports and an Elder to address Trevor's substance use and depression, but he refused. He was confined in **secure services** for 25 days and completed a secure services risk assessment. Several recommendations were made, but could not be implemented because he was again incarcerated.

While in jail, Trevor received addictions counselling, therapy, anger management, and educational programming. Caseworkers and his youth worker visited him regularly. Between the ages of 16 and 18 years old, Trevor was incarcerated 10 times, had more than 30 criminal charges, and was placed on suicide watch 6 times. When he was released, he did not follow his probation conditions, which resulted in further incarceration.

On his 18th birthday, Trevor entered into the first of five support and financial assistance agreements. He was incarcerated soon afterward, and a psychological assessment recommended he receive mental health and addictions services while in jail. Caseworkers and justice staff met to discuss community-based addictions and mental health services that could support Trevor, but he was often rearrested on new charges. While incarcerated, he told his therapist that he had tried to end his life several times. A psychological assessment indicated that his lifestyle and mental health affected his ability to follow the conditions of his probation. Trevor said that he was heavily involved in gang activity and did not have a stable home.

Circumstances Surrounding Trevor's Death

Trevor and his caseworker would communicate or see each other every other day. When his caseworker was unable to reach him for four days, he was reported missing. The following day, police found 20-year-old Trevor. He was a victim of an apparent homicide. The circumstances surrounding Trevor's death are still being investigated by the Office of the Chief Medical Examiner. A wake and a funeral were held for Trevor, and many friends and family members came. He is greatly missed by those who loved him and worked with him.

Closing Remarks

Although this investigative review includes the circumstances of nine young people each one was an individual who must be remembered as such. Whitney, Josh, Greg, Camden, Chara, Marino, Skye, Natalie, and Trevor continue to be mourned by their loved ones, to whom I extend my sincerest condolences.

This report references dozens of my previous recommendations, the majority of which have been met or substantially completed. Good work has been done. However, I continue to see the same issues related to assessments, information-sharing and collaboration, so I have introduced two new recommendations in an effort to address these persistent areas of concern.

Current quality assurance measures in child-serving ministries are primarily quantitative and evaluate the occurrence and completion of tasks. We must have a balanced perspective and consider outcomes for young people and their families when evaluating the effectiveness of supports. Furthermore, services are often offered to address the presenting concern, without considering the longer-term safety and well-being of the young person. Young people have histories and challenges beyond the presenting concern, and their circumstances are also likely to change over time, so assessments should not be viewed as a singular event but should be ongoing. Service providers should assess young people's circumstances within the context of their histories, families and communities, so they can respond to changing needs.

By collaborating and breaking down barriers to information-sharing between systems, service providers can help ensure that young people's overall well-being is addressed in decision-making. A key area of collaboration must be focused on service provision for Indigenous people and their families, who remain markedly over-represented in government systems. This issue cannot be resolved without equitable and accessible funding and services for these populations. Often, federal funding for First Nation communities to provide public services is not comparable to their provincially funded counterparts. Governments need to work collaboratively to address this deficit so support services are equitable and accessible for Indigenous people.

It is my hope that by revisiting my previous relevant recommendations and completing any outstanding work to meet them, as well as implementing my new recommendations, Alberta's young people will receive the services they need to succeed in their lives and communities.

APPENDICES

APPENDIX 1: GLOSSARY

anxiety	A feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome.
anxiety disorder	A mental health disorder characterized by excessive worry or fear that impacts school, work and relationships.
assessment	The gathering and analysis of information to determine whether a child is in need of intervention under the *Child, Youth and Family Enhancement Act*.
asthma	A chronic or long-term condition that intermittently inflames and narrows the airways in the lungs.
Ativan	Also known by the generic name lorazepam, Ativan is a prescription medication for anxiety.
Attendance Board	An education panel that takes referrals from public and private school authorities when chronic non-attendance cannot be resolved locally. The panel may give direction to the student and/or the parent/guardian that it considers appropriate and enforce the ruling by registering it as an order of the Court of Queen's Bench.
borderline personality disorder	A mental health disorder that affects self-image, relationships, and self-regulation of emotions and behaviour.
custody agreement	A voluntary agreement between guardians and Child Intervention Services. Decision-making is shared and the young person is placed outside the home.
depression	A mood disorder that causes a persistent feeling of sadness and loss of interest.
depressive mood	Mood characterized by feelings of tiredness, sadness and worry.
drug toxicity	Occurs when a person has a dangerously high amount of a drug in their system, leading to an acute adverse reaction and potentially death. Both the high drug dose and the resulting reaction/death may also be referred to as an overdose.

enhancement agreement with youth	A voluntary agreement that Child Intervention Services will provide supports to a young person aged 16 to 18. It is intended to address protection concerns while the young person lives independently.
family enhancement agreement	A voluntary agreement that Child Intervention Services will provide supports to a family. It is intended to address protection concerns while the child remains with a guardian.
Family Support for Children with Disabilities (FSCD)	A voluntary program that provides individually assessed family-centred supports to help strengthen families' abilities to promote children's healthy development and participation in activities. Parents remain guardians.
fentanyl	A prescription painkiller up to 100 times more potent than morphine. Fentanyl is often produced and sold illegally. It is frequently mixed with other drugs and is difficult to detect.
fetal alcohol spectrum disorders (FASD)	Disorders resulting from exposure to alcohol in utero. People with FASD may experience a variety of physical, mental and behavioural effects.
home assessment	An assessment to determine if a family is suitable to provide a safe placement resource and has the capacity to meet the needs of children or youth in the care of Child Intervention Services.
hypoglycemia	Low blood sugar, often related to diabetes and its treatment.
individualized program plan (IPP)	Programming tailored to a student's unique educational needs. IPPs are provincially required for all students with special needs.
intake	A report completed when Child Intervention Services receives a community or professional concern about possible risk to a child as per the *Child, Youth and Family Enhancement Act*.
integrated threat and risk assessment	A risk assessment used by police to determine the likelihood that a person with a history of violence will reoffend.
major depressive disorder	A mental health condition characterized by symptoms such as persistent low mood, fatigue, sleep issues, loss of interest in most activities, and significant changes in appetite or weight.

Mental Health Act	Provincial legislation that provides safeguards, supports and supervision for mentally ill individuals.
methamphetamine	A synthetic drug manufactured from chemical ingredients. Methamphetamine is an illegal and highly addictive substance with long-term health effects.
naloxone	A medication that can temporarily reverse opioid poisoning.
neonatal intensive care unit	A hospital unit for seriously ill or injured infants.
Non-Insured Health Benefits program	A federal program that provides eligible First Nations and Inuit clients with health benefits for care needs not covered through other services. Benefits may provide coverage for vision and dental care, counselling, medical supplies, medications, and transportation to distant health service sites.
oppositional defiance disorder	A behavioural disorder diagnosed in children who display a pattern of irritable, defiant, vindictive behaviours for six months or longer, disrupting activities and relationships.
OxyContin	An opioid prescription pain medication, often taken recreationally.
Parent Link Centre	Information and referral centres for parents. They may offer a variety of family-based services, such as parent education programs and support groups.
pneumonia	An infection, ranging from mild to severe, that causes inflammation in the air sacs of the lungs.
polysubstance use	The use of multiple substances, such as prescription and/or illicit drugs, often with the goal of increasing the effects on the user.
post-traumatic stress disorder	A condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world.

private guardianship order

A court order that appoints a person to be the guardian of a child upon application by that person. The person applying should be an adult and have had care of the child for a period of more than six months, or should be a parent other than a guardian of a child.

probation order

An order that serves as an alternative sentence to incarceration for individuals convicted of a crime(s). Probation orders allow for an individual to remain in their community while abiding by conditions (e.g., curfew, substance abstinence) and reporting to a probation officer according to a set schedule.

***Protection of Children Abusing Drugs Act* (*PChAD*)**

Legislation pertaining to minors who use substances. Minors can be placed in secure services facilities under this legislation.

***Protection of Sexually Exploited Children Act* (*PSECA*)**

Legislation pertaining to sexually exploited youth. Children/youth can be placed in secure services facilities under this legislation.

protection order

An order granted by the police or court when there is violent or threatening behaviour between family members and there is evidence that immediate protection is necessary to prevent further incidences of violence.

psychological parenting assessment

Also referred to as "parenting assessments" or "custody and access reports," these evaluations are performed by psychologists with the goals of assessing parental capacity and identifying parental behaviours that may negatively impact children. These assessments are typically ordered during custody disputes.

psychotic disorder

A type of serious mental health disorder characterized by hallucinations (hearing, seeing, smelling, tasting or touching something that is not real) and delusions (false beliefs, such as fear that someone is poisoning you), and confused or disrupted thoughts and speech.

public health nurse

A community-based nurse who focuses on health at both the individual and population levels. They provide health education and, depending on how remote or low-income the region, they may be key health service providers.

qualitative measures	Methods of evaluating the qualities of the research subject. Qualitative data is fairly subjective and may be captured through methodologies such as interviews or surveys.
quality assurance measures	Methods of ensuring that a product or service is consistent and meets the standards of the producer or service provider.
second-stage shelter program	Apartment-style residences intended to help a person transition between emergency shelters and independent living. Second-stage shelters typically provide wrap-around services and are commonly available for terms of six months to two years.
secure services	The *Child, Youth and Family Enhancement Act* allows for the confinement of a child for up to 30 days for stabilization and assessment when the child is found to be an immediate danger to themselves or others.
sepsis	A life-threatening medical condition triggered by the body's outsized response to infection.
streptococcus	A type of bacteria responsible for a variety of infections.
substance use disorder	A diagnosis for a demonstrated inability to control the use of a legal or illegal drug or medication despite the harm it causes.
supervision order	A court order granting mandatory supervision of a young person to Child Intervention Services. Custody remains with the guardian.
systems thinking	A framework for analyzing systems to predict outcomes and make changes.
temporary guardianship order	A court order that grants Child Intervention Services custody and guardianship of a child for a specific period. The child is in the care of Child Intervention Services and guardianship is shared with the parent/legal guardian of the child.

tube feeding

A feeding technique used when a person cannot safely eat or drink a sufficient amount by mouth, typically due to an illness or health condition. There are several types of feeding tubes, including gastrostomy tubes (inserted through the belly) and nasogastric tubes (inserted through the nose).

warm handoff

A method of transferring care from one service provider to another. The goal is to reduce issues and increase the client's comfort. The initial service provider introduces the client to the new provider either in person or by phone. Providers are transparent about their conversations and allow clients to listen in, and clients have the opportunity to make clarifications and ask questions.

APPENDIX 2: EXTERNAL RECOMMENDATIONS TO ADDRESS INEQUITIES FOR INDIGENOUS PEOPLE

Over the past three decades, there have been a number of national and provincial inquiries, commissions, and tribunals to address inequities experienced by Indigenous people. These challenges have been well-documented and pathways to solutions have been provided, yet Indigenous people continue to experience negative impacts from these inequities and are disproportionately represented in government systems.

Ongoing public awareness is important to keep pressure on all levels of government to work towards fulfilling the many recommendations made to address the mistreatment and inequities experienced by Indigenous people.

Document	Actions	Progress
Report of the Royal Commission on Aboriginal Peoples (1996)	44 recommendations[50]	The TRC was one of the biggest recommendations to be achieved.[51]
Declaration on the Rights of Indigenous Peoples (2007)	In 2016, Canada officially adopted and promised to implement this United Nations declaration. On December 3, 2020, the Government of Canada introduced legislation to implement the declaration.[52]	The act received royal assent on June 21, 2021 along with a commitment for an action plan by 2023.[53]

50 Royal Commission on Aboriginal Peoples (1996)

51 Trojan (2016)

52 Eggerman et al. (2020)

53 Government of Canada (2021b)

The Final Report of the Truth and Reconciliation Commission of Canada (2015)	94 calls to action[54]	Although some work has been done, there is no consensus regarding how many calls to action have been fully implemented. The assessment of completed actions varies from 8 to 14 across those evaluating their implementation.[55 56 57] The Government of Alberta has committed to work on implementing several calls to actions including: 1) The *Indigenous Cultural Understanding Framework* to educate Children's Services staff on delivering culturally appropriate support, services and programs to Indigenous children, youth, families, and communities. 2) Education for Reconciliation is a commitment towards rebalancing the education system, advancing reconciliation and supporting the commitments.[58] There has been significant criticism that the new Alberta curriculum falls short of the commitment made to include treaties and residential schools in the K–12 curriculum.[59]

54 Truth and Reconcilliation Commision of Canada (2015)

55 Jewell & Mosby (2020)

56 Nardi (2021)

57 Barrera et al. (2018)

58 Government of Alberta (n.d.)

59 Rupertsland Institute (2021)

Ruling from Canadian Human Rights Tribunal (2016)	Ruled there was inequitable funding for Indigenous child and family services and that Jordan's Principle was being implemented in a manner that defeated its purpose.[60]	There continues to be non-compliance orders and government challenges to the ruling, delaying implementation of the relief orders.[61]
A Stronger, Safer Tomorrow: A Public Action Plan for the Ministerial Panel on Child Intervention's Final Recommendations	A provincial commitment to implement the recommendations from the Alberta Child Intervention Panel. Two actions are specific to addressing funding inequities in services for First Nation communities.[62]	Some of the recommendations are being addressed through the day-to-day work of the ministry. The Government of Alberta made commitments for longer-term actions to be implemented by 2022. There have been no public updates on progress since 2019.[63]
Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)	231 calls for justice. The province accepted the National Inquiry's final report in June 2019.[64]	The Alberta Joint Working Group on Missing and Murdered Indigenous Women and Girls was struck on May 5, 2020 and was given a one-year mandate. Their mandate has been extended to December 2021 to provide advice and recommendations.[65]

60 First Nations Child & Family Caring Society (n.d.)

61 Anishinabek News (2016)

62 Alberta Children's Services (2018)

63 Legislative Assembly of Alberta (2021)

64 National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)

65 Government of Alberta (2021b)

APPENDIX 3: EXPERTS CONSULTED

Del Graff, MSW, RSW

Mr. Graff is the Child and Youth Advocate for Alberta. He has worked in a variety of social work, supervisory, and management capacities in communities in British Columbia and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, and addictions treatment and prevention. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth, and families.

Elder Francis Whiskeyjack

Elder Whiskeyjack supports students at the University of Alberta, MacEwan University, and Concordia University. He is a recognized Elder, wears a coat of many colours, does traditional art and song, and is a community cultural resource advisor. He has been with Amiskwaciy Academy for the past 17 years. Fluent in both English and Cree, Elder Whiskeyjack is an Adjunct Professor and Cultural Advisor at the University of Alberta and received an honourary Doctor of Law in June 2019.

Katherine Haight, MN, BSN, RN

Ms. Haight teaches a variety of courses in the Faculty of Health Sciences at the University of Lethbridge. Her specific interests include health promotion, program planning, implementation, evaluation, and community health nursing. She has over 17 years of experience teaching at the undergraduate and graduate levels. Her experience as a community health nurse working in rural and remote areas, including various Indigenous communities, contributes to her depth and breadth of understanding of complex health issues across the life span and inequities in different care systems within Canada. Ms. Haight worked as a medic with the Canadian Forces, which provided opportunities to work with a wide variety of populations in diverse settings. Her specific areas of research, consulting, and advocacy experience include health-related program design, implementation science, monitoring and evaluation, and quality improvement initiatives.

Rosina Harvey-Keeping, BA, BSW, RSW

Ms. Harvey-Keeping is a registered social worker based in Newfoundland and Labrador. She is one of nine trainers and consultants licensed with Signs of Safety in Canada. She is currently the Regional Director for Elia, the new home for Signs of Safety. Ms. Harvey-Keeping has more than 20 years of experience in the field of child welfare and child protection. She has presented her work using Signs of Safety from the frontline and supervisory perspective at various international gatherings. In addition, she has presented to other organizations and implementation agencies in North America. Presently, Ms. Harvey-Keeping is a full-time licensed trainer and consultant. She works with several implementing agencies across Canada to support child protection staff and manage provincial implementation plans, and she assisted Resolutions Consultancy in Ireland with their whole system implementation.

Rachel Hayward, MPA

Ms. Hayward has over 15 years of experience working in the privacy field. She has been in her current role as Director of Compliance and Special Investigations with the Alberta Office of the Information and Privacy Commissioner for four years. Her team leads high-profile and offence investigations, including the largest offence investigation in the history of the office, which resulted in 38 charges under the *Health Information Act* and additional criminal charges. Ms. Hayward has a Master of Public Administration and is a certified privacy professional and information privacy manager. She was recently awarded the status of Fellow of Information Privacy by the International Association of Privacy Professionals. She is also certified in risk and information systems control.

Murray Knutson, BA

Mr. Knutson is the Deputy Director of the Bent Arrow Traditional Healing Society, where he helps oversee 18 programs and services. Bent Arrow is committed to building upon the strengths of Indigenous people to enable them to grow spiritually, emotionally, physically, and mentally so that they can walk proudly in two worlds. Mr. Knutson has worked as youth worker and provided leadership to programs that support children, youth, families, and Elders for over 20 years. He works with the Canadian Accreditation Council as a peer reviewer and member of their quality improvement committee. Mr. Knutson has a Bachelor of Arts degree with a specialization in criminology from the University of Alberta.

Rebecca Many Grey Horses, MA

Ms. Many Grey Horses is from the Kainai Nation (Blood Tribe) in Southern Alberta. She was raised and immersed in the Blackfoot culture and ceremonies, teaching her to be a keeper of history and knowledge. Her educational background includes a Master of Arts in Jurisprudence in Indian Law from the University of Tulsa. She worked with Alberta Health Services for eight years as a health promotion specialist, team lead, and infant preschool development educator. Currently, Ms. Many Grey Horses is working as a consulting health care analyst with the Blood Tribe Department of Health. In 2019, along with her colleague Ms. Jorgensen, Ms. Many Grey Horses developed the Blood Tribe Addictions Framework, which won a national award from the Institute of Public Administration of Canada for innovative management.

Colleen McCord, BSW, RSW

Ms. McCord has over 35 years of experience in child intervention. She recently retired as the Regional Director for Calgary Region. Prior to this, she held a senior management role for over 10 years. Ms. McCord was one of the service delivery leads for the *Child Intervention Practice Framework*. She assisted in updating staff training (including sessions focused on improving skills for interviewing young people and framework-specific training); participated in the development of competency profiles to include principles and best practices in recruitment and retention materials; and staff support. Ms. McCord worked with the Child Advocacy Centre in Calgary to develop a regional delivery model to support all regions to adopt and implement child advocacy centres.

Linda McFalls, LCSW, RSW

Ms. McFalls is a clinical social worker with more than 30 years of experience providing direct practice, consultations, and clinical therapy to children, youth, adults, and couples. She has worked with Alberta Children's Services, Edmonton Public Schools, and her own private practice. Ms. McFalls has advanced training and certification in play therapy, emotionally focused therapy, cognitive behavioural therapy, and trauma-informed practices. In conjunction with her various roles, she also developed specialized training in the areas of trauma, mental health, child protection service delivery, and leadership development. Ms. McFalls is currently in a doctoral program exploring the impact of emotions on school leadership practices.

APPENDIX 4: TOWN HALL QUESTIONS AND FEEDBACK THEMES

On May 6 and 7, 2021, the Office of the Child and Youth Advocate (OCYA) hosted four virtual town hall meetings with service providers from various child-serving systems and agencies, including Children's Services, Community and Social Services, Justice and Solicitor General, Alberta Health Services, school divisions, and community-based agencies across the province. The sessions held on May 7, 2021 focused on Indigenous service delivery. Over this two-day period, 101 service providers participated to share their insights and experiences related to information-sharing, collaboration, and assessment to improve services for young Albertans. On May 13, 2021, the OCYA held an internal meeting with 18 staff from Intake Services, Indigenous Engagement, Education and Engagement, and Advocacy Services. On May 17, 2021, the OCYA held a meeting with our youth council to gather their insights into these same issues.

Topic 1: How effective/accessible is information-sharing and collaboration across child-serving systems?

Prompts:

- What guides these practices?
- How does information-sharing and collaboration work in your community?
- How does the *Children First Act* assist with information-sharing and collaboration?
- What is working well?
- What are the challenges and barriers?

Theme 1: Building relationships

- Offering multiple services out of one location (i.e., interagency, co-location, "one-stop shops", and/or community hubs) is an effective method of service delivery.
- Trusting relationships are key to effective information-sharing; high rates of staff turnover are often a barrier. Building relationships takes time and in-person contact, and relationships must be reciprocal.
- Collaborative meetings, multidisciplinary practice tables, and/or community sharing circles are helpful for information-sharing and case planning; however, these approaches must be proactive rather than crisis-driven.

Theme 2: Role clarification

- Participants said that Regional Collaborative Service Delivery (RCSD), a provincially funded, multi-ministerial program, was effective and worked well at bringing different systems and agencies to the table to collaborate. There was confusion whether RCSD is still in practice, and if so, which system is leading. Some participants said that RCSD was still occurring in their community, while others stated that the program was no longer in existence.
- Participants had concerns about child-serving systems understanding each other's mandates and the overall impact this has on service delivery to young people and their families.

Theme 3: Formalized processes to facilitate information-sharing and collaboration

- There is a lack of shared understanding regarding the *Children First Act (CFA)*. Participants noted a lack of training across child-serving systems, and some expressed discomfort/hesitancy referring to the *CFA*.
- Participants also expressed that the *Freedom of Information and Protection of Privacy Act (FOIP)* is often referenced as rationale to withhold information from other systems and agencies.
- Participants had concerns about service providers understanding the *Health Information Act (HIA).*
- There is an overall lack of clarity and understanding around confidentiality that is negatively impacting collaboration across systems and agencies. Participants advocated for ongoing, cross-system training on legislation that impacts children, youth, and families.
- In some cases, formalized information-sharing processes, such as memorandums of understanding (MOUs) and cross-ministry protocols, have facilitated improved collaboration. Some participants noted that their organizations had developed their own informal information-sharing processes to improve communication and better serve young people.

Theme 4: Structural barriers to information-sharing and collaboration

- Service providers on First Nations noted challenges between municipal districts and Nations working together.
- Participants stated that a lack of shared language was a barrier to effective information-sharing. Different ministries and/or agencies have differing definitions for the same word (e.g., "complex"). Additionally, processes between different programs and services often do not intersect or parallel each other.

- Staff recruitment and retention is an ongoing issue. Many participants expressed concerns about heavy caseloads, a lack of knowledge retention, and the impact this has on their ability to collaborate with other systems.
- Participants discussed how technology and differing virtual platforms make information-sharing and collaboration challenging.
- First Nations and rural communities face multiple structural barriers and challenges (e.g., service availability and accessibility, transportation, funding) to supporting young people and families.
- Service providers noted high acuity and increasing complexity of young people and families and difficulty locating services to meet their needs.
- Participants discussed a lack of funding and resources for prevention efforts.
- Participants voiced concerns about information-sharing to guide case planning for post-18 young people.
- There were concerns with identifying key contact people and/or legal guardians of young people.

Theme 5: Impacts of the COVID-19 pandemic

- While participants noted that the COVID-19 pandemic has improved collaboration through technology, others expressed that they felt disconnected from their clients and other professionals.
- Participants noted that different systems only permit participation via specific platforms (e.g., Zoom, WebEx, Skype, Microsoft Teams).

Topic 2: What information informs assessments, assessment of parental capacity, and decision-making? How do you know a young person has sufficient supports and services?

Prompts:

- If they are not sufficient, how do you decide to refer to or involve other systems?
- How are multiple systems involved in this process?
- Where do you gather the information that informs decision-making during assessments?
- How is information analyzed during assessment?
- What happens if a child is at risk? Who do you call?
- What are the tools/strategies/models used?
- Is information readily available?
- How do systems coordinate?
- What is working well?
- What are the challenges and barriers?

Theme 1: Importance of collaboration, relationship, and role clarification in assessment activities

- Assessment activities differ across child-serving systems. There are limits on what can be assessed, depending on the program's mandate and the purpose of the child and family's involvement.
- Participants expressed differing understandings of Regional Collaborative Service Delivery (RCSD). They stated that it seemed to depend on whether it had been identified as a priority area and if someone had taken the lead on it. Participants communicated that RCSD was a valuable platform that facilitated organic relationships and networks.
- Service providers said that they often develop informal collaborative networks to compensate for information gaps. Information-sharing works best when based in relationship, and community-based approaches tend to be the most successful. This was noted as a strength in smaller communities and more challenging to achieve in large urban centres.
- Participants noted deferral to other systems driven by a lack of understanding of mandates. Service providers from various school divisions across the province noted that schools are often acting as the "hub" and organizing wrap-around meetings to support students. Professionals expressed that the Family Support for Children with Disabilities (FSCD) program tends to be the "catch all." Participants noted difficulty staying on top of continually changing programs and resources.
- Building strong relationships with young people requires trust and consistency. Participants expressed concerns about retraumatizing young people and their families by requiring them to continually repeat their stories to different service providers. Many expressed that this could be mitigated by effective and consistent collaboration balanced with discretionary information-sharing to respect the young person's privacy.
- Assessments must be inclusive of the young person's cultural identity, community, and connections. Service providers must support young people to develop and maintain their connections. Healthy attachment and supportive, reliable relationships are key to success.
- Assessments or diagnoses can negatively impact young people and families (e.g., labelling and stigma). Participants encouraged language awareness during assessment activities.

Theme 2: Assessing parental capacity and engaging parents

- Participants stated that parental capacity is fluid and that service providers must assess the context that capacity is occurring in. While some participants said that developing support networks was key to increasing child safety, others asserted that safety planning often provides a false sense of security and that situations change quickly.
- Service providers stressed the importance of educating parents on services and resources; however, they also noted that parents often have the ability, but the resources they need are not available when they need them for children with complex needs (e.g., waitlists, insufficient specialized services, lack of respite or caregiver supports). Many families also experienced barriers related to accessibility of services (e.g., lack of localized services, transportation to surrounding communities).
- Parents often need support connecting with resources; wrap-around services and warm handoffs help.
- Participants noted challenges balancing support for young people with parental engagement.

Theme 3: Structural barriers to assessment activities

- Participants across various child-serving systems expressed that they faced the same challenges: high caseloads, decreased funding, long waitlists (particularly for young people with mental health issues, substance use concerns, and/or complex needs), and an overall lack of resources (in part due to the COVID-19 pandemic). They voiced that they could deliver more effective services with smaller caseloads and asserted that burnout often leads to siloed work.
- Service providers voiced concerns that Children's Services involvement with young people and families is crisis-driven and lacking focus on prevention. Many felt that this impacted their ability to provide holistic, wrap-around services to children in need.
- Participants expressed ongoing concerns regarding cultural training for service providers working with Indigenous young people and families. It is vital that professionals have a strong understanding of the impacts of colonialism, residential schools, intergenerational trauma, and other barriers that Indigenous young people face. Participants advocated for mentorship opportunities and/or committees for non-Indigenous workers to learn how to best support Indigenous young people and families.

- Professionals providing services for young people and families on First Nations and in rural areas questioned the lack of resources available and reinforced the toll that this takes on young people, families, workers, and communities. They noted the geographical impact on service availability and placement options and having to travel to urban centres to access necessary resources. They felt that they had to be creative in their approach to deliver effective services. They expressed that rather than travelling to outside communities, localized services would be more relevant, relationship-based, and better able to meet the needs of young people from isolated communities.
- Participants said that services are not adequately preparing young people for adulthood and reasserted the importance of continued support post-18.

Theme 4: Impacts of the COVID-19 pandemic

- Participants said that young people are experiencing challenges connecting with their supports because of limited access to technology (e.g., they do not have access to a cell phone or financial means to pay for a phone/data plan).
- Young people may be reluctant to engage virtually (e.g., counselling, aftercare programs), which has impacted their continuity of care.
- Services available during the pandemic are changing frequently, so staff must be proactive in keeping on top of what is available.
- Community events that promote connectedness between young people, service providers, and families have ceased.
- Access to in-home supports have been impacted.

APPENDIX 5: TERMS OF REFERENCE

Authority

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act* (*CYAA*). The role of the Advocate is to represent the rights, interests and viewpoints of young people receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or the youth justice system.

The *CYAA* Section 9.1(10) provides the Advocate with the authority to investigate systemic issues arising from the death of a young person who was receiving a designated service at the time of their death or within two years of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Objectives of the Investigative Review

To review the experiences of children who have passed away and their families with child-serving systems as related to:

- adequacy of assessment
- information-sharing and collaboration between systems when multiple systems are involved in service delivery

To comment on relevant protocols, policies and procedures, standards and legislation.

To prepare and submit a public report that includes findings and recommendations arising from the investigative review.

Scope/Limitations

An investigative review does not contain any findings of legal responsibility or any conclusions of law, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an investigative review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of young people who receive child intervention services.

Methodology

The review process will include:

- examination of critical issues
- review of documentation and reports
- review of policy and casework practice
- personal interviews
- consultation with experts
- other factors that may arise for consideration
- notification and involvement, as the case may be, of the young person's family, Band, Delegated First Nation Agency, community or cultural group, relevant ministry, law enforcement agency, Office of the Chief Medical Examiner, Alberta Health Services and any other person the Advocate considers appropriate

Consultation with Experts

Relevant subject matter expertise will be obtained by convening a committee—to be determined by the Advocate and the OCYA Director of Investigations. The purpose of consultation is to review the investigative review report and to provide advice regarding findings and recommendations.

Reporting Requirement

The Child and Youth Advocate will release a public report once the investigative review is complete.

APPENDIX 6: BIBLIOGRAPHY

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