

Connecting the Dots:

A report on the condition of youth-at-risk and youth with very complex needs in New Brunswick



Ombudsman

Child & Youth
Advocate



“As Child and Youth Advocate, I am reluctant to place any greater emphasis on one of the recommendations in this report over any other. In my view, many of the solutions proposed are critical elements of a plan to move the province forward on its agenda of making sure that children come first. However, as a starting point, it would be timely to draw a line in the sand and say that we are going to stop letting the youth criminal justice system pickup the pieces and be the stop-gap measure or solution to our historic failings in the area of child and youth mental health services. The reason for this priority emphasis is, of course, the magnitude of our error in allowing the current situation to go on for as long as it has. It is not merely a question of devising mental health solutions for mental health patients because, quite honestly, that makes more sense than treating them as criminals. The problem is that, when we make the youth criminal justice system our default solution for children with complex needs, we are deliberately placing young, vulnerable children directly in harm’s way. The approach is so fundamentally contrary to Canadian values that the average Canadian would be amazed to learn that it happens as routinely as it does.”

Bernard Richard, Connecting the Dots, 2007, p. 49

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Cover photo: Early in the winter of 2007, a New Brunswick youth left home and wound up on the street seeking shelter in mid-winter. He found refuge in a vacant home. In March of last year the house was destroyed by a kerosene lamp used for light and heat. Fortunately, no lives were lost.

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Ombudsman and Child and Youth Advocate Report

Bernard Richard
New Brunswick Ombudsman and Child and Youth Advocate
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Table of Contents

	Page
Executive Summary	1
Overview	3
Jasmine’s story	6
Investigation methodology	17
Chapter 1 - Political direction and accountability: <i>Gabriel’s story</i>	20
Chapter 2 - Service integration: <i>William’s story</i>	29
Chapter 3 - Community-based residential care: <i>Jacob’s story</i>	37
Chapter 4 - De-criminalizing youth with mental health disorders: <i>Nicholas’s story</i>	46
Chapter 5 - Tailoring educational services for youths with complex needs: <i>Benjamin’s story</i>	60
Chapter 6 - Supporting families of youth-at-risk and children and youths with complex needs: <i>Samuel’s story</i>	71
Chapter 7 - Closing the gap: age discrimination in youth services	81
Conclusion	86
Appendix I - Table of recommendations	90
Appendix II – Stakeholders consulted	102
Appendix III – Integrated Complex Case Diagram (proposed process)	103
Appendix IV - Bibliographical references	104

Executive Summary

The Ombudsman and Child and Youth Advocate is tabling a report in the Assembly further to his investigation into youth-at-risk and youths with very complex needs. The investigation began in February, 2006, but the Ombudsman was not granted access to records to carry out the investigation until early 2007. The report includes a review of seven individual complaint files relating to youths with very complex needs and makes 48 recommendations to government. The Ombudsman and Child and Youth Advocate is committed to reviewing these recommendations with government in a year's time to measure progress made. The report and recommendations are divided into seven broad areas and themes. All are intended to improve services to children and youth in the Province of New Brunswick.

The first set of recommendations aims at creating conditions for greater political direction and accountability in child welfare. These recommendations are divided into three parts. First, those relating to the Child and Youth Advocate's own oversight function call for: timely access to youth correction and child protection records; a more active presence and accessible advocate to children in group homes and residential care; and more emphasis on regular monitoring by the Advocate of child welfare services. A key recommendation relates to Cabinet direction and oversight. It calls for the appointment of a Minister of Child and Youth Services with a legislative mandate to coordinate and integrate services to children and youths across all government departments. The report also recommends increased vigilance by civil society in relation to child welfare matters.

The second broad theme involves recommendations aimed at service integration. The report recommends that the Minister of Child and Youth Services have the legislated authority to broker disputes among departments and agencies in relation to payment of services and to facilitate information-sharing among public authorities in relation to children and youth receiving services. Operational and legislative steps are recommended to improve the flow of information, and further study is recommended into establishing a joint electronic records management system for children and youth in need. Finally, government is encouraged to establish improved public health information systems to guide families of children in need.

The third set of recommendations relates to the provision of community-based residential care. The report calls for establishment of two centres of excellence in the province. One would be dedicated to research and the provision of services to children with very complex needs, including the establishment of community-based residential capacity for these youths; the second centre of excellence, located in another New Brunswick community, would focus on the broader category of youth-at-risk to develop and pilot community-based interventions for them. The report also recommends stable core funding to youth transition homes and program support to recruit and retain specialized staff in these homes, and to improve wages, training and clinical support to group home and youth transition home staff, with a view towards making the mental health system first-responders in times of crisis rather than involving the public safety system. These recommendations encourage government to renew its efforts to provide child-centric

services and continuity of care so that stable relationships may be developed with youth-at-risk and youth with complex needs. The involvement and leadership of regional health authorities (RHAs) is viewed as critical to the implementation of these initiatives.

The fourth broad theme is central to the entire report and calls for the decriminalization of youth with mental health disorders. It recommends child and adolescent psychiatry services be developed in all RHAs, including the recruitment and retention of specialized psychiatrists and psychologists and other health care professionals, and that the responsibility of RHAs be increased for the post-discharge care of youths with significant mental health disorders. The report recommends more research into the use and benefits of psychotropic drug therapy for children and the implementation of measures to ensure that children in care and youths in custody remain on the medications prescribed by their treating physicians. It also recommends that the New Brunswick Youth Centre increase its efforts to inform youths of their rights and recourses while in custody and that it immediately suspend its practice of shackling and strip-searching youths with mental health disorders when placed in isolation pending further review of all its practices in relation to the use of isolation and transfer protocols for this population.

The report then addresses recommendations in the area of educational services and suggests that the Department of Education make renewed efforts to engage and involve public health services, child welfare services, and public safety officials in multidisciplinary approaches to inclusive education. This could be achieved through increased use and expansion of the Youth Treatment Program, through the establishment of a Special Education Authority for youths with complex needs, through increased provision of educational services in alternate settings to the classroom and development of pilot programs, such as outdoor education, education through the arts, and vocational education programs, as alternatives to the traditional classroom. Finally, it is recommended that the Minister of Child and Youth Services coordinate cross-training efforts for teachers, other classroom employees, mental health employees and child welfare employees as a means of further integrating and coordinating service delivery.

The report next encourages measures to support families of youth-at-risk and children and youths with complex needs. It recommends establishing mobile crisis teams to intervene on an emergency basis in the family home; the development of guidelines to favour and exhaust family-based interventions over residential placement options; improved post-diagnostic supports to families in partnership with community-based stakeholders; an improved attention to continuity of care and life-long care for children with very complex needs; and improved mechanisms to promote family relationships following placement outside the home.

The report closes with a chapter recommending the elimination of discrimination in youth services through amendments to the *Family Services Act* that would remove the gap in services for children aged 16 to 19 years of age.

Overview

We hold few things in life more dear than our children. Our lives are consumed with efforts to make a good home and provide our children with every opportunity in life. As a society, we value our investments in children and youth. New Brunswick was among the first jurisdictions in the world to create a ministry for families. Our laws and our political discourse are replete with references to the best interests of the child, to accessible education for all, to the need to provide a loving family home for every child, to improve investments in early childhood services.

Given the rhetoric and the principled commitment to children and youth, one would hope to find, in the field, near universal affirmation of these goals, and service delivery solutions for every case of a child in need. But let's take off the rose-coloured glasses for a moment.

In my tenure as Ombudsman and in the past year as Child and Youth Advocate in this province, one of my constant priorities has been to improve the level of services to children and youth. In my first report into a systemic investigation as Child and Youth Advocate, I wanted to focus squarely on the areas of greatest need. Complaints to my office revealed these to be: 1) the gap in services generally for New Brunswick youth, particularly those aged between 16 and 19 years; and 2) the lack of services and coordination of efforts to meet the needs of children and youths with highly complex needs.

One of our former prime ministers, Pierre Elliott Trudeau, reminded us often that the true measure of any democracy is the manner in which the majority treats its discrete minorities. Among the voiceless and the faceless in our midst are the children and youths whose stories are told in the vignettes of this report. This province simply cannot afford to rest upon the laurels or success of its adoption services program, or to boast about its leadership in the area of mainstreaming and inclusive education. This report is all too full of accounts of children left behind. They are forgotten because of their age. They are forgotten because of their level of ability. They are marginalized because of their behavioural and mental health problems. They are often abandoned because they are so very hard to love.

However, on most days, their humanity and their vulnerability can level the strongest amongst us.

If our goal as a society is to become truly self-reliant, then we cannot afford to race ahead without ensuring that we are all in the race together. Any measure of self-sufficiency as a society must take into account how well the State levels the playing field and provides the basic necessities and equal opportunities to those in greatest need. My investigation into the complaints from parents analyzed below has convinced me of how far we have yet to go on the equal opportunity agenda. As we build from this foundation and reach beyond, towards self-sufficiency, we cannot afford to make gains on one front at the expense of the other.

In my opinion, the challenges facing New Brunswick youth generally at this time, and children and youths with complex needs, in particular, are so demanding that I have taken the unprecedented step of calling on all members of the Legislative Assembly to work together towards implementation of the recommendations herein, by tabling this report in the Assembly. The *Ombudsman Act*, and recent amendments to the *Child and Youth Advocate Act*, allow that, for certain recommendations that have escaped government's urgent attention for too long, the Ombudsman may table his report and recommendations in the Assembly. Generally, this process is the Ombudsman's ultimate sanction, and to my knowledge none of my predecessors in this office has ever taken this last step in the Ombudsman process. These recommendations, however, are far-reaching and would take some time to implement. The report, in my view, deserves a high degree of attention and the cooperation and involvement of our elected officials on all sides of the House. I have therefore decided to table this special report in the Assembly with a view towards revisiting each of the recommendations with government in a year's time.

Throughout this lengthy investigation, I, and members of my staff involved in this effort, have been struck by both the courage and the despair of the parents of children and youths with complex needs who have sought help from this office. As an Advocate and Ombudsman, I have only a power of recommendation. To underscore the recommendations made in this report, I felt I could do no better than to give voice to the parents and youths whose stories have resonated so deeply with me.

The bulk of this report is therefore a graphic account of the challenges and of the lack of services and lack of coordination of efforts encountered by the youths and parents who have complained to me. In material respects, these vignettes are the stories of the youths themselves, as recounted by their parents and loved ones. My investigators have heard these accounts and measured them against the voluminous records disclosed by departments and agencies of government to test their veracity, but the stories remain those of the parents themselves and the impressions government's efforts have left with them. I struggled at length before deciding to change all the names of youths portrayed in the report to fictitious names that would protect their identity. I wondered whether it was more respectful of the human dignity of each young person and family involved to recognize them by name and bear witness to their story more publicly, or to shield their identity. In the end, I have decided to leave that choice to the youths and parents themselves, recognizing that, for the sake of this report, which will remain a public record, their privacy is perhaps best guarded through the use of aliases throughout the text.

The vignettes of these young persons are arranged so as to illustrate the various chapters of the report. Each chapter is introduced by one youth profile and the recommendations for reform under that particular theme follow. The recommendations for reform are grouped according to the following main themes of the report: increased political direction and accountability; integration of services; improved offer of residential care services; de-criminalization of conduct by youths with mental health disorders; the provision of tailor-made educational services for youths with complex needs; and support

for families of youth-at-risk and youths with complex needs. I close with a chapter focusing on the gap in services for children aged 16 to 19 years of age.

I begin with a review of the methodology of our inquiry and comment upon the procedural difficulties we encountered as, I believe, these bear mentioning. I then relate the stories of Gabriel, William, Jacob, Nicholas, Benjamin and Samuel to the six key areas of recommendations brought forward. Finally, I conclude with a summary of recommendations. However, in order to situate the reader, I begin with the story that began my investigation--Jasmine's story.

*Born the most wonderful day of her life
Even the church bells couldn't stifle Radegonde's first scream.
Ouuuaahh!
And the bells answered: Et Verbum Caro Factum est.*

...

*The bells pealed. Radi pealed out louder, each in a fight to bury the other. Then on all sides it was couchi-couchi and tickles under her chin, look you could swear she understood! She didn't scream in fear, she rang out with the bells, all fists and feet, to proclaim herself to the world, in broad daylight.
The most wonderful day of her life.*

Extract of an unpublished text of Antonine Maillet,
Printed in limited edition, April 23, 1990
Papeterie Saint-Gilles, Charlevoix, Quebec¹

Jasmine's Story

Jasmine's mother, like all the parents mentioned in this report, sought the help of the Ombudsman's office after having knocked on every door she could. My investigators met with her more than once, and each time her account of Jasmine's story was detailed, accurate and complete. She has recounted it often. Students of social work and clinical psychology often marvel at caregivers who can give such textbook accounts of their charge's social or medical history. Unfortunately, if the story is so well-rehearsed, it is only a testament to the unsuccessful attempts of every system - educational, medical, social, legal and penal - to respond to Jasmine's needs.

Inevitably, this mother's story began with her pregnancy and the birthing process. The stories of the families related here have, in common with so many of our individual stories, a happy beginning of hope and expectancy. In some cases, those happy days are short and few, as a spiral of illness, isolation, taunting, abuse, problems in school and problems with the law engulfs the family circle, as can sometimes happen with oppositional-defiant, or some autistic children. In other cases, mental health problems don't surface or become overwhelming until mid- or late-adolescence, and childhood passes blithely by, as can happen with schizophrenia or milder forms of Asperger's

¹ Translation from original French text: *Née le plus beau jour de sa vie
Même l'angélus n'a pas réussi à étouffer le premier cri de Radegonde.
Oùàà ! Et la cloche a répondu : Et Verbum caro factum est.*

...

*La cloche hurle. Radi hurle, c'est à qui enterrera l'autre. Puis de tous côtés c'est des guidi-guidi et des chatouilles sous le menton, regardez on jurerait qu'elle comprend ! Elle n'a pas crié de peur, elle a sonné avec les cloches, des pieds et des poings, et s'est annoncée elle-même en plein midi.
Le plus beau jour de sa vie.*

Syndrome. From the parent's perspective, however, the sense of loss and grieving in watching one's child battle mental health problems is painful and enduring; it matters little when it began.

Jasmine is diagnosed with chronic schizophrenia. Typically, one might expect that Jasmine's mental health problems would not have surfaced until she was much older, but her story is exceptional in that respect and this may help explain why the early interventions were so ineffectual and why her case remains so troubling.

Jasmine's infancy was like that of most children. She was born naturally, with no complications, and she appeared to develop normally, walking and talking at the appropriate stages. But, around the age of two or three, her mother noticed that she had become a nervous child. A single parent, her mother found that Jasmine needed someone around constantly and had difficulty entertaining herself. She slept a lot. Still, at the ages of four and five, she was quite sociable and seemed to adjust to kindergarten. But, upon reaching Grade One, she became more withdrawn.

At seven years old, her grandmother died. As a young child, she had lived for several weeks with the grandmother and become quite attached to her. Jasmine's mother had difficulty explaining the death to the child, and she became more withdrawn. She began having trouble relating to her peers. Even her interactions with younger children, whom she frequently chose as companions, were very upsetting to her. It was not unusual for her to be sent home crying after playing with younger children. She had many crying episodes, often without apparent triggers.

Between the ages of seven and nine, Jasmine had trouble concentrating; she was disorganized and often somnolent. No medical reason could be found for her aches and pains. Gradually, she became more aggressive and oppositional. She took up to four hours to do her homework. In general, she had turned from a happy, compliant child into an angry and defiant one, although the defiant behavior appeared to be confined to her home; she was not yet displaying this behavior at school.

Problems began outside the home when Jasmine was in Grade Six (at the age of 11 or 12). She was being bullied at school because she was different. Switched to another school, she was bullied there, too. Other children played tricks on her, and she began resisting going to school. Grade Six would be Jasmine's last year in the regular educational system.

Her behaviour at home got worse, too. She collected garbage and kept it in her room. Jasmine imagined herself as a child cop patrolling the neighborhood. She appeared anxious around other children, did not socialize with them, and became jealous if her mother paid attention to the others. Discipline became harder because Jasmine would hit, kick and bite. Taking a time-out was the only thing that would calm Jasmine and her parents "child-proofed" her room so that she could be sent there. The child would not eat and believed she was being poisoned. She said her food tasted like urine or alcohol.

In February 2000, when Jasmine was eleven years old, her mother called Mental Health Services and was put on a waiting list. Her case would not be assigned to a worker until May 2001².

During this time, her mother or step-father sometimes found Jasmine hiding, and when they did, she stared through them. Others noticed this behaviour, too. Jasmine also began having problems at school.

One day, her mother caught Jasmine trying to jump out a third-story window and immediately called mental health services. They promised to return her call. According to Mental Health Services, they tried to call the mother back over the next couple of days but were unable to reach her. At school, she became defiant and angry. A resource teacher suggested she should be taken to a psychologist. Meanwhile, her mother called mental health services daily, seeking help. She wondered: when does a child with behavioral problems like Jasmine's become a priority?

In May, 2001, her mother took her to a psychologist. (She did this at her own expense, as she did not have insurance.) Jasmine resisted returning to the psychologist, but, at the mother's insistence, the consultations continued for four or five sessions. The therapist recommended Jasmine be assessed in hospital. It was suggested she bring her to the emergency room next time there was a crisis. (Her mother said she would have pursued this option much sooner had she known it existed.)

Jasmine, at 12 years of age, was getting progressively worse. Unable to sleep and starting to display compulsive behavior, she would stay up all night cleaning. This went on for several weeks. On weekends, she was taken to her grandfather's home so that her mother could sleep.

Jasmine was taken to the hospital following an incident when she went missing from school and was subsequently found in the bathroom. She continued to exhibit difficult behavior in the school yard and the school recommended that her step-father take her to the hospital.

During her assessment in hospital, Jasmine told the staff she was being abused at home. Jasmine's mother was informed of these allegations, and as per protocol, the case was referred to the Department of Family and Community Services (FCS).

An investigation concluded that the allegations were unsubstantiated. The psychiatrist, feeling the parents were overwhelmed with the challenges presented by their daughters' condition recommended child protection remain involved, in order to help the parents. It

² According to records from Mental Health Services, the mother called for the first time in February 2000. Jasmine was placed on a waiting list. In January 2001, the mother called again and was told that things were not going well in the delivery of service and that it was not possible at that time to assign a worker. In May 2001, the mother called again. The priority for intervention was reassessed. Later in May a worker is assigned. Shortly after, the mother leaves a voice mail message for the worker. The worker calls the mother back the same day and leaves a voice mail message. In June 2001, the mother finally gets a hold of the worker and relates that her daughter was admitted to the hospital

was becoming increasingly evident to the parents that Jasmine's behavior was related to a mental health problem. During this stay in the hospital, Jasmine was diagnosed with "psychosis disorder with pronounced paranoia".

A psychologist involved in the care of Jasmine recommended a placement outside the family, because of Jasmine's deterioration in her condition. The parents however, wanted to learn about Jasmine's illness and how to deal with the presenting behaviors. Jasmine was discharged home.

Jasmine's behaviour became increasingly erratic. Concerned for the child's security and that of others, her mother followed her wherever she went. Convinced that at least Jasmine was not suicidal, because she would stop when things hurt, her mother took to sitting outside when Jasmine was in an angry fit. This was so the neighbours wouldn't suspect her of abusing her daughter. (The police had already been called because of the commotion created in the home when Jasmine was in crisis). Her mother describes situation where Jasmine would fly into a state of rage where she would punch, kick and swear at her mother. The girl's delusions became more fantastical—she claimed bugs were in her, that her skin was a coat, that her mother kept the body of a dead boy in the closet. She also claimed she was hearing voices and hallucinating.

The mother called the psychiatric ward the day after Jasmine's discharge and had her re-admitted to the child and adolescent psychiatric unit. Placed in seclusion for observation, she was very aggressive and paranoid. Several drugs were tried in an attempt to manage her behavior.

In August, 2001, her psychiatrist said Jasmine was one of the most complex cases he had seen. He recommended placing her in a therapeutic foster home or in a group home. Two psychiatrists assessed Jasmine, and both recommended placing her in a structured group home. By this time, a referral to the local Mental Health clinic had been made by the hospital, and Jasmine's case was removed from the waiting list and Mental Health professionals became involved.

In September, 2001, her mother took Jasmine to a psychiatric unit out of the province for a second opinion. She was placed on an open unit and, after a three-month stay; her diagnosis was Psychosis NOS (Not Otherwise Specified). Discharged in November, Jasmine returned home, and her erratic behavior resumed. She was prescribed Seroquil and Paxil, but did not take it readily or regularly. She believed she was being poisoned.

In late November, 2001, her mother asked FCS to come and get Jasmine. She was placed in a group home in the Moncton region. Hallucinations and other symptoms noted during her stay out-of-province were less, but she continued to have trouble functioning in a community environment.

The group home placement provided a strict and structured environment, but Jasmine's condition required more specialized care. Still, she stayed for 12 months even though the home was an emergency crisis home, designed for a short term stay. During this time,

Jasmine was charged with many criminal offences such as assaults, property damage, breach of conditions and breach of probation. She was back and forth from the group home, to court and remanded to the New Brunswick Youth Centre (NBYC), the provincial youth correctional facility in Miramichi on several occasions.

In November, 2002, Jasmine, aged 13, was again released to her mother's care. An altercation arose, and she pushed her mother down a set of stairs. The police was called for help. They said they could not intervene unless the mother pressed charges. Since all else had failed, (the group home placement had failed, and the hospital would not take her back) and the mother felt she could no longer provide a safe home for her daughter, she decided to proceed in the hope that police intervention would lead to a new source of help for her daughter. Jasmine was charged with assault, property damage, and resisting arrest and was remanded to the NBYC, pending trial. In preparation for the trial, her mother was asked to complete a victim impact statement. Recalling this moment five years later, the mother said, through tears, that she was still offended by this request. Didn't anyone understand that the true victim in this tragedy was Jasmine and not her mother? Wouldn't anything be done to help her daughter?

In March 2003, Jasmine pleaded guilty to all charges and was sentenced to six months detention at the NBYC in Miramichi.

During her stay at NBYC, Jasmine was sent on a few occasions to Therapeutic Quiet (TQ). TQ is the acronym for NBYC's isolation/segregation unit. Residents at the New Brunswick Youth Centre are sent there when their disruptive behavior requires it. On one occasion when a group of youth was playing basketball in the gymnasium, a conflict erupted between Jasmine and another youth. Such a situation is not out of context especially not within a centre such as the NBYC. But this conflict landed her in TQ.

There is a protocol at NBYC for transferring residents from their unit to TQ, which is in a separate cottage. Following the basketball incident, two custodians arrived to escort Jasmine to TQ. The guards wore riot gear with vests, helmets, and visors. Their role was to support the supervisor. In addition, for this transfer to a unit a few hundred yards away, Jasmine was handcuffed and shackled. She resisted verbally and physically before complying. At the TQ unit, she was strip-searched before being placed in isolation. According to the correctional centre's protocol, the entire process must be video-taped. Although the camera angle was focused only on the female custodian performing Jasmine's search, the audio feed captures all of the young girl's protestations and offers a very disturbing account of the indignity suffered.

I have viewed the recordings. I have grave reservations about the need to treat any child in this manner. Treating a child with serious mental health problems like this seems to me wholly indefensible. That Jasmine should have been subjected to this treatment for the alleged misconduct on the basketball court is simply baffling. Adequate descriptions of the serious concerns that arise from viewing the video are hard to find. Essentially, however, the serious issue to be determined is whether this is a cruel and unusual punishment. Certainly, to the uninitiated it appears that it is.

At the end of July, 2003, while serving time at the Miramichi Youth Correctional Centre, Jasmine was charged with uttering threats to a correctional officer. She pleaded not guilty. A trial date was set for October.

Pending her release from closed custody (her review in Youth Court was scheduled for August 6), FCS obtained a custody agreement from the mother and stepfather that placed Jasmine under ministerial care for six months. It was voiced by the Department that they felt they could not provide a secure specialized placement to meet this child's needs, at least, nothing better than what the parents could do in their own home. However the temporary care agreement placed a certain onus on them to provide service for Jasmine. They eventually identified a foster home willing to accept her. Visits by the foster home parents to the Miramichi facility and a weekend visit by Jasmine to the foster home were arranged. But Jasmine's deteriorating condition of distorted perceptions, delusions, paranoid tendencies and her refusal to comply with her medication regime caused the foster parents to withdraw.

At the August 6 Youth Court Review, FCS advised the judge they did not have a placement for Jasmine. According to FCS casenotes, the mother stood up in Court and said that if there was no place for her daughter to go to except NBYC, she would take her home. The judge reminded her that the Minister had a 6 month custody agreement and was therefore legally responsible for her daughter's care. August 27 was set for the next review.

From this period on, Jasmine's condition deteriorated quickly. She began to wet herself and spread her feces all over her room, bathroom and shower, and would refuse to clean herself up. She would curse at others and talk to herself. Not being able to leave her with the other youth population in these conditions, she was placed in segregation. NBYC, understanding this youth was a young offender, were recommending she be hospitalized as her needs were beyond their capacities to help this girl.

On August 13 a case conference was held with the many professionals involved. Her treating psychiatrist while at NBYC indicated that he thought Jasmine showed signs of early childhood schizophrenia. Her previous psychiatrist indicated he now believed his young patient was 'fabricating her symptoms, delusions and hallucinations'. He further stated that NBYC should administer her medication even though she did not want to take them. The representative from NBYC responded that their protocol prevented them from forcing youth to take medication. Hospital staff in a hospital setting however could.

Notes reflect a tense relationship between FCS and Jasmine's mother. At this point, the latter is pressuring the department to come up with a placement for Jasmine. On the other hand, the department is holding against the mother the fact she is sending mixed messages to Jasmine: wanting to take her home, and wanting her placed because of the challenges she presented.

On August 26, the day before the case was due back in Youth Court, the psychiatrist treating Jasmine at NBYC informs her social worker that he believes her diagnosis is

clearly one of schizophrenia, and recommends she be admitted to CAPU against her wishes. He also states he knows there was no vacant bed at CAPU at the time.

At Youth Court the next day, a report from her psychiatrist is presented. He indicated that she “would be at ‘immense’ risk for herself or others if not given proper treatment.” Her previous psychiatrist indicated that with proper services, Jasmine could be cared for at home. Finally, the judge ordered a 30 day assessment at CAPU. Shortly after the court appearance, professionals involved in the case received a telephone call from court officials saying the judge was reconvening everyone, as CAPU was refusing admission, despite the court order. Notes show that the judge considered sending her to the Restigouche Hospital Center; however others said this was ill advised. At Restigouche, she would be placed with adults dealing with severe mental illnesses. The judge called CAPU from his chamber to complain about their refusal to admit. Jasmine was returned to NBYC. Later on that afternoon, Jasmine’s social worker received a call from the judge’s office advising that the youth’s psychiatrist from CAPU was making arrangements for admission. The judge would apparently request psychiatrists, the one from NBYC and the one from CAPU to appear in his court on September 3 to ‘explain their report and to give recommendations.’ On September 2nd Jasmine was brought from NBYC to CAPU for admission.

On the morning of September 3, the judge ordered Jasmine to remain at CAPU. If she were to be discharged before September 23, she should go back to NBYC to finish her sentence. Beyond September 23, the judge said FCS was responsible for providing a ‘therapeutic placement’.

While Jasmine remained at CAPU a request from FCS was made to her psychologist at Mental Health services asking for assistance in providing Jasmine with help around specific issues. The note on file reads as follows: “ ...psychologist at Mental Health Clinic in Moncton ...explains that the Minister of Health and Wellness could not provide any support service in order to help Jasmine with community reintegration, initialization of a school system, understanding and coping with her illness, etc.” The reason given was that no funds were available for such things.

During this period, the social worker from FCS advocated strongly for Jasmine to return to school to complete her education. Because she was now 14 yrs old, she could no longer remain in middle school, although she was academically at a middle school level. Unfortunately, she never completed her schooling. Jasmine was discharged from the hospital on November 19. Since no alternative residential or therapeutic placement had been found, she returned to the crisis unit.

A few weeks later, Jasmine was returned to CAPU, where she remained for approximately six months. Although the crisis unit was deemed an inappropriate placement, it was deemed more appropriate than a hospital placement. Therefore, Jasmine would return to the crisis unit every time she was discharged from the hospital. During this period, notes indicate that FCS was investigating the possibility of two residential programs in the United States. These placements never materialized.

In March 2004, documentation shows the struggles between FCS and Mental Health in coming up with a permanent long term placement for Jasmine. Since this youth was dealing with a mental health issue, FCS was saying Mental Health should be finding the placement and paying for it. Since the issue was finding a residential placement, Mental Health was saying it was up to FCS to find the placement, and pay for it. Case notes show how at one point one psychiatrist got upset during a case conference about the fact that no placement could be found or created for this young girl. A representative from Mental Health replied that he "...knows the Mental Health Act states they are responsible for community placement for a child due to psychiatric issues. However his department does not have the funds." Other professionals in the meeting stressed the fact that departments had to work together to resolve this issue. The meeting was adjourned without a plan. In the meantime, Jasmine remained 'in limbo'. During this period, she received 16 sessions of electroconvulsive therapy (ECT) or shock therapy, in order to help stabilize her condition.

In August 2004, at the age of fourteen and a half, Jasmine was placed in a foster home. A lot of information was shared about Jasmine's situation with the foster parents. Soon into the placement, Jasmine started refusing taking her medication. The foster family was told to call the police if they needed any help. On September 9, the foster mother called FCS. Jasmine's worker was out so another worker took the call. The foster mother indicated that she had just called the police because Jasmine was out of control and breaking everything. She wanted the social worker to meet her at the emergency room where she would request she be brought. After consultation with her supervisor the social worker advised the foster mother she thought her plan was good, and that if she had any more trouble to call the emergency after-hours social worker, or the regular social worker upon his return from training.

Jasmine was sent back to the NBYC. A few days later she appeared in front of a judge and was ordered to go to CAPU for a 30 day assessment on her capacity to stand trial. During her stay, staff from the hospital indicated that their service was for short term assessments and treatment, and would not support recommended or court ordered future hospitalization of Jasmine on their unit. Creating a placement specifically for Jasmine was deemed to be too expensive therefore not feasible. A report was submitted to the court indicating that Jasmine was deemed Not Criminally Responsible (NCR) and unfit to stand trial. She was remanded to the hospital pending a review board hearing.

Jasmine's behavior stabilized while at CAPU. Following the review board hearing in July, 2005, Jasmine was released to the group home. It was decided she was not a danger to herself or to society and that she should be cared for in her community. The review board ordered the Department of Family and Community Services to provide Jasmine with an appropriate residential placement in her community. However, Jasmine was turning 16 that fall, and under the *Family Services Act* FCS was no longer obligated to keep her as a child protection case. The department viewed Jasmine's problem as a mental health case and found that the review board had erred in directing its order to FCS when, in fact, mental health services should be providing for Jasmine's care. Eventually

both FCS and Mental Health refused to comply with the order, and Jasmine remained at the group home.

In October 2005, Jasmine was back in court on further charges. She was remanded to the Restigouche Hospital Center in Campbellton, where she would undergo an assessment to determine if she was fit to stand trial. She was released back to the crisis unit until the Review Board reconvened on her case.

It was about this time that Jasmine's mother contacted my office. We began an investigation and tried to assist government departments in finding an adequate placement for Jasmine.

It was convenient for Jasmine to be at the crisis unit during Christmas time so that she could be close to her family for the holidays. One evening in January 2006, Jasmine protested when she was called to supper. She dallied and arrived after the others had eaten. She became upset and ran out of the house and down the street. It was a cold January night, and she wore no shoes. Police picked her up, took her to the hospital, and the next day she was returned to the RHC in Campbellton.

In late January, 2006, five members of my staff visited the Restigouche hospital and toured the facility. They met Jasmine, her psychiatrist, her mother, and her grandfather and observed a further hearing before the Review Board. The Board was considering its interim placement order, Jasmine's breach of conditions and her eligibility for discharge.

Hearings of the review board are conducted under Section 672.38 of the *Criminal Code* in cases where the accused has been found not mentally competent to stand trial. It is the task of the review board to review annually, until the date of absolute discharge, whether the accused is "a significant threat to the safety of the public". The review board may discharge the accused absolutely, or subject to conditions, or it may order the person be detained in hospital until he or she is no longer considered a public safety threat.

A lawyer appointed as deputy chairperson presided over the hearing in January, 2006. The board consists of a chairperson, a practicing psychiatrist, and a practicing psychologist in the province. Crown counsel is present to defend the public interest in public safety, and duty counsel is provided to the accused. Jasmine was present, as were her mother and grandfather, her psychiatrist, and a social worker representing the Department of Family and Community Services. Three nurses and orderlies and the members of my staff were also present.

As he had indicated to my investigators before the hearing, Jasmine's psychiatrist told the board that she would benefit from a community placement where she could be close to her family but living in a supervised environment that was safe for her. He was asked several times if she was a threat to public safety. He said only that she could harm herself if she was not appropriately supervised. Many questions were asked about Jasmine's medical condition. The social worker and Jasmine's mother also spoke. Then the board suggested it would break for lunch and deliberate. Jasmine now asked to speak. It was

surprising to hear this person, the object of such intense public scrutiny, speak so well about her wish to be kept in a place where she would be safe. She revealed an understanding of her breach of conditions and the risk at which she had placed herself. She said she would be more careful in the future about looking after herself.

The board decided that Jasmine was a threat to herself and therefore to public safety. It refused to discharge her, even with conditions. The board chair remonstrated with Jasmine about her lengthy young offender record and admonished her to steer clear of the path she was on by respecting the conditions placed upon her. Whether this admonishment or any aspect of the review board process was beneficial for Jasmine, or in her best interests, or appropriate in any way, is difficult to determine. What is certain is that the youth criminal justice process had been engaged, earlier attempts to find a rational solution based upon an appropriate residential placement had failed, and the case still had to be addressed. In the end, the problem was that there was no safer place to send Jasmine, even though everyone recognized that the provincial psychiatric hospital was not an appropriate placement and ran the risk of increasing Jasmine's reliance upon institutional care.

Part of the difficulty with the placement at RHC is its distance from home and loved ones. Jasmine's mother traveled to Campbellton every weekend to visit her after she was placed there. As this became too taxing on the mother's own health, she modified her schedule to travel every other week and made arrangements with Jasmine's grandfather to do the same so that, as much as possible, her daughter would have some family contact on a weekly basis.

In October, 2006, Jasmine's biological father, who had not been in her life for many years, requested permission to visit his daughter. He persuaded her that he was working with FCS to have her released from the hospital to go live with him. After a few visits in Campbellton, and a weekend visit to his home, he was unable to cope with her, and she has had no further contact with him. According to her mother, this ordeal seriously hampered and interrupted Jasmine's course of treatment.

It was following Jasmine's review board hearing that I decided to broaden my investigation and look at the systemic problems of meeting the needs of, and providing equal opportunities to, children and youth like Jasmine. A number of parents with equally challenging children had sought my assistance, and rather than investigate each case individually, I thought it would be more appropriate to join them together in a systemic investigation.

At the time of writing this report, efforts to find a placement for this young woman have faltered again and after three months in a group home setting she is back in Restigouche. This most recent attempt to devise a placement specifically for Jasmine was orchestrated unilaterally by Family and Community Services as Mental Health services' position is that the responsibility for residential placements lies with FCS. Although staff involved in caring for Jasmine in her new placement agree that she made some progress in her three months there, the threat of potential physical assaults against them (although there

were none) when Jasmine became aggressive made them decide it was best if the placement ended. The mental health team involved with her decided they could not help her and recommended she be sent back to the Restigouche hospital Center. She was charged with a breach of her review board conditions and sent back to the RHC where apparently, she feels more secure. There is, as yet, no plan in place specifically to address Jasmine's educational needs, and she continues to be monitored by the review board because she received a conditional release from RHC, not an absolute discharge. As Child and Youth Advocate, I am discouraged by the repeated failure of our public safety, health, education and child welfare systems to meet Jasmine's needs. I am alarmed by the fact that the best way we could help Jasmine through the years has been by placing her in psychiatric institutions. It appears she has become "institutionalized" to the point where she feels most secure and comfortable in a psychiatric hospital setting. I believe we can do a better job of connecting the dots in Jasmine's treatment plan.

It is extremely disturbing to read throughout Jasmine's file how, despite efforts on each side, two of the biggest government departments in this province could not agree on the sharing of responsibility and cost in this complex case. This inability paralyzed the process at certain critical times in the planning for this young girl's treatment. Each department camped on their respective mandates and eligibility criteria leaving this child and her mother without much needed services. I agree that mandates are necessary and useful. However when they are used in a rigid manner, they serve no one, not even the government. If government departments cannot work together on cases like these, then new means must be forced to force them to do so.

* * *

Jasmine's case was not necessarily more complex or disturbing than the others, but it was, and remains, disturbing enough to warrant a serious second look. It is only guesswork to suggest what Jasmine's expectations from life may have been had she received early and more successful interventions. Looking forward, it is still difficult to provide adequately for her care and to predict what quality of life she may enjoy as an adult.

Jasmine turned 18 last Fall. Looking back, it is clear that many things with respect to government interventions in her life should have been done differently.

- Mental health services should have been available to her from a much younger age, had adequate outreach and education programs been effective.
- The lengthy stay in the group home crisis unit and the extended stay in the Moncton hospital's child and adolescent psychiatric unit were not appropriate because these facilities are observation units and crisis and should not be used as a residential option.
- The extended placement at NBYC was also inappropriate because the alleged crimes which led to Jasmine's involvement with the youth criminal justice system, and the infractions at NBYC which resulted in her staying there longer than her original sentence, are not truly criminal in nature, given her condition

and the particulars of the alleged offences themselves. Better ways of dealing with the inappropriate conduct of youths with mental illnesses must be devised. Her mother was right to say that Jasmine was a victim, not a criminal.

- As I have indicated, the handcuffing, shackling, strip-searching and placement in isolation are not appropriate interventions for a child in Jasmine's condition.
- NBYC's inability to keep Jasmine on the course of medication recommended by its own visiting psychiatrist further underscores the inappropriateness of her placement there.
- It was also inappropriate to lock her, or a child like her, away in a hospital for the criminally insane because she bolted out the door barefoot in winter.
- The Department of Family and Community Services' refusal to act on the review board order and create an appropriate residential placement for Jasmine close to her home was inappropriate, and the mental health division's inaction in this context was equally blameworthy.
- More care should have been taken before attempting to re-unite Jasmine with her estranged biological parent.
- The review board's conclusion that Jasmine was a danger to herself and to public safety was in my view unwarranted, as was the public castigation of Jasmine's conduct by the review board chairman.
- The continued custody of Jasmine at Restigouche Provincial Hospital, contrary to her psychiatrist's recommendations, is detrimental to her because she is now quite dependent on institutional care.
- Finally, throughout the past six years, Jasmine's educational needs have been completely forgotten and disregarded, and she has been hampered for many more years by a lack of psychological counseling and follow-up.

As I have stated earlier, Jasmine's case was complicated by the lack of a compelling psychiatric diagnosis, or any diagnosis, early on. But this does little to excuse the many failings of every system of public service along the way.

I am convinced that we can do better. For our sake and Jasmine's, we must.

Investigative methodology

This investigation was initiated as one of the first systemic investigations undertaken by the Ombudsman's Office since I undertook this mandate. It was meant to be resource-intensive, exhaustive, consultative and timely. A snapshot that would get at the structural causes of the several complaints, like Jasmine's that we were receiving.

The investigation was initiated through notification letters forwarded in late February, 2006, to the deputy ministers of Education, Health, Public Safety, and Family and Community Services. Detailed disclosure of departmental information and personal information related to six individual files of youths with complex needs was sought from each department. Three investigators and two support staff from my office were originally assigned to the investigation, and the office's legal counsel, Christian Whalen,

was assigned as lead investigator. Following my appointment as Child and Youth Advocate, Francine Cantin was recruited and added to the team as a senior investigator and social worker.

The notification letter, however, was greeted with stony silence. I was informed that the search for the information requested would take time. Ultimately, the disclosure of documents obtained revealed that an interdepartmental committee had been struck to coordinate the response of departments to the investigation, and there was some discussion among officials as to whether departments should cooperate fully, regardless of what recommendations might follow, or whether more political direction was required before responding. In the end, I was informed that much of the information sought would have to be withheld because of various confidentiality provisions.

The greatest reluctance in terms of transparency seemed to come from FCS. I requested a meeting with the deputy minister, and I explained that, in my view, under the *Ombudsman Act*, the department was required to disclose the records sought. The deputy minister informed me that the attorney-general's office had advised him otherwise. I offered to put the matter to a judge for clarification. The deputy agreed and promised his department's full cooperation should the judge order such. The next day, I filed, in court, an application for clarification of my powers to compel the release of documents. The case involved was unrelated, but it was one where I was meeting with equal resistance from FCS to produce records. It involved an investigation into the departmental response to a child protection case in which a two-year-old girl had died in her mother's care. A court date for my motion for declaratory relief and production of the departmental records was set for late August, 2006.

At the hearing in August, the matter was put over until the fall, when the attorney-general's motion to proceed with the application *in camera* could be considered. Later that fall, I was appointed Child and Youth Advocate, and the newly elected premier announced his intention to amend the *Ombudsman Act* and the *Child and Youth Advocate Act* in the spring in order to blend both legislative schemes and confirm my interim appointment. At the hearing in the fall, the attorney-general agreed, upon the judge's prompting, to release the documents in the child protection case and to put off the hearing of the application *sine die*, pending the anticipated legislative amendments.

Following this consent order, the departments involved in this investigation responded more positively and made documents available. In February, 2007, a year after the notice of investigation had been sent, I was granted access to the records necessary to commence my investigation.

I am pleased that, in the late spring of this year, amendments were made to the *Ombudsman Act* and to the *Child and Youth Advocate Act* that have clarified and consolidated this province's long-standing practice of turning over to the Ombudsman records which he deems necessary to his investigatory functions. In fact, the final bill was much improved as a result of floor amendments brought forward by Government after the bill's introduction. The bill has confirmed the Ombudsman's and the Advocate's long

reach when it comes to policing public administration and compliance with measures aimed at improving services to children and youth.

Following review and receipt of the requested records, which filled nearly a dozen banker's boxes, the investigative team was able to conduct interviews with parents, youths, care-providers, educators, case-workers, external stakeholders and departmental officials in order to identify the issues and arrive at possible areas for recommendation.

The investigative team also completed its own environmental scan and attempted, as much as possible for generalists like ourselves, to augment and base the following recommendations not only upon the complaints and case-studies in question, but also upon empirical evidence-based research in the areas of mental health and child welfare.

At the time of printing Cabinet has announced its intention to rename the Department of family and Community Services to the Department of Social Development, a change which, I hope augurs well for the reforms proposed in the following pages. However, for ease of reference, this report will continue to refer to that department by its former acronym: FCS. Also despite feedback from clinicians and social workers, while the words children and youth are often used together in this text, unless the context indicates otherwise, children include youth and any person under the age of majority. Finally I also use the term mental health condition, and similar terms broadly to include mental illness, but also conduct or behaviour disorders.

A full list of interviewees and agencies consulted is provided in an appendix to this report. I want, however, to acknowledge with thanks the kind assistance provided by all stakeholders and departments in completing the investigation. Among the stakeholders I would like to thank, in particular, are the administration and staff of the Restigouche Hospital in Campbellton, the Moncton City Hospital's provincial Child and Adolescent Psychiatric Unit, the directors and administrators of the Spurwink Facility in Portland, Maine, Dr. Nicole Letourneau, Canada Research Chair in Healthy Child Development at UNB, and Dr. Susan Reid, Director of the Youth-at-Risk Research Centre at St. Thomas University.

Following the initial wrangling over disclosure of records, all government departments have offered their full support and collaboration to the investigation and have in fact welcomed the opportunity to work together in addressing a critical area of common concern. I extend my thanks, in particular, to Joan Mix, Ian Walsh, Barb Whiteneck and Bob Gerard and the colleagues who have assisted or succeeded them. Many of the recommendations made herein have been initially identified by departmental officials, and I am hopeful that, if accepted by Government, the recommendations will be capable of early and effective implementation. Most important, I want to acknowledge, with thanks, the support of parents and youths themselves who have participated very fully in this process and provided me with their consent to share their moving and very personal stories.

The issues:

1. **Political direction and accountability: *Gabriel's story***
2. **Service integration: *William's story***
3. **Community-based residential care: *Jacob's story***
4. **De-criminalizing youth with mental health disorders; *Nicholas's story***
5. **Tailoring educational services for youth with complex needs: *Benjamin's story***
6. **Supporting families of youth at risk and children and youth with complex needs: *Samuel's story***
7. **Closing the gap: age discrimination in youth services**

Chapter 1 - Political direction and accountability: *Gabriel's story*

One of the parents we met reminded us of a confession he had heard from a former minister of health in this province. The minister had called mental health services the black sheep of our health care system. The minister was Brenda Robertson, and her assessment was given 30 years ago. Some public servants admit quite candidly that not much has changed.

All departmental officials are acutely aware of the gap in services that arises from the age-based criteria that exist for services to children and for adult protection services, but leave youths hanging in the middle. This gap in services, for youths aged 16 to 19, is a fault-line that complicates the resolution of every complaint involving child and youth services. Even as a child nears the age 16 cut-off, problems loom, and the fall-out from the gap in services in many cases continues to affect him or her well into early adulthood. According to the former deputy minister of health, the problem is not unique to New Brunswick and, in fact, exists in most jurisdictions across Canada.

Everyone we spoke with agreed that government departments could and must do a better job of working together to harness all public resources available and develop a client focus. There was little agreement, however, on how this could be done. The only consensus was that nothing would change without strong political will and direction.

Our investigation has shown that, in New Brunswick, youth with very complex needs are often overlooked. However, when political pressure is applied, and where there is a strong political will to deal with a young person's needs, we can and do make a difference. The problem is that few cases are addressed in this way, and the high end treatment of high-profile cases is an expensive and ineffectual allocation of scarce resources. Gabriel's story is a case in point.

Gabriel's Story:

Gabriel was born to a single mother. She had a reported history of being significantly mentally challenged and was a member of a visible minority. At the time of his birth,

Gabriel and his mother both lived with her foster parents. There were reports of early neglect, deprivation and emotional abuse, resulting in global developmental delays and failure to thrive. When the child was two years old, he was taken into protective custody. Less than a year later, he was adopted. Gabriel remained in this home with another adopted child and a step-brother nine years older until he was 12.

From age three onward, Gabriel made limited developmental progress. He was diagnosed with Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder (ADHD). Prescribed medication, he reacted negatively. He was hospitalized for about two months during a psychotic phase. In the next few years, several diagnoses were discussed, and medication was prescribed accordingly. Today, Gabriel's diagnosis is still being debated. The latest, from the Spurwink Treatment Center in Portland, Maine, where Gabriel has been since October, 2005, is Post-Traumatic Stress Disorder, with a possible underlying Bipolar Disorder.

From the time he started school, Gabriel had difficulty in adapting. So his adoptive mother decided to school him herself at home. Despite the involvement of FCS and mental health professionals, it appears his schooling and educational needs were not addressed; he received very few education services. As he grew, he became increasingly difficult. He began assaulting his adoptive mother, threatening to kill her. He showed dissociative behaviour and was defiant and uncooperative.

In June, 2004, Gabriel's adoptive parents informed FCS they could no longer care for him. They turned his guardianship over to the Minister. Gabriel was placed with Moncton Youth Residences Inc. (MYRI).

After a year with MYRI and, although he was provided with two-on-one staffing and three-on-one staffing in situations where he exhibited uncontrollable behaviour, it became evident that New Brunswick lacked the specialized services to meet Gabriel's increasing needs.

Some of the behaviours he presented were: mood swings resulting in unpredictable violent episodes, biting staff, assaulting staff, and smearing his feces on staff's faces and clothes. The staff felt it was becoming difficult to keep themselves, and Gabriel, safe.

According to Gabriel's social worker, she "contacted everyone in New Brunswick" to try to find or develop a placement for him. She was unsuccessful—professionals across the province were at a loss to understand and deal with the behaviour he was manifesting.

The Province approved placing him with the Spurwink Treatment Centre in Maine. Before he went to Maine, he needed a place for a four- to six-week period because MYRI could cope with him no longer.

In September, 2005, the family apartment at New Brunswick Youth Centre in Miramichi was designated as an interim child care residential centre under the *Family Services Act*. FCS and the Department of Public Safety entered into an agreement where Public Safety

would provide an apartment, meal and housekeeping services, and FCS would provide the staff to supervise Gabriel. When needed, NBYC would provide emergency assistance.

Although Gabriel was not placed with the young offender population at NBYC, his placement made headlines and raised waves of concern and protest across the province. To this day, although Gabriel's identity was protected throughout this process, people still remember this as the case of the 13-year-old autistic boy who was at NBYC because there was nowhere else to send him.

In October, Gabriel went to the Spurwink Treatment Centre in Maine. He was, and still is, the sole resident of a house there. The home is staffed at a two-to-one ratio at all times. Gabriel goes to school every day, for about half an hour, although not in a classroom setting. It does get him accustomed to leaving the house in the morning and being exposed to others around him. In school, he receives occupational therapy.

The Spurwink staff have noticed the following about Gabriel: he sexually acts out when restrained; he has made huge progress on his personal hygiene; he now eats with a fork, sitting at the table, and puts his dishes away; he can calmly stay alone for a little while; he asks to read a book when he feels like it; he has stopped his continual pacing; he now makes eye contact; and he uses functional language like "I'm all done now." According to the staff, Gabriel has now "reached a level where he is accessible".

At Spurwink, my investigators met with Gabriel's psychiatrist. She was very encouraged by her recent session with Gabriel: he had acknowledged her by name and said goodbye at the end of their meeting. In fact, in all of the meetings we had with the Spurwink care-providers, they were intent on celebrating the successes Gabriel had achieved, however small. The directors of the facility admitted that Gabriel and the other two New Brunswick residents currently placed at Spurwink are receiving a "Cadillac" treatment that no other resident from Maine or from out-of-state is receiving. The cost of providing services to Gabriel is in excess of \$500,000 a year.

On the one hand, the department had agreed to these extraordinary expenditures because of the lack of alternative solutions in New Brunswick. This decision was taken well before Gabriel's temporary placement at NBYC and the swell of protest that ensued. On the other hand, one has to wonder whether the investment would have been maintained without the pressure of the political fall-out from the stint at NBYC.

There is no question that, for the first time in a long while, Gabriel has halted a downward spiral of anti-social and self-mutilating behaviour and is making real progress in terms of basic life skills. The question is: how much nurture and love will he continue to require and how best can we sustain it? More fundamentally, we have to ask ourselves, as New Brunswickers, why Gabriel had to be sent out of province and out of his country in order to start making significant progress.

* * *

My review of the cases analyzed in this report leads me to one inescapable conclusion: progress on this file will require taking ownership of the problem; and taking ownership means that, as a society, we have to stop shipping sick kids away. We need New Brunswick-based solutions and capacity within the province to deal with the problems of our children and youth, including those with very complex needs.

It is true that, in Gabriel's case, placement out of the province may have been the most reasonable and viable accommodation the province could make for the time being, given his exceptional needs and the lack of other options. One cannot deny the progress he has made since his placement there. But since three New Brunswick residents are there now, and others may follow, owing to the lack of treatment options here, more families are put through the strain of separation because of distance and the international border. As a long-term solution, referring these cases to Spurrwink could easily bring with it the "out of sight, out of mind" problems that institutionalization within New Brunswick once posed. I remain convinced that true equality for these young persons demands that we, as a society, look after our own.

One of the most important themes to emerge from this review is the lack of political accountability and direction for the dire straits in which youth-at-risk and youth with complex needs can find themselves. There has been no lack of proposed solutions, and much time has been spent over many years analyzing these issues and cogitating within the bureaucracy.. Senior civil servants have produced reports from 15 and 20 years ago where the same issues parents raised in complaints to us were flagged and corrective action recommended³. For the most part, little was done, and what *was* done has not proven effective.

Many factors are responsible for this lack of political direction and influence: 1) the absence of a political voice for the constituents affected; 2) the dispersed nature of government services to youth across several departments and agencies, most of which do not, for various good reasons, view child or youth services as mission critical (whether in relation to jails, hospitals, income assistance rolls, or transportation matters); 3) the principled deference to family and to the private sphere and the state's reluctance to intrude, particularly where problems lie not generally with parental capacity but with mental health concerns of the youths in question; and 4) the obvious cost consequences of any course other than inaction.

This problem is also not unique to New Brunswick. Many jurisdictions in Canada and abroad have been devising strategies and new approaches to ensure greater accountability and political direction to these issues. The Ontario Child and Youth Advocate recommended in her 2005 report, *Snakes and Ladders*, creation of an Ontario ministry of child and youth services. The United Kingdom has also adopted this type of regulatory approach in recent years.

³ Public Safety's Youth At Risk report; Department of Education's 1992 Student Services Review report. These reports are, for example, two indicators of the long road toward establishing a Child and Youth Advocate, for which Public Safety officials had been clamouring for nearly 15 years.

The recommendations which I make, under the broad theme of accountability and political direction, are divided into three distinct areas: 1) recommendations in relation to the Legislative Assembly's oversight through its officers; 2) recommendations in relation to ministerial accountability and responsibility for these matters within the Executive Council; and 3) recommendations in relation to civil society.

The independent oversight function

During the course of this investigation, I have been encouraged by the welcome, and certainly the expectation, with which youth, parents, those who work with them, and departmental officials have met news of the appointment of a Child and Youth Advocate in this province. The fact that the Government elected last year had sponsored this legislation while in opposition, that it moved quickly after the election to fill the vacancy, which had existed for nearly two years, and that it amended the legislation last Spring to reinforce the Advocate's independence and broad investigative powers are all encouraging developments. Essentially, the Advocate's role is to be the voice for disenfranchised youth, and to ensure that this voice is heard by elected representatives and that youth concerns are acted upon. To voice those concerns adequately, I have sought from the outset to adopt a proactive stance as Child and Youth Advocate, rather than merely respond to the numerous and troubling nature of complaints received. However, addressing the caseload while moving ahead with a proactive advocacy agenda is a difficult task, especially for a small office.

My first recommendations, before making any recommendations to Government, are therefore directed primarily at myself. I intend in this manner to render my own efforts somewhat more accountable by outlining more formally the role which the Office of the Child and Youth Advocate can play in holding government accountable and ensuring that necessary political direction is given to child and youth matters.

1. An active presence, accessible to children and youth

Following my appointment as Child and Youth Advocate, I was concerned to learn that the Department of Public Safety had discontinued the services of its internal child and youth advocate and begun to redirect all inquiries to my office. I was able, however, during the last budget exercise, to convince government to direct new resources to my office so that additional staff could be retained to continue this significant advocacy function. In reviewing materials related to this investigation, I recognize that the Department of Public Safety had been recommending the establishment of an independent advocate for many years and had developed its own internal recourses only as a stop-gap measure. The work carried out by advocates within the department has been an instructive and effective model for my officers. Early this spring, I designated one of my investigators as a permanent liaison with the New Brunswick Youth Centre and with the Portage Program for Drug Dependencies Inc., near Sussex. This officer has been available to residents at NBYC and Portage on a bi-weekly basis since the spring. Another officer has now been named the Advocate's liaison for youth residing at the

Restigouche Provincial Hospital (RPH) and at the Child and Adolescent Psychiatric Unit at the Moncton City Hospital.

My goal over the next year will be to increase the frequency of our visits, from bi-weekly to weekly, which will put us on a par with the Children's Ombudsman unit in Nova Scotia, and also to develop a process with adequate resources to ensure an active presence and accessibility to children in residential placements and group homes throughout the province.

2. *Monitoring child services*

The *Child and Youth Advocate Act* grants the Advocate a broad power to initiate investigations on his own motion, just as an Ombudsman may. However, while these powers of the Ombudsman are exercised more as the exception than the rule, it appears that the Advocate's function requires a more proactive auditing exercise. As the guarantor of effective public services to children and youths, the Advocate has a specialized mandate that will require him to take proactive measures to ensure that children and youths receive the services they need, rather than merely a response to complaints. This may entail "social audit" or monitoring functions, such as regular requests to authorities for numbers of children in care, in custody, in hospital settings, or on special education programs, and year-by-year comparisons of expenditures in relation to such services. It may also include use of the Advocate's powers of entry and inspection of institutions where children and youths reside to verify compliance with applicable regulations and guidelines. Over the course of the next fiscal year, I will hire an additional staff person to allow this monitoring function to be implemented.

3. *Privileged access to electronic records*

Last spring, important amendments were made to both the *Ombudsman Act* and the *Child and Youth Advocate Act*, reinforcing the broad right of access to records of these legislative officers. The amendments were welcomed by our staff and departmental officials alike, since they clarified and greatly simplified the process for sharing information while addressing concerns on all sides around confidentiality and professional ethics. At the same time, in order to achieve the goals regarding child welfare monitoring and the Advocate's active presence for children and youths, it makes sense to designate staff within the Advocate's office for the same ready access to electronic records as the departmental officials whose work they are asked to oversee. One of my officers has recently taken over the job responsibilities of the former in-house youth advocate within the Department of Public Safety; however, as he is not a public safety department employee, he does not currently have access to youth records in the department's electronic records management system. To that extent, our work is significantly less effective than that of the in-house expert we are replacing. Access to the system would allow our officer to easily determine from a youth's direct report what follow-up may be required, what has been done or not been tried before, and to intervene in a timely fashion. Similarly, Advocate investigators should have the same access to child protection files as the social workers and case-managers whose work they are

reviewing. This is the type of access that investigators in the Alberta Youth Advocate's Office have and is the timeliest and most effective means of assuring proper oversight in this sensitive area of public administration. The *Protection of Personal Information Act* currently allows non-consensual sharing of information from public records "(a) to protect the health, safety or security of the public or of an individual" or "(b) for purposes of an investigation related to the enforcement of an enactment." It is clear now that the broad access provisions under the *Child and Youth Advocate Act* take precedence over the confidentiality provisions of section 11 of the *Family Services Act*. For greater certainty, section 11 could be amended specifically to allow on-going monitoring and access to electronic records by designated members of the Child and Youth Advocate's investigative staff.

4. *A legislated oversight function for group homes and youth transition homes*

The *Child and Youth Advocate Act* appoints the Advocate to monitor defined "services" to children and youths, but it provides the Advocate only with powers to inspect the premises of defined "authorities" under the Act. Private group homes, youth transition homes, and special care homes are generally not public authorities. So the Advocate has no specific legislated mandate to inspect these premises, and, in fact, there is no other independent overseer of these agencies, although they operate largely on the basis of public sector funding. In my 2003-2004 Ombudsman report, I recommended that Government appoint an independent oversight agency to monitor the operations and service delivery provided in nursing homes and special care homes. While that recommendation stemmed largely from concerns relayed to my office regarding the treatment of seniors in our province, this investigation has revealed that the treatment of youth in similar facilities is no better, and it suffers from the same lack of independent oversight. I recommend that the *Child and Youth Advocate Act* be amended to extend the oversight functions and mandate of the Advocate to include services to children and youths in privately operated group homes, youth transition homes and special care homes.

A cabinet minister for child and youth services

The most common, and perhaps most significant, problem identified by officials during this investigation has been a lack of political will and direction. The most common and significant complaint of parents was not knowing who to turn to and the feeling that no one is in charge.

Jasmine's case, outlined earlier, where the review board ordered the Department of Family and Community Services to create a safe residential care option for a 15-year-old schizophrenic, and the department's refusal to comply, illustrate the point. Family and Community Services could legitimately point to the provisions of the *Mental Health Act's* sections 22 and 23, which allow the Minister of Health to approve buildings and homes for the placement of discharged persons and to make payments for the care of discharged persons in approved homes. A stalemate and lack of services arose from the fact that the minister of neither department had preponderant authority in relation to

services to children and youths. Unfortunately, this is only one example from many situations where the lack of authority and inability to get past the gridlock in child and youth services across many government departments is manifest.

5. *The minister responsible*

I would recommend a number of measures to counter this problem. The first measure would be to appoint a minister responsible for services to children and youth⁴. While it may not be advisable to attempt to carve out services to children and youths from the mandates of Public Safety, Family and Community Services, Health, Education, or other departments or agencies, a clear need nonetheless exists to provide greater direction and leadership to the integration of these services across many departments. This would be in the best interests of New Brunswick children and youth. It is also essential that this task not be left to a junior minister or department, as the integration of such services will require the clout and leverage of a minister with significant influence over the purse strings. Since the Department of Education is a large department, with a mandate directed solely and specifically at children and youth in the province, it may make sense to have the Minister of Education ultimately responsible for the integration of all public services to children and youth. Alternatively, the requisite political direction could easily be given this matter if responsibility for the integration of such services was placed squarely with the Premier. Either approach could work, or another viable approach might be found. The key is to initiate a political commitment that will benefit children in this province.

6. *The minister's mandate and authority*

In addition to making one minister responsible for child and youth services, Government could provide the necessary leadership in this area by granting that minister a legislative mandate to ensure the integration of services to children and youth in the best interests of the child. The minister's mandate should include:

- fostering a child-centered approach to the delivery of public services in order to meet the needs of children and youth;
- development of agreements within and among departments to further this approach through joint funding of programs and services and information sharing;
- authority to enter agreements with other provinces and levels of government to enhance service delivery to children and youth;
- operational responsibility for the various agencies, committees and programs established to achieve the integration and coordination of services to children and youth.

⁴ This admittedly is not breaking new ground, since others have done it, and it was in fact recommended that New Brunswick do so as long as eight years ago: Province of New Brunswick, Children Come First: Child Welfare Comprehensive Review and Redesign – Final Report NB Health and Community Services, October 1999, p. 66 Recommendation 27.

Care should be taken to provide adequate resources for the service integration and coordination function while respecting the spending power and investments required by the stakeholder departments and agencies of government. The minister must be the leader, with the effort and resources coming from all departments and agencies operating as a team.

Accountability and civil society: living child and youth advocacy

Acting in the best interests of children is ultimately not a task that can be left to government alone or to one person or group of persons. It is a shared responsibility. For good reason, that responsibility is largely entrusted to parents and other primary caregivers, but it must never be very far from the minds of all of us, even bystanders not directly involved.

Under the Quebec Civil Code, and in various statutory pronouncements in common law, there is increased use of Good Samaritan laws, ie, laws requiring us to help our neighbours in specific and exigent circumstances. In recent years, the law in this province, under our *Family Services Act*, has placed great emphasis on the reporting obligations in cases of child abuse and neglect. An area deserving further study and review is whether reporting laws go far enough, would societies such as ours benefit from legislating a more taxing standard of care with respect to our obligations towards youth generally?

In the not-so-distant past, society was much more outwardly homogenous and conformist, and the law did not shrink from reproofing conduct deemed offensive to public morals or likely to corrupt youth. Today's society is, by comparison, far more permissive. It encourages children and youth to find their own way rather than be molded toward a certain ideal. A question we must ask, though, is: how are the children coping? Are they getting the right dose of guidance, support and self-determination? Have we remained vigilant, interested and respectful guardians of their development? Or have we left them to fend for themselves, taking the humble view that we are no better equipped than they to figure out the straight and narrow path, or whether there is one?

7. *Nurturing child welfare as a civic virtue*

Whether children and youth would benefit from Good Samaritan laws directing all of us to be more mindful of them is a topic that requires more discussion and consideration. In the meantime, as Child and Youth Advocate, I would invite all of civil society to take a renewed and personal interest in matters of child welfare. We should remain vigilant and mindful of the fact that, in our democratic system, children have no voice but ours. The press, the media generally, academics, professional associations, and the voluntary sector all have a strong role to play in keeping government accountable for the delivery of programs and services to children and youth. In the past year as Advocate, I have been encouraged by the extent to which my efforts are shouldered, strengthened, and, at certain times, even outpaced by members of civil society. Advocating on behalf of children and youth is a civic virtue to be nurtured.

One of the most challenging aspects of this investigation has been to bring forward recommendations that replicate the conditions for successful interventions for youths with very complex needs. From our review of these files, the key ingredients for successful interventions have been a life-long perspective, stable loving and caring relationships, community-based care, and the patience of Job. It is not surprising that these are many of the attributes of relationships based upon family and kinship. They are also present in our foster parent models and in charitable movements such as l'Arche, the community-based movement founded in 1964 by Canadian humanitarian Jean Vanier. In l'Arche, people with developmental disabilities, and those who assist them, share life and daytime activities together in family-like settings integrated into local neighbourhoods. L'Arche operates in 34 countries. It has 27 communities in Canada operating nearly 200 homes and workshops or day programs, many of them in Quebec and Nova Scotia. There is, however, only one in New Brunswick, which opened recently in Saint John.

I recommend that the Government of New Brunswick actively promote volunteer, professional and community-based investments in child welfare, recognizing the Province's overarching responsibility in matters of child welfare, but balancing this consideration with the value-added contributions that not-for-profit agencies, professional associations, municipalities, charitable organizations and others can provide in building strong, caring communities for children and youth.

Chapter 2 – Service integration: *William's story*

If we agree to set a framework of accountability, and we commit ourselves politically to renewed vigilance in matters of child welfare, as the current Government seems prepared to do, given its program of action over the past year, then we can begin the honest work of coordinating our efforts toward these ends. It is not an easy task. In the words of one departmental official, it's a little bit like turning an ocean liner on a dime. This investigation covered only four departments. Many other departments, agencies, and non-government stakeholders are concerned. The four departments operate in a context of scarce resources. Information-sharing is strictly limited because of its sensitive nature. Very distinct organizational cultures exist in the departments and within the branches of their operations. And, despite the recommendations outlined above, the current reality is a chain of command and case-management pressures that exacerbate the competition for scarce resources and lead to off-loading responsibility for individual cases of children and youths in need.

There is however, widespread acknowledgement and recognition among officials that we do a poor job of coordinating our efforts, and that many efficiencies and better service delivery could be achieved. We have the technological capacity to do a much better job of sharing information. Doing so is recognized as a privileged means of achieving the goal of service integration, provided it is done in a manner respectful of privacy concerns. Various models of service integration exist in other jurisdictions that we can learn from. These include the model in the State of Maine, where three of our most complex-needs youths – all profiled in this report – are now receiving care. The significant expense of

providing for these three young people at the Spurwink facility is proof that a New Brunswick-based solution would be more cost-efficient. All experts point to service integration as a critical element in dealing effectively with complex needs youth⁵.

The story that most poignantly describes the varying standards of care available to youth with complex needs, and also describes how the integration of services can benefit such a young person, is one the public and the media know well. It is the story of a deeply autistic young man whose detention in Centracare several years ago became a rallying cause for the parents of autistic children in New Brunswick. This is William's story.

William's story

When my investigators met with William's father, it was obvious his family had been on a long journey. After spending years advocating for his son, William's father agreed to relate his story one more time.

As a baby, William "was normal as a child can be." He was basically meeting all of his milestones until he reached the age of two. At that time, he could play video games and communicate his needs. When he reached three, William's parents, concerned about a slowing development, took him to a psychologist, who told them not to worry, that children are often delayed in certain areas. Two more years passed. At five, William was sent by a psychologist to the Isaac Walton Killam Hospital in Halifax. The diagnosis was autism. William's father had never heard the word, and had no idea what it was. Apart from some restlessness, William had exhibited no behavioural problems, or at least nothing the parents couldn't handle.

In a school setting, however, William required many interventions. Although he benefited from an inclusive educational model, he did not, despite the many interventions, progress developmentally much beyond the cognitive or communicative skills of a child of two or three. His behaviour became disruptive, and he had to be removed from the regular classroom for extended periods to an alternative setting created for him. In fact for many years, William spent a great deal of time isolated within the schools into which he was "integrated".

His father relates that, although William had certain difficulties, on the whole schools coped with him, and he coped with them. His father recalls that, as a child, William was able to help out with certain tasks at home, including in the kitchen. He loved to jump

⁵ Zanglis, I., Furlong, M.J. and Casas, J.M., *Case study of a community mental health collaborative: Impact on identification of Youths with Emotional or Behavioural Disorders* Behavioral Disorders; Aug 2000; 25, 4; pg. 359- 371; Keys, S. G., Bemak, F., Carpenter, S.L. and King-Sears, M.E. *Collaborative Consultant: A new role for counselors serving at-risk youth* Journal of Counseling and Development Spring 1998 Vo. 76, pp. 123-133; Becker, D., Hogue, A., and Liddle, H.A., *Methods of Engagement in Family-Based Preventive Intervention* Child and Adolescent Social Work Journal, Vol. 19, No. 2, April 2002 163-179.

and run and swim in the family's backyard pool. But, when he began having seizures a few years later, the pool had to be closed.

When William was about 19, his psychiatrist prescribed a new medication, which affected him negatively. His seizures became more severe. He was more difficult to manage at home. The parents requested respite care, and William was placed during the day in an FCS group care environment. Then he started spending two nights a week at the group home, and eventually he moved there. A few months later, the parents noticed a marked deterioration in their son's behaviour and cognitive abilities. A psychiatrist was following his case, and a psychologist was visiting him at the group home. During the day, William attended his local High School, and he had regular contact with his family.

During this period, the parents started noticing burn marks on their son's body. According to the father, they were given inconsistent explanations about the marks. They continued to raise their concerns with FCS but, in their view, were not heard.

About five months after they first mentioned their concerns, the parents were told William had to leave the home. The group home operator, they were told, could no longer provide for William's care, because of his strength and unpredictable, aggressive behaviour. FCS undertook to find a new placement for William. A few proposals were put forward, but FCS denied these because of the high cost.

The group home operator then agreed to place William in an apartment with one-on-one staffing until another placement could be found. In this highly structured environment, his behaviour problems were minimal. He continued his therapy, visits with his family, and schooling. But these interim arrangements could not be extended beyond a few months.

In 2002, when William was 21, FCS advised his parents that he could no longer live in the apartment. The department proposed moving William to Centracare in Saint John. The parents were concerned about this move and requested a 30-day extension of William's stay in the apartment while they explored options and sought expert advice. The parents presented a report from William's family physician stating that Centracare was not a good placement for William. The doctor said it could cause his condition to deteriorate. His psychiatrist and his psychologist also disagreed with this move, and so did the staff at Centracare. However, the Minister rejected the professionals' opinions and denied the request for a 30-day extension. William was sent to Centracare.

The plan was that William would be placed in the rehabilitation unit, with a view to one day returning to his community. In fact, he was put in a "sustained care unit" with limited access to programming and therapy. The staff at Centracare further advised FCS that the unit available for William was very noisy and inappropriate for an autistic young man. They said William was at risk of being assaulted by other residents, a warning supported by an earlier psychiatrist's report. These warnings were subsequently borne out when William was repeatedly assaulted, including a sexual assault. As a result, William's

behaviour deteriorated, and he lost most of the cognitive abilities he had gained during the previous years. His father believes this damage is probably irreversible.

In a statement of claim in a lawsuit the parents launched against the Province, they said that, on one visit, they “. . . found William to be heavily sedated, no longer recognizing his parents and lying in his bed with his hands over his ears complaining of the noise. They also found him naked in isolation . . . on many occasions afterwards.”

Sixteen months after his placement at Centracare, William was sexually assaulted. Using any means they could to be heard, the parents continued to advocate for their son to be removed and placed in an appropriate environment. Many people in New Brunswick will remember this case, because William’s father never hesitated to speak publicly about his son’s plight, and it attracted much media attention.

Three years after being admitted to Centracare, William was transferred to the Spurwink facility in Portland, Maine, at an annual cost of over half a million dollars a year. His parents have no means of transportation to make the six-hour drive to Portland. They are pleased that he is receiving the care he needs, but would prefer that their son could receive this kind of care in New Brunswick, so that they could visit him.

When he arrived at the American facility, William was placed in a house where he was, and still is, the sole occupant. Initially, he was cared for by a couple who lived in the house with him. But it was very demanding on the couple, given William’s state on arrival, so the arrangement was changed to his being cared for by staff working in shifts. Spurwink staff told my investigators that according to their information, in his last year at Centracare, William was not once taken outside. It goes without saying that he was, and still is, a long way from his former self. But, in his two and a half years at Spurwink, he has made constant, if slow, progress. Staff working with him have said the following:

“William definitely seems to have skills. He picks up on things. The potential is there. . . . He seems interested in education. . . . Some methods used with others are not successful with William. But he is starting slowly to show results. . . .”

Concerning William, and the two other New Brunswickers being cared for in Maine, unavoidable questions arise: why did they have to be placed outside the country to receive the level of service they require? How can we integrate our services in New Brunswick to make them work for William and young people like him?

This puzzle has many pieces. The recommendations outlined above regarding accountability and political direction are, of course, an important element. As well, the lessons of Spurwink make it clear that ensuring the service delivery model is child-centric, or tailored to the child’s needs, is another important first step. Two problems looming over these discussions concern the brokering of disputes over control of resources and control of information. In other words: who will pay? And who needs to know? Better systems for sharing information must be devised, ones that are also accessible to parents, young people, and their entire circle of care. A properly integrated

service delivery model is one where parents feel supported and receive services without getting the run-around. In some aspects of our work, service integration can be achieved merely by doing more of what we do well. Our review has led to recommendations that explore these various possibilities.

8. *A Child-centred service delivery model*

All the text-books talk about it. As far as we can tell, it is also public policy in our province. We aim to deliver services that are child-centric and individually responsive to the needs of children and youths accessing services. Our investigation has revealed, however, that, while we have perfected the “talk,” we have difficulty “walking the walk.” Parents have told us that they dream of the day when a case-worker or social worker will ask them, “What does your child need, and how can I help you access it”? Social workers have told us that, 30 years ago, early in their careers, they used to enjoy field work and working in the family home with children who needed assistance. Now, they say regretfully, their jobs have become ones where they act merely as service brokers, with little real contact time in the home. They also regret that, all too often, they are required to refuse services to children in need whose profiles don’t happen to meet program criteria, and no other programs are available to assist the particular cases of those children.

This is what we mean when we say: it is time to turn that ocean liner around. We recommend the minister responsible for coordination of child and youth services establish guidelines and training programs for front-line staff in all departments to ensure that we meet the legitimate needs of children and youth seeking service. The Government must move from a system of exclusion as a result of criteria-based program delivery, to a system of service. Financial accountability has required us to make a strict application of program eligibility criteria. This is a good and necessary measure. What I am recommending is that, in matters of child welfare, we also have to develop social accountability measures to ensure that our programs start meeting their service delivery goals.

9. *Legislating cooperation and resource-sharing in child welfare matters*

The main challenge in service integration is control over the purse strings. How can you create a minister responsible for child and youth services if he or she does not have control over the program spending on children and youth in various line departments? How can you grant such power to the minister without compromising the independence of his colleagues in Cabinet and their duty to apportion scarce resources across very diverse departmental priorities? These are difficult questions. In the end, however, my view is that it is a false dilemma. The real question is: does Government want to make service delivery to children and youth a priority in this province? If there is a political will for this, then the way forward should be clear.

Over the past few years, aboriginal youth advocates in Canada have successfully insisted on the application of “Jordan’s Principle” in implementing services to youth. Jordan was

a young First Nations child born with complex medical needs. After spending the first two years of his life in hospital and benefiting from significant community support, doctors said he could go to a family home. This decision should have been a time of celebration, but, for federal and provincial governments, it was a time to begin arguing over which department would pay for Jordan's care at home. The jurisdictional dispute lasted more than two years, while mediation and legal action ensued over such matters as who should pay for a wheelchair ramp or modified showerheads. The jurisdictional dispute was finally resolved shortly after Jordan's fourth birthday in hospital. But it was too late for him—he died before he got the chance to live with his family. Jordan's Principle, which developed out of this sad event, requires that, in such jurisdictional disputes, the service provider who has the first contact pays for the services and then seeks contributions from other branches of government. Thus jurisdictional issues can be addressed without depriving a child of care.

William's story, like Jasmine's, was unnecessarily complicated by jurisdictional battles between Family and Community Services and the Department of Health. As he languished in Centracare, victimized by other patients, the departments debated who should pay for services to him. We recommend the Government devise a legislative and institutional response to put Jordan's Principle, or something like it, into application in this province. In my view it is inevitable that the Minister of Child and Youth Services would need sufficient appropriations to allow him to broker financial disputes effectively without always imposing costs on one department or another. However in most cases, the Minister's central role would be to determine effectively and rapidly which services are needed and which Department should pay.

It would, for example, be possible to grant a minister responsible for coordination of child and youth services the power to order a financial contribution or payment of services by a given department in cases of disputed access to services. If the minister had such authority, it would rarely need to be invoked, because departments would prefer to find a mutually agreeable solution rather than have one imposed on them. Any abuse of the minister's authority could effectively be addressed in Cabinet.

10. Legislating interdepartmental coordination in child welfare matters

It is one thing to name a minister responsible and to provide him with some decision-making power to direct the payment of services in disputed cases. However, the day-to-day operation of so large an effort of coordination and integration of services would need to be structured at the highest levels of the public service in order to ensure active participation by all the lead departments concerned. We recommend that a steering committee of the deputy ministers of Education, Health, Public Safety and Family and Community Services be struck to meet quarterly and report regularly to the minister responsible. An executive director reporting directly to the minister could assist in this task and act as secretary to the deputy ministers' committee. Thus without considerable additional expenditure a small central government group could be created and specifically tasked with the vital policy and planning effort needed to coordinate services

across such governments. Similar agencies have contributed greatly to policy development in this province in areas such as the status of women and aboriginal affairs.

11. Legislating information sharing in child welfare matters

As stated above, a further area of cooperation that may require a legislative framework is information-sharing in child welfare matters among departments and agencies of government. Generally, the *Protection of Personal Information Act* (POPIA) provides that, when issues of interpretation arise regarding confidentiality principles, they should be resolved with reference to the Statutory Code of Practice under POPIA. The Code of Practice would allow information to be shared without consent in order to protect the health or safety of an individual or a group of persons. The *Family Services Act* allows personal information to be shared among government agencies without express consent, but the reality is that the sharing is not free-flowing. Even in cases where sharing information is in a child's best interests, pockets of resistance will arise out of concern for a child's or a youth's right to privacy. Accordingly, it may be helpful to reassert formally—in legislation affecting the information and privacy rights of children in educational, health, public safety and social service matters—an obligation on the part of public data custodians to share that information with other public agencies, if doing so may reasonably serve the child's interests. In other words, the standard should be clear that, while protection of a child's privacy is an important right, the obligation to share information with other public service providers to benefit the child is a paramount concern.

Specialized legislation in this field could help clarify any ambiguity and improve integration of child welfare services. Detailed provisions could be developed to establish priorities for levels of disclosure. Thus, it may be appropriate that certain basic health information be made readily available to school officials; that school officials be required to disclose information that may assist in an investigation of possible abuse or neglect; that social workers assist youth correctional workers by disclosing information that may assist in a child's rehabilitation or treatment program in custody. In all cases, officials should be required to act in a manner consistent with the standard of a prudent and caring parent. While in many areas of public administration, principles of transparency and privacy must be carefully balanced, the Supreme Court has held that, in cases of doubt, privacy should be held paramount. In child welfare matters, any doubt about the paramount concerns of privacy and transparency should be resolved in favour of information-sharing if there is any possibility of advancing a child's interest. This is even truer where a minister or other public official acts concerning a ward of the state. In these situations, the child's best interests are almost always served by disclosure to other public agencies within the circle of care to the child or youth in question. New Brunswick law is generally consistent with this approach. It may benefit, however, from a clearer legislative pronouncement regarding personal information about children and youths receiving public services.

12. *A joint electronic records management system for children and youths in need*

If the preceding principles are well understood and well articulated in law, it will be possible to harness the information and records management technology now being developed in the health sector to help integrate services. Much work would have to be done to determine whether health records or school records would be the logical starting point for a joint electronic record for children and youths in need. However, the benefit of involving case-workers, correctional workers, methods and resource teachers, classroom teachers, health care professionals, teaching assistants and parents in a child or youth treatment program are readily apparent. In the area of intervention with autistic children, certain programs exist that demonstrate the potential of bringing all the interveners to a common forum or table, in developing, monitoring and adjusting a child's treatment plan or educational plan.

While it may be too costly and unnecessary to develop such a joint electronic record for every school-age pupil, it may be appropriate to do so for pupils who are on a special education plan. An appropriate pilot program might be to design and develop such a system for pupils with highly complex needs.

We recommend the minister responsible for child and youth services establish a study group to report on the most appropriate means of sharing information among departments and to explore the possibility of establishing a joint electronic records management system for children and youths in need.

13. *A single entry point for information and service access for families*

Service integration really does require that officials in all departments develop increased expertise with respect to the government service delivery options available to youth and their parents. To the patient or consumer, every public official is the voice of government. This is why they are frustrated when they have to explain to one group of officials what they have learned from public servants in another department. Parents tell us constantly that they have to relate their story from A to Z, explaining to officials, who should know, why services from other departments are no longer available to them, or to their child. They also relate their frustration when they learn, too late, about a program or service they could have accessed long ago. What most parents agree on is that, following their child's diagnosis, they were left very much to fend for themselves. They realize, in hindsight, that they were given little idea of what mental illness problems look like. Had this been done, they might have been better equipped to cope. These parents have asked: why is there not a single entry point into the system, following diagnosis, where parents and youth can access information, learn about the support programs and services available to them, and obtain guidance and support in accessing those services?

This type of service has been developed for drivers' licenses, hunting and fishing permits, land registry and personal property registry systems. Why can't it be achieved in the health service field? How can government respond to these needs? While government has recently devolved responsibility for mental health services to regional health authorities,

there may be some benefit in working together and avoiding duplication of effort in establishing accessible and reliable public health information for the parents of children and youths at risk and those with highly complex needs.

We recommend that, in addition to developing closed systems for sharing information among public officials who provide services to children and youth, government must invest significant new resources to develop open, public health information systems that will help guide parents and families through the array of programs and services that may assist their child following diagnosis of a mental health condition. A review of the type of information available through the University of North Carolina's TEACCH Centre may be a helpful reference⁶. The partners in this process should include regional health authority mental health service managers, the mental health patient advocate, the New Brunswick Association for Community Living, The Autism Society of New Brunswick, the Child and Youth Advocate and the Canadian Mental Health Association.

Chapter 3 - Community-based residential care: *Jacob's story*

I come now to the premise that helped launch this investigation. Assuming that we do everything we can to build in accountability and foster political direction and better coordinate and integrate our efforts across government departments, the problem cases will still not go away. We will still be faced with a critical lack of trained professionals and too few residential placement options. Continued placement and referral of youths like William to Spurwink in Maine, at half-a-million dollars a year per youth, will not be financially viable in the long run. How then do we move from our current practice of exporting our most severe cases of complex-needs youths out of the province and country to a point where we have a community-based model of care for them here in New Brunswick?

Another major theme of this investigation is the issue of removing people from an institutional environment, and the fall-out resulting from this, and whether the alternative of community-based residential care can be achieved without making this alternative into simply another kind of institution.

We started, in Jasmine's case, with a premise that the problem was a lack of residential care facilities. Immediately, however, our investigation raised questions: is the problem a lack of facilities or a lack of support services to families? Is the problem the lack of long-term care facilities for youth with complex needs, or is it a lack of institutional capacity for managing acute care needs of young mental health patients? If better community-based residential care options can be devised for youth with complex needs, what roles do communities and the non-profit sector play in this type of service delivery? What about the needs of youth-at-risk? What residential services options are available to them? Why are youth transition homes round the province constantly in a crisis of survival? Can new residential facilities be developed to meet the needs of both these youth

⁶ See, for instance, Chapel Hill TEACCH Center, *A Family's Reference Guide to Services For Youth and Young Adults with Autism*, University of North Carolina, http://www.teacch.com/info_family.html

constituencies? What about the intersection with educational services, health services and crime prevention? How do we integrate services on a local and case-specific level?

I propose to discuss all of these questions after a closer look at the story of a young man who, before his placement at Spurwink, in Maine, had burned most of the bridges and residential-care options available to him in New Brunswick. He has a large and supportive family, but his violent and aggressive outbursts have prevented his reintegration with them. We were well into this investigation when I first heard from his mother. My investigators then had a chance to meet her son in Maine. They were happy to encounter a complex-needs youth who was highly communicative, had a sense of humour, and showed some real potential. The file regarding interventions at his home in New Brunswick, however, paints a much less optimistic portrait of this young man. This is Jacob's story.

Jacob's story

Jacob was born in the spring of 1989 and is now 18 years old. He has a twin brother and four other siblings. Because of fetal distress of Jacob, his mother delivered her twin boys by Caesarean section at 39 weeks. As early as eight months later, his mother began to be concerned about a noticeable difference between Jacob and her other children. By the age of three, his behaviour was strange enough that his mother took him to a doctor. The doctor did not see any need for a further referral.

The boy was five years, seven months when his mother sought further help. He was manifesting an increasing number of problems: spells of staring, a short attention span, aggressive behaviour, and bedwetting. Thus began Jacob's encounter with therapies and medicines. He has taken various medications over the years, prescribed by the many doctors who have treated him. He was on Tegretol and Risperdal for a long time, until they were no longer effective. Lithium was another drug he was given. There were positive aspects to his drug therapy but, one of the effects of Risperdal was substantial weight gain. As of 2006, his full diagnosis was: Pervasive Personality Disorder, Not Otherwise Specified (NOS), Tourette's Syndrome, and Oppositional Defiant Disorder; he also exhibits co-morbid symptoms of Obsessive-Compulsive behaviours and ADHD.

With regard to schooling, the file review shows that Jacob began to struggle as soon as he started kindergarten. He did not pick up on cues, had behaviour problems, and was physically aggressive. In Grade One, his aggressive behaviour continued, despite an excellent teacher and good parental communication. Academically, he was always below expected levels. He achieved moderate success with some Special Education Plans, although not consistently. In his early school years, he started back to school each September without a teaching assistant being assigned to him, but, after a few behavioural incidents, one would be assigned. This kind of reactionary service was problematic for Jacob. It created more behaviour problems because he always struggled with transitions. When he reached middle school, his mother encountered a principal who was similarly "waiting for a problem to arise before doing anything". One aggressive episode followed another. In the year he was 12, Jacob was out of school by November.

A team worked to help re-integrate him into school on a half-day program. His mother also noticed that Jacob was much better in summer, when there was no stress from school.

Like many other kids with complex needs, Jacob's aggressive behaviour eventually led to problems with the law. His mother had noticed physical aggressiveness as early as when he was in kindergarten. As a child, he set fires. His behaviour can be highly aggressive, but it is usually not triggered by particular things. Rather, it is more likely to be a direct negative reaction to being emotionally over-stimulated and then suffering a meltdown. He also has less control over his aggressiveness during changes in his medication regime. This behaviour escalated over the years to the point of assault in 2005, when he held his mother at knife-point and threatened to kill her. He also attacked his foster father and brother in 2006, and then, in that same year, violently assaulted his foster mother in an episode that could have been lethal had her daughter not beaten him off with a chair. Since then, precautions have been taken when Jacob is undergoing changes in his medication regime. He has completed the youth corrections system's alternative measures program twice. He also assaulted his foster father, and was at the NBYC for four months.

One has to wonder to what extent changes in his support structure and the place he calls home may have affected Jacob's behaviour and condition. He was six years old when he first got involved with social services, and, at the age of nine, he was assessed at the IWK in Halifax. At 12, he spent a month at the Pierre Caissie Centre in Moncton, undergoing extensive tests and evaluations. Jacob has lived in several foster homes for varying amounts of time since 2001, the year in which he was taken out of his family home because of his mother's fear for the safety of her other five children. The last time Jacob was in his house he had a violent outburst in the evening. When the family called FCS, they were told to call the police. Jacob was put in a police car and taken to hospital; later, he was moved to a youth residence in Fredericton. When he was subsequently taken to another foster home, he assaulted his foster father. Attempts have been made since then to re-integrate him with his family, but these have been unsuccessful because of his aggressiveness.

After a stay in the youth correctional facility, Jacob was transferred to a crisis unit in Fredericton, where he was the only resident in a house with trained staff. This arrangement, however, was not financially viable for the province. FCS' clear assessment is that Jacob will never be capable of living independently; it has been recommended that, because of security risks resulting from his aggressive behaviour, he should not live either at home or in a foster home, but in a residential treatment facility.

Jacob's mother was particularly troubled by the apparent lack of services for her son in the province when he was between 16 and 19 years of age. He did not qualify for the special needs programs; his case was treated as a child protection case, even though it did not meet the requirements for one. At this point, the Office of the Ombudsman became involved, and options for out-of-province residential treatment were considered. Jacob

eventually was accepted for placement at Spurwink, which was able to meet his needs of secure, individualized residential care.

* * *

It is unfortunate that, in our rush to remove people from institutions, to close down the training school, to insert every child with special needs in this province into the mainstream (the famous “no child left behind” policy), we went so far in dismantling many of the service delivery options that existed previously. It is an accepted truth that the vast majority of young persons receiving health care, or educational services, or social services in an institutional setting throughout the 1950s, 1960s and 1970s could have benefited from less segregationist policies and treatment. It is also true that only now are we reaping the benefits of taking them out of institutions and implementing the inclusive approaches to education developed through the 1980s and 1990s. But this investigation has convinced us more than ever that the pendulum has swung too far, and that the varied needs of our diverse youth require more than an all-or-nothing, one-size-fits-all approach. Family supports, extended family residential placements, community-based group homes and foster home placements, inclusive education approaches and hospitalization only for acute care mental health needs are preferred approaches in all cases. But they are not sufficient to meet all needs. Youth with highly complex needs, in particular, require more options available to them. Youth-at-risk also need a broader social safety net to meet their housing, social and developmental needs. We clearly need more capacity in terms of residential options for youths with high-end needs, but by supporting communities and families, we can reduce the pressures for such residential options and the demands on hospital and correctional services currently being made in the absence of such alternatives.

14. A provincial centre of excellence for youths with highly complex needs

Gabriel, William and Jacob are all receiving excellent service in an integrated community-based setting that is allowing them to make significant progress in their respective treatment plans. Each is placed in a home in a residential urban or rural setting with a staff model of care; each is the only resident of the home. Through Spurwink, they have access to specialized schools, to community-based work programs, to psychological, psychiatric, medical, dental and occupational therapy services, all of which are integrated and coordinated through program directors responsible for their care. Because Spurwink is an established treatment centre in the Portland, Maine, area, with nearly 50years’ experience of service to mental health clients, community-based services are well acquainted with the needs of such youth. Because most of the facility’s residential-based programs are run out of homes in the Portland area, there is a critical mass of needs in this community that supports the establishment of specialized professional services.

In a province the size of New Brunswick, it is not possible to roll out specialized educational, health and social services to all communities in the province. I recommend establishing a provincial centre of excellence for youth with highly complex needs. This

centre of excellence could be located in a New Brunswick community and mandated to recruit and retain expert services in child and adolescent psychiatry, developmental psychology, audiology, speech pathology and other support services in matters of child welfare. While it is important that this provincial centre of excellence be geographically accessible, and its services available to New Brunswick residents in both official languages, proposals for its location should come from interested communities themselves, and the final choice should be based in part on the basis of a demonstrated ability to integrate services to youth across a broad range of community-based interventions.

I have spoken publicly in recent weeks about the need to abide by our international legal obligations and keep youth correctional populations separate from adult correctional populations. Building a new youth correctional centre in Moncton is an option worth exploring and one which I will canvass further in my report into youth correctional services offered in this province to Ashley Smith. The centre of excellence for complex needs youth must work closely with the NBYC, wherever it is located and while both facilities might benefit from being co-located within a given community, it is important to keep these separate facilities at a healthy distance one from the other and avoid any unnecessary mixing of young offender and youth with complex needs populations. Most importantly the centre of excellence may provide services to youth with complex needs from a central facility, but youths in question should reside in the community in keeping with their rights under the UN Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.

15. A provincial centre of excellence for youth-at-risk

Youth with highly complex needs represent the apex of the pyramid of youth needs in the province. Cases as demanding as those of the youths profiled in this report are relatively few, but providing services in such highly complex cases is necessarily a costly venture. While such cases will inevitably arise from time-to-time, consultations with community autism centers, departmental officials, and parents have satisfied me that the incidence of such cases can be reduced by focusing on better and earlier interventions.

There is also a broader number of youth-at-risk in the province who may be in danger of deepening their mental health problems, harming themselves or others, developing a drug dependency, committing a criminal offence, or dropping out of school and living on the streets. Youths in this category may be far more self-reliant and have much better coping skills and less acute needs than youth with highly complex needs. But having appropriate supports in place for this next large segment of youth-in-need is another aspect of the plan required to prevent an escalation of problems in individual cases and the development of more cases of youth with highly complex needs. Interventions at this level can cost less and have the potential of benefiting many more families in the province.

For this reason, I also recommend establishing a separate provincial centre of excellence for youth-at-risk. This centre of excellence should also be established jointly with a

willing partnership of community agencies in a given locality within the province and be mandated to develop and pilot innovative approaches and best practices in the field of youth welfare services.

16. Supporting the role of youth transition homes

There are currently a number of youth transition homes operating within the province that provide an alternate residential placement for youths who have left their parental home but are still having difficulty living independently. These homes help youths, who voluntarily choose to live there, adapt to independent living, complete their educations, develop and achieve employment goals, acquire social skills and basic life skills. There is currently a transition home for young girls in Fredericton called Chrysalis House and co-ed facility in Miramichi (Miramichi Youth House) and First Steps Housing in Saint-John, where young girls who are parenting young children or are pregnant can receive the services listed above until their baby reaches the age of one. All three are run by volunteer boards of directors and have faced chronic sustainability problems since opening during the past 10 years. Because they are not approved special care homes or nursing homes licensed or recognized by the Department of Family and Community Services, they do not receive any permanent funding from the Province, and the flow of information between FCS and the staff of these facilities is in many cases not good.

On the other hand, each of the facilities in Saint-John, Fredericton and Miramichi has received significant funding from government, year after year, and they have frequently been kept open as a result of significant public pressure and a financial bail-out from time to time. I recommend that the Department of Family and Community Services develop a program to guarantee stable core funding to these youth transition homes and to assist community organizations elsewhere in the province on a regional basis to establish similar homes in order to meet the housing needs of young men and women who might otherwise be living on the streets. Similarly, it is recommended that such homes be assisted in recruiting and retaining specialized staff to meet their client needs, and that the staff within these homes be included within the circle of care for youths placed with them, and that the flow of information from public records that could assist in the care of these young people be facilitated in the child's best interests.

17. A transition home cluster for youth with highly complex needs

Most of the youths profiled in this report could not thrive in a transition home. They would not be sufficiently self-reliant to be placed there and would be at risk of harming themselves or others. In fact, in many of these cases, an individualized placement has had to be developed, with a 24-hour, seven-day-per-week staff model, as we work towards a goal of integrating these young people into some form of family-based placement. For the time being, these types of placements have been made at the Spurwink facility, where supervised placement can be arranged with a highly experienced clinical intervention team. One of the problems that surfaced in every case reviewed was the lack of adequate facilities to provide care to youth with complex needs even as more stable long-term placements were being arranged. The Restigouche Hospital Center was not appropriate

for Jasmine, NBYC was inappropriate for Gabriel, Centracare was the wrong place for William, the Albert Street Crisis Centre in Fredericton was the wrong place for Jacob. This was true even though all had to stay in these places for months or years at a stretch while more appropriate placements were devised.

It is recommended that the community selected as the provincial centre of excellence for children and youths with highly complex needs have available an appropriate number of residential homes that could be used as staff model special care homes, and that a dedicated cluster of such homes throughout the community where the centre is located be developed to provide housing and shelter for up to eight youths with highly complex needs on a transitional basis. The units must be independent of one another, allow for two-to-one staffing, and be permanently staffed by qualified care-givers. In a staff model home, rotating shifts of care-givers provide continuous care to the resident on a one-on-one or two on one basis, round the clock and seven days per week.

18. *Study Woods Street Centre model from Nova Scotia*

In the aftermath of the tragedy investigated by the Nunn Inquiry⁷, the Government of Nova Scotia recently reviewed and improved its service delivery model through a specialized secure custody facility for youth-at-risk on the outskirts of Truro, N.S. My investigators had an opportunity to visit this centre last spring and discuss its mission and approach to dealing with youth-at-risk. The centre is mandated to provide a secure custody residence to youths who are at risk of harming themselves or others, but who have no young offender record. Youths may be placed there on an involuntary basis by order of the director for a five-day evaluation, during which a court order must be obtained to continue the placement. The placement may be confirmed by judicial order for 30 days or subsequently for 90 days and, in exceptional cases, the latter order may be renewed. The centre houses male and female youth and offers on-site psychological services and regular psychiatric, medical and dental clinics. The goal of the centre is to provide youth-at-risk with a safe environment where they can refocus and prepare to return home or to a new foster home or residential placement. Initially, the centre opened with a mixed staff model of custodial and social work staff, but in time the custodial staff was replaced to make way for a more nurturing model of care. I have strong reservations about the need to legislate an involuntary placement of children or youth in a closed-custody facility on the mere apprehension of a risk of harm to themselves or others, however serious. But, should alternative measures proposed in these recommendations fail to remedy the problems encountered through this investigation, the Nova Scotia model may warrant further study.

⁷ Nunn Commission of Inquiry, Final Report Dec. 5th, 2006 “*Spiralling Out of Control: Lessons Learned from a Boy in Trouble*” D. Merlin Nunn, Commissioner, <http://www.nunncommission.ca/home/index.cfm> inquired into an incident in which a Nova Scotia woman died in a fatal car crash involving a boy who had been released two days earlier from a detention centre.

19. *Trained, competent staff for group homes and youth transition homes*

The front line of care for youth at risk and youth with highly complex needs in New Brunswick is not the teachers, nurses, individual case-workers, or even parents. In cases of greatest need, the front line is the foster parents and the care-givers on shift in youth transition homes, in group homes, and, at times, in special care homes across the province. All measures recommended in this report will come to naught if the Province does not invest significantly in new training programs and professional development opportunities for these workers and volunteers. What is apparent from the individual case reviews conducted in this investigation is that these front-line workers can make a crucial difference in helping a child or youth manage his or her medication, in de-escalating a crisis, in accessing professional help. They can make a difference by knowing how and when to use any physical restraints, how and when not to and with whom, by knowing how to set limits and how to model desired conduct, how to listen and how to support a child or youth in need. On the other hand, taking the wrong approach with mentally ill children can have very negative results⁸.

Contractual arrangements with staff must be reviewed, because staff whose job status is precarious tend to leave for workplaces that are more stable and offer permanent employment. I challenge the belief that New Brunswick is lacking the potential to develop a solid workforce with the necessary expertise to deal with these youths. In fact, we were surprised to learn that one of the main areas where Maine's Spurwink facility recruits its staff is in New Brunswick. They have assured us they have no difficulty in finding solid, competent staff in New Brunswick.

I recommend the province invest significantly in better training, clinical support and better wages for group home staff with demonstrated competencies.

20. *A clinical framework as first responders*

A strong clinical framework needs to be in place to help when a crisis arises. All too often, staff will call police, usually on weeknights or weekends, because they don't know how to de-escalate a situation and because they receive no help from supervisors on call. Behaviour management and setting limits and house rules are important, but effectively supporting youths emotionally should be the focus. We need to foster a nurturing and loving approach to service delivery across the system.

21. *Improved funding to autism initiative and community autism centres*

Another critical front line of support to children, youths, and their families are the community autism centres the province has recently helped establish in cities round the province. Considering the impact of the outreach services provided through these agencies, more should be done to support them. At the same time, their role could be expanded to cover a broader array of behaviours and disorders in children requiring

⁸ Ross W. Greene, et al A transactional model of oppositional behavior: Underpinnings of the Collaborative Problem Solving approach *Journal of Psychosomatic Research* 55 (2003) 67– 75.

community interventions. This cannot come, however, at the cost of other aspects of the autism initiative, which is already critically under-funded because of the strong demand for early intervention services⁹. Early last fall departmental officials were already forecasting a 60% or \$2.5 million shortfall in this program this year. It is recommended that Government renew its investment in the autism intervention strategy in a manner consistent with the needs identified, and that the proportion of funding directed to supporting the community autism centres in the province be increased and their role expanded¹⁰. The New Brunswick Government should seek assistance from the Government of Canada to cost-share its strategy in this regard, as recommended in the recent Senate report on autism families in crisis¹¹.

Research demonstrates that parents are the best and natural behaviour interventionists and that children and parents can benefit from parental training in dealing with autism spectrum disorders¹². It is therefore also recommended that the Government consider re-directing its investment in training programs towards more broadly based training components, including on-line programs to assist parents, care-givers, field-workers, nurses, teachers and teacher assistants, as opposed to merely developing more autism support workers.

22. *Continuity of care*

One of the service goals we must start striving towards in social services, health services, and educational services for youth-at-risk and children and youth with highly complex needs is to maintain continuity of care whenever possible. Most of the cases studied in this investigation reveal how difficult it is for these children to handle transitions and

⁹ Our goal should not be to provide ABA therapy to every parent with an autistic child who wants it, but rather to have an array of community-based intervention programs that are adaptable to the several needs that exist in the community. Some experts have sounded a caution regarding parents who may view ABA or IBI therapy as a panacea: Schoen, Alexis A. *What Potential Does the Applied Behavioural Analysis Approach Have for the Treatment of Children and Youth with Autism?* 2003 Journal of Instructional Psychology Vol. 30 No. 2.

¹⁰ As to the growth in needs, research has shown that, in the U.S., schools are reporting a 800% increase in the rate of diagnosis of autism between 1992 and 2005: Stahmer, A.C., Collings, N.M., and Palinkas, L.A. *Early Intervention Practices for Children With Autism: Descriptions From Community Providers* Focus On Autism And Other Developmental Disabilities, volume 20, number 2, summer 2005 pages 66–79; A recent World Bank Symposium reported, for its part, that early intervention was a critical path of investment for social planning efforts in response to these needs: Mustard, J.F., *Early Child Development and Experience-based Brain Development - The Scientific Underpinnings of the Importance of Early Child Development in a Globalized World* Canadian Institute for Advanced Research, February, 2006.

¹¹ Senate of Canada, The Standing Committee on Social Affairs Science and Technology Final Report on the Enquiry on the Funding for the Treatment of Autism: Pay Now or Pay Later – Autism Families in Crisis, Hon. Art Eggleton, Chair, March 2007.

¹² Stathopulu E, Zwi M, York A. Parent-training intervention in school-aged children with autistic spectrum disorders. (Protocol) *Cochrane Database of Systematic Reviews* 2003, Issue 3. Art. No.: CD004255. DOI: 10.1002/14651858.CD004255.

adapt to changes. Whether changes are made in their home environment, at school, in care providers, or in medications, all of these transitions present significant challenges, much more so than for the average student, or the average student with special needs. Beyond these challenges in managing transitions, our investigation suggests that what has the greatest potential for positive outcomes with these youths is the development, nurturing and modeling of lasting relationships. Developing and maintaining relationships with youths, between youths and their families, youths and their peers, and youths and their community mental health professionals is a critical component of successful intervention plans. This approach was evident in all the services provided to the residents my investigators visited at Spurwink. Officials there reminded us several times that: “We believe relationships make people grow.” For Gabriel, William and Jacob, that growth is now underway.

If we decide in this province to make children and youths a priority, and provide the necessary political direction to that end, if we coordinate and integrate our efforts to support children and youth, and if we nurture community-based residential models, properly staffed and clinically supported, we will have come a long way. These investments will also pay dividends--in reduced demand on our courts, on our youth correctional services, and on our acute mental health treatment services (such as they are). However, these results should not be a happy by-product of our efforts. Government must, as a matter of public policy, make it a priority to provide continuity of care and promote the development of stable relationships around youth with mental health disorders.

Chapter 4 - De-criminalizing youth with mental health disorders: *Nicholas's story*

It is obvious from the preceding chapters that much of the investment in service integration and community-based residential care is proposed as an alternative to jail. Unfortunately, in many cases, NBYC is the only secure residential option currently available to youths with complex needs in this province. Of course, you have to be charged to get there. But often, as in many of the cases we have presented thus far, when these youth get big and strong enough, a criminal charge is just around the corner. It is not that these young children and adolescents with mental health challenges are destined for a life of crime. It is, rather, that they often need to be kept safe from harming themselves or others for reasons that neither we nor they can easily control. Unfortunately, in New Brunswick currently, the local jail is often the only placement available.

No one whom I have spoken to during the course of this investigation has denied these sad facts. The investigation has not found a single defender of the status quo. Parents despair in disbelief that they have to stand by and watch their children commit a crime in order to get services for them, yet they admit to having done it. Public safety officials are the first to admit that they are not psychiatric nurses and are ill-equipped to deliver mental health services, but they recognize that they are duty-bound to provide services as best they can to the youths placed in their care by the youth criminal justice system. Judges have been saying from the bench for years that these children don't belong in

jails, but they keep sending them there because, when faced with an individual case, there is nothing else they can do.

As Child and Youth Advocate, I am reluctant to place any greater emphasis on one of the recommendations in this report over any other. In my view, many of the solutions proposed are critical elements of a plan to move the province forward on its agenda of making sure that children come first. However, as a starting point, it would be timely to draw a line in the sand and say that we are going to stop letting the youth criminal justice system pick up the pieces and be the stop-gap measure or solution to our historic failings in the area of child and youth mental health services. The reason for this priority emphasis is, of course, the magnitude of our error in allowing the current situation to go on for as long as it has. It is not merely a question of devising mental health solutions for mental health patients because, quite honestly, that makes more sense than treating them as criminals. The problem is that, when we make the youth criminal justice system our default solution for children with complex needs, we are deliberately placing young, vulnerable children directly in harm's way. The approach is so fundamentally contrary to Canadian values that the average Canadian would be amazed to learn that it happens as routinely as it does. The risks to the children concerned, children and youths like Jasmine, Gabriel, William and Jacob, are very real. The case that demonstrates this fact all too well is Nicholas's story.

Nicholas's story

“I have witnessed the phenomenon which I call the ‘criminalization’ of persons with mental illness. Although the causes for this tragic occurrence are many and complex, we as citizens and policy leaders have the responsibility to understand the reasons for, and the tragic consequences of, criminalization. We have the duty to make right a situation which no civilized society ought allow to occur.”

--Harold E. Shabo, Supervising Judge, Mental Health Departments, Superior Court of California, Los Angeles County, California, November 2001

Nicholas is the second child of a family of four children. He was diagnosed with Asperger's Syndrome at a young age. Asperger's Syndrome is defined as follows:

‘Individuals with AS can exhibit a variety of characteristics and the disorder can range from mild to severe. Persons with AS show marked deficiencies in social skills, have difficulties with transitions or changes and prefer sameness. They often have obsessive routines and may be preoccupied with a particular subject of interest. They have a great deal of difficulty reading nonverbal cues (body language) and very often the individual with AS has difficulty determining proper body space. Often overly sensitive to sounds, tastes, smells, and sights, the person with AS may prefer soft clothing, certain foods, and be bothered by sounds or lights no one else seems to hear or see. It's important to remember that the person with AS perceives the world very differently. Therefore, many behaviors that seem odd or unusual are due to those neurological differences and

not the result of intentional rudeness or bad behavior, and most certainly not the result of "improper parenting."

By definition, those with AS have a normal IQ and many individuals (although not all) exhibit exceptional skill or talent in a specific area. Because of their high degree of functionality and their naiveté, those with AS are often viewed as eccentric or odd and can easily become victims of teasing and bullying.'(OASIS)

Like many kids with Asperger's Syndrome, Nicholas was always very active and would rarely sleep for more than two hours at a time. According to his mother, Nicholas has been "exhausting to raise." When he was three, his mother consulted their family doctor because she felt something wasn't quite right. She was told not to worry, that he would grow out of it. She notes that Nicholas was always jumping, climbing and moving. He once broke his arm as a result of being extremely active, and showed a high threshold for pain. Around the age of eight, Nicholas would pull out his hair, teeth and nails, apparently feeling no pain. At an early age, he had a fascination with food, and the medication he had to take over the next few years to treat some of his behaviours promoted a significant weight gain. As of recently, Nicholas weighed about 400 pounds, which represents another challenge he has to deal with.

It was very clear from an early age that Nicholas had difficulty with over-stimulation. He became quickly aggressive if too much was going on around him. He's been known to react strongly to people talking to him and to thinking they were shouting when, in fact, they were not. He was also hypersensitive to tags on his clothes. He had a fixation about singing "O Canada" at any time of the day or night. He would memorize the phone book and license plate numbers, particularly of police cars and fire engines. He obsessed over details about machines and inventions and over certain words, like "Rubbermaid." He was very bright in reading and writing. Specialists recommended a specific approach with Nicholas: having a predictable routine, having a quiet place to go to wind down when he felt too much stimulation ("graceful exits"), breaking up his day so he could get less stimulation and more control, and reviewing rules and expectations before moving on to a new activity, because he cannot deal well with sudden changes.

Nicholas was seven and a half years old when his parents started requesting help from Family and Community Services. This marked the beginning of a long involvement with "the system." Nicholas was referred for an assessment to the Pierre Caissie Centre, a residential six-bed provincial facility in Moncton. The assessment, conducted over a three-day period, recommended that the local mental health team become involved with Nicholas and his family. The assessment notes: "...he is a child with long-standing temper tantrum difficulty and sensitivity to noise...it is possible that environmental stimuli lead and precipitate his temper tantrum."

His parents recall that from the moment Nicholas started school, he experienced bullying, particularly on the school bus. He would be teased and tormented by other kids. In turn, he would scream, threaten, and use foul language. From Grade One to Grade Three, there were behaviour problems in school. He performed above-average academically but needed to be busy all the time, lest he became disruptive. He had difficulty sitting through a 50-minute classroom period.

Nicholas had a tremendous capacity for learning. On the other hand, his social learning (boundaries, difference between what's appropriate and what's not, etc.) was very difficult for him and often got him into trouble. By the time he was in Grade Eight, he was on a modified school schedule. Over the next few years, he was never reintegrated into regular school, and missed a significant amount of time. What little education he received subsequently was outside the regular school system. Although assessed as having average to above-average intelligence, Nicholas has yet to complete high school.

In the early years, specialists were consulted and diagnoses made--from Tourette's Syndrome to ADHD, to Obsessive Compulsive Disorder, to Oppositional Defiant Disorder to Asperger's Syndrome. Medication was prescribed accordingly. The parents relate a story of changing specialists, therefore changing diagnoses, therefore changing medications. They became confused as to what they were supposed to look for behaviourally in their son and the care they were to provide for him. Like many parents of children and youths diagnosed with a mental illness, Nicholas's parents tried to navigate within the system as best they could. In the first years, they were, as any parents might be, quite ambivalent and, at times, opposed to medication regimens, imposed by specialists, that some people have called chemical straight jackets. Medication sometimes caused their son headaches and led to increased hyperactivity, aggressiveness and hypersensitivity. Specialists were already recommending a multi-disciplinary approach for Nicholas, i.e. medical, educational, mental health, and youth treatment.

Despite the involvement of many professionals, despite assessments and recommendations from experts, Nicholas' behaviour continued to be difficult to manage. This put tremendous strain on his parents and siblings. Notes on file reveal no shortage of professional involvement in this case. In fact, so many professionals were involved that, at times, it was difficult to set priorities over which services should be provided first. It appeared there was no coordinated approach to serving the family. When the parents voiced their opposition to involving yet another service, they were characterized as uncooperative.

A psychiatric evaluation of Nicholas when he was 13 states: "Gentleness is the better way to work with Nicholas, rather than anger. I do not think that he is a defiant child. I feel that he is inflexible based on the diagnosis of Asperger's Disorder rather than on him being a 'bad kid'." Despite this evaluation, Nicholas was eventually moved from group home to group home and frequently sent to the local RCMP lock-up when crisis interventions by group home staff failed.

Another psychiatric assessment recommended that he be put in a small-size class because he was easily distracted. It was also noted in his file that, in school, Nicholas could help other children with computer programming because he was good at it. Indeed, Nicholas has said many times over the years that computer programming is what he would like to do.

When Nicholas was 14, allegations were made that he had exposed himself to children. The parents felt that, by reporting this to FCS, Nicholas would receive the services he needed. Much to their surprise, he was criminally charged. Since there were younger siblings at home, Nicholas was taken into protective care. According to his parents, their understanding was that they either agreed to a placement outside their home for Nicholas, or FCS would place their three other children in protective care. This, according to the parents, marked the beginning of Nicholas's journey through the system, with significant negative effects on their son.

From the outset, Nicholas' group home and foster care placements did not go well. There was much confrontational behaviour, many threats to others, and significant property damage. The police were called on numerous occasions, particularly when staff felt they could not restrain or handle Nicholas. Because of his increasingly imposing size, staff felt their physical safety was at risk. Since Nicholas had been diagnosed with Asperger's, his parents felt he needed a fixed and predictable routine and stability in his living arrangement. Staff at the group home were constantly changing, other residents came and went, approaches taken by staff were inconsistent, and there was a high level of noise, which often triggered aggressive behaviour in Nicholas. Moreover, there was no quiet place where Nicholas could go to calm down when he felt his emotional state escalating. Combined with the fact that he had difficulty controlling himself in a demanding emotional or social situation, Nicholas's placements were difficult at best.

His parents recall feeling anger and disappointment because they had hoped professionals could better meet their son's needs than they could. Very often, Nicholas's father was called by the group home to attend to the latest crisis until Nicholas was calmed down. To this day, they wonder if the situation might have been different if they had continued to care for their son, without involving social services.

Between July and November, 2003, Nicholas accumulated 16 charges of assault, property damage, and breach of probation. Reviewing notes from the placements, the reader is struck by the obvious helplessness felt by staff in dealing with Nicholas. Recommendations by some professionals for occupational therapy, social skills training, and anger management never materialized. One difficulty in providing services to Nicholas was the fact that he was constantly being moved from one place to another. Therapists and intervention plans were continuously disrupted, put on hold, or permanently discontinued because of this.

A series of placements in FCS group homes, at home with his parents, at the Child and Adolescent Psychiatric Unit of the Moncton Hospital, and at NBYC (even frequent moves within NBYC) began for Nicholas. Twice the police "tasered" him. (Police use a taser gun to immobilize an individual. The gun releases two barbed fish hooks that shoot thousands of volts into the body.)

After Nicholas misbehaved one night in September, 2003, when he was 15 years of age, the local police detachment was called. He was put in a holding cell for the night and was sexually abused by the guard. Over the next few months, whenever he was returned to the

holding cell, the same guard sexually molested him. Nicholas later disclosed this abuse, and the guard was charged. The guard pleaded guilty and was sentenced to jail time.

Nicholas's situation can be tracked in the files as follows: he would stay at a group home for a period of weeks, would then have a conflict with another resident, (sometimes for an incident as minor as the other resident calling Nicholas names), Nicholas would get upset, the situation would escalate until he assaulted the other resident, and the police would be called to help control Nicholas. Often, the police took him in, and he would end up back at the New Brunswick Youth Centre. When he returned to the group home, new residents would be living there. The situation was chaotic. His behaviour would become progressively more difficult, turning into more assaults, followed by other charges and another transfer to the New Brunswick Youth Centre. Staff wrote that they could see the escalation in Nicholas if no appropriate intervention were put in place: "Redirecting him in terms of crisis such as going to his room or going for a walk sometimes helps, although ongoing commotion or noises or arguments with other youth will cause a snowball effect and then he would end up having a behavioural episode." Following such a "behavioural episode," Nicholas was usually charged and sent to NBYC. Staff at NBYC have documented the fact that they do not think Nicholas's needs are being appropriately met in a youth jail, and that they do not feel equipped to deal with a youth with Asperger's Disorder. From December, 2004, to December, 2005, Nicholas had six placements. With so much instability in Nicholas's life and place of residency, it is easy to understand how continuity in his treatment was difficult to maintain.

It is also important to note the challenge facing the staff in group homes as well as the staff at the New Brunswick Youth Centre. Nicholas has bitten, kicked and assaulted staff. He has done significant property damage, pulling doors out, breaking windows, punching holes in the walls, pulling out a toilet. As he got older, the challenge became increasingly severe as his weight and strength dramatically increased. It is undisputed that the youths we have met through this systemic review present significant challenges for the professionals caring for them. In fact, they have challenged every system available to them in this province. When reviewing the case notes and correspondence among staff within FCS, one is struck by the concerns of front line staff about the lack of successful intervention for these youths.

On December 9, 2003, Nicholas, still 15, appeared in Provincial Court, where Judge Henrik Tønning refused to send him to jail. The judge said criminal court was not the place to send youths presenting behavioural problems. In his opinion, to continue the shuffling around between group homes without addressing the root of the behaviour problems was creating a "revolving door" situation. Judge Tønning said: "You put him in an inappropriate environment and he reacted the way we would expect him to react....It's pretty hard to suggest it's criminal in nature."¹³

I agree with the Court's assessment. Regrettably, the point may have been lost upon Nicholas when at 15 years of age, he was escorted to a court-ordered assessment in leg

¹³ As reported in the Telegraph Journal, Dec. 10, 2003

shackles. Recent studies by child welfare specialists in Canada decry the high rate of incarceration of mental health youth in Canada:

Youth custody facilities are filled primarily with marginalized youth, including Aboriginals, the poor, and the disabled. It is estimated that up to 75 percent of the children in custody have some form of disability. The [*Youth Criminal Justice Act*] lacks provisions that specifically address the importance of accommodating the special health or other needs of a young person in custody or under supervision.¹⁴

Other New Brunswick judges have recently lamented this same situation: “Jails have become de facto mental institutions....[G]overnment needs to put more resources in place so mentally ill people get the treatment they need and aren’t left to be dealt with by the justice system.”¹⁵

That we should care so little, as a society, about the impact and outcomes of our approach to mental health services and the way we treat people with mental health disabilities is a shame. That we treat children and young people with disabilities with the same lack of concern is doubly shameful.

At a case conference on December 14, 2005, when Nicholas was 17, his parents made it clear that they felt their only option was to bring their son home. What FCS was offering could be done only if they relinquished their parental rights. FCS did not feel they could offer the level of service Nicholas needed to remain with his family and in his community. The parents were not prepared to relinquish their parental rights and thought it unreasonable to be asked to cede permanent guardianship to the minister. Finally, an agreement was reached to extend the custody agreement already in place instead of going for a guardianship order.

In March, 2006, Nicholas appeared in front of the Youth Court for charges related to his behaviour while at NBYC and Moncton Youth Residences. Nicholas then had 38 offences on his youth record. Moncton Youth Residences were unable to take him back because they felt he was a danger to other residents in the home. In a psychiatric report assessing Nicholas’s ability to stand trial, the psychiatrist wrote: “Precipitants of behavioural episodes mostly appear due to his difficulty to tolerate changes in routine, difficulty to tolerate noises or commotion.” At 17, Nicholas had described his situation to a psychiatrist, who wrote: “...the loud noises or commotion while other youths are having a crisis at the group home or calling him names, makes him agitated, nervous and angry. He sometimes tries to control this and goes to his room. If these things continue or if there is a change in his routine or conflicting instructions from staff, he feels confused, anxious and ends up having an episode of aggression where he would punch the wall or destroy his room. . . .[H]e feels quite upset about these episodes which keep on happening and cause him to go back to NBYC.” A report from a psychiatrist stating that Nicholas was responsible for his behaviour some of the time was submitted to the court. Nicholas was ordered to be held at the Restigouche Hospital Center, with an adult

¹⁴ Children’s Rights in Canada: A Question of Commitment, 2007, p. 168

¹⁵ Judge Irwin Lampert as quoted in the Moncton Times and Transcript on April 24, 2007.

population, for a period of 45 days, or until the Mental Health Review Board could meet with him.

Nicholas later described to his social worker what his life was like at the RHC. The worker wrote: "...[H]is day usually consists of getting up in the morning, getting breakfast, taking meds, sleeping, having dinner, sleeping, then waiting for supper. He stated that he does not like to watch TV and that there is not much else to do."

Although at 17 Nicholas still had the right to educational services from the Province of New Brunswick, he received none during this period. He believed he had been "permanently suspended" by two different school boards for his behaviour.

On June 7, 2006, Nicholas appeared in front of the Mental Health Review Board. His new psychiatrist expressed some reservations about his diagnosis of Asperger's. The board ordered Nicholas to stay at RHC and scheduled another review in 12 months. This would give FCS time to plan an appropriate placement. During our investigation, RHC staff have also said that their facility was not the right place for Nicholas.

At his next review, 12 months later, it was acknowledged that Nicholas had made improvements to his behaviour. But it was found that he still represented a threat to public safety and should therefore remain at RHC. In October, 2007, FCS closed his child protection file because he had turned 19. Nicholas currently is working towards completing his high school diploma and he hopes one day to move into a community placement.

* * *

Decriminalizing youth with mental health disorders is a matter that Government must urgently address. One response would be for the judiciary to order placements that are more appropriate. A straightforward refusal by judges to criminalize this type of conduct or even to engage the alternative processes under the *Youth Criminal Justice Act*, as some judges have begun to do, is a salutary first step. These children need clinical treatment and interventions, not restorative justice, community service orders and sentencing circles. However, one wonders whether the criminal defense bar has raised, in the appropriate forum, the wisdom and constitutionality of these types of proceedings. Is the criminalization of mental health misconduct by our youth consistent with the Charter of Rights and Freedom's guarantees of equality, of life, liberty and security of the person, and of its various legal rights of due process? To protect the rights of children and youths unjustly accused, can the courts not order effective remedies for these children and the communities where they live so as to avoid a repetition of the problems that brought about the criminal charges in the first place? It would indeed be a welcome development if our courts took some initiative and ordered meaningful solutions by way of example in appropriate cases. The *Youth Criminal Justice Act* encourages judges to take proactive steps to move youths generally away from criminal justice processes and explore

alternatives. Youths with mental health problems and behavioural disorders deserve no less.

The real problem, of course, is that the criminal justice system is filling the gap where our mental health system and child welfare systems have faltered. Judges may declare the law inoperable where it fails to conform to our constitution, but they are not legislators. My general recommendations under this rubric are therefore aimed primarily at the Legislative Assembly, the Department of Health and the regional health authorities and only subsidiarily at our courts and our public safety system.

23. *Engaging regional health authorities as sponsors of change*

It is difficult to say whether the recent devolution of mental health services from central government to the regional health authorities will improve matters, or whether it will cause further disparity in services. The advantage of this development is that it should facilitate the integration of services and the development of functional teams from mental health care providers, the health care system in general, and partners at the local and regional level, such as school districts, regional social services offices and other community partners. It is recommended, however, that the minister responsible for the coordination of services to children and youth take measures to ensure the participation of all regional health authorities in the service integration efforts undertaken, as they will be lynchpin participants in this process.

24. *Regionalised child and adolescent psychiatric and mental health services*

One of the key components of reform is to increase the capacity of our hospital system to manage the acute care needs of children and youths with complex needs. Currently, the only hospital in the province with a dedicated child and adolescent psychiatric unit is the Moncton Hospital, which has a total capacity of six beds. Children with acute care needs in other parts of the province have to be transferred to Moncton (if beds are available) or discharged to their parent's care, as they cannot be admitted to the adult psychiatric wings of other hospitals for their own security, and often cannot be treated safely in pediatric wards and may pose an unacceptable risk to other children there. However, sending a psychotic youth back to his or her family's care after a serious assault or other traumatic incident at home is often unacceptable. All too often, youths with acute mental health care needs in New Brunswick are confronted with the problem of having no place to go for treatment. For example: it is surprising that, in a city the size of Fredericton, with a regional hospital serving one of the largest populations in the province, no dedicated child and adolescent psychiatry unit is available. In Miramichi, the hospital's staff psychiatrists provide services to youth at the New Brunswick Youth Centre, but, although the custodial population there is known to have a very high incidence of mental health disorders, the regional hospital has no secure unit to treat child and adolescent psychiatric patients. In Campbellton, the Restigouche Hospital Center is an adult facility, but New Brunswick youths with mental health problems are sometimes placed there for observation, assessment or temporary residence owing to the lack of facilities elsewhere; surprisingly, this institution also has no dedicated program or unit to treat this particular

mental health population, and the children and youths are mixed with various adult populations, or, worse still, they are simply turned away.

It is recommended that the Department of Health, the minister responsible for coordination of services to children and youth, and the regional health authorities develop a phased plan to establish child and adolescent psychiatric treatment services in each regional health authority.

25. *Making regional health authorities accountable for post-discharge care*

It may be that not all the beds would be used at all times, and, of course, the scarcity of resources is such in the hospital setting that there may be significant pressure to close unused beds, or to discharge mentally ill children and youths as early as possible. Increased responsibility of the regional health authorities for the post-discharge care of these patients may be the best means of ensuring them the guaranteed access and continuity of care that they deserve, given their vulnerability and disenfranchisement. Notwithstanding the general need to rationalize expenditures in the health care sector, and notwithstanding the dangers of increased dependence on institutional care, it is preferable, when a child with pressing mental health disorders is in crisis, to offer clinical care and supervision in a hospital setting, rather than send the child to jail or to secured detention in a youth correctional facility.

26. *Designation of facilities as approved observation sites under the Criminal Code*

When an adult is charged with a criminal offense and his lawyer requests, or the court orders an assessment, the accused is not sent to jail for the assessment. That however often happens with youth in this province. Judges send children charged under the YCJA to NBYC for assessment purposes, because there is no other designated hospital facility available where the assessment can be done. In the design and development of these regional facilities, care should be taken to meet the appropriate standards so that the institutions where the units are located can be recognized as a hospital within the meaning of the *Criminal Code of Canada* and designated by the Minister of Health as hospitals for assessment purposes under the *Code*.

27. *Recruitment and retention of mental health professionals*

Establishment of this regional capacity to offer child and adolescent psychiatric services throughout the regional health authorities will necessarily require, in some cases, dedicated efforts to recruit and retain child and adolescent psychiatrists and other specialized health care professionals. We noted through our investigation that few psychiatry departments in the province have experienced, specialized staff to serve this patient group. The specialized child and adolescent psychiatrists in the province tend to have been recently trained and recruited out of province early in their careers. It is recommended that the Department of Health and the regional health authorities collaborate to ensure that we can retain qualified and experienced child and adolescent

psychiatrists, psychologists, and other mental health professionals and that the staff recruited have adequate incentive to commit to work in this province over the long term.

28. *Support research into drug treatment of children and youths with mental health disorders*

I have been following with interest for several years the public debate in this province with respect to the alleged over-prescription of Ritalin. Parents of youths profiled in this report routinely held the view that their children were victimized through the trial and error approach to drug therapy recommended by their psychiatrists. In several cases, they had serious concerns about the significant side-effects of certain drugs, particularly in relation to weight gain and mood swings, and they expressed the need for assistance for youths and their families in managing these risks. It is recommended that the provincial centre of excellence for children and youths with highly complex needs develop partnerships within the province and with national research agencies and funding partners to support research that will help advance our knowledge of the benefits and risks associated with psychotropic drug therapy for our children, and regarding its prevalence in our society as compared to counseling, psychological therapy and other interventions¹⁶. There has been great interest in the last 10 years in multi-systemic therapeutic approaches in treating severely conduct-disordered youth¹⁷. It is suggested that the Province may gain from investing more resources in these latter approaches, although admittedly more research is required.

29. *Implementing effective drug prescription practices in all youth placements*

Another damaging complaint registered by parents was the inability of care providers in residential care settings, particularly in custodial settings such as NBYC, but also in

¹⁶ Early studies regarding pharmacological versus behavioural treatment of ADHD suggest, however, that drug therapy used alone has consistently better results: Green R.W. and Ablon J.S. *What Does the MTA Study Tell Us About Effective Psychosocial Treatment for ADHD?* Journal of Clinical Child Psychology 2001, Vol. 30, No. 1, 114–121

¹⁷ Littell JH, Popa M, Forsythe B. *Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17*. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD004797. DOI: 10.1002/14651858.CD004797.pub4.

Multisystemic Therapy (MST) is a multi-faceted, short-term, home- and community-based intervention for families of youth with severe psychosocial and behavioral problems. Based on social ecological and family systems theories, and on research on the causes and correlates of serious antisocial behavior in youth (Henggeler 1998, Henggeler 2002a), MST is designed to address complex psychosocial problems and provide alternatives to out-of-home placement of children and youth.

...

As described by its developers (Henggeler 1998), MST uses a 'family preservation service delivery model' that provides time-limited services (4 to 6 months) to the entire family. Treatment teams consist of professional therapists and crisis caseworkers, who are supervised by clinical psychologists or psychiatrists. Therapists are mental health professionals with masters or doctoral degrees; they have small caseloads and are available to program participants 24 hours a day, seven days a week. Treatment is individualized to address specific needs of youth and families, and includes work with other social systems including schools and peer groups (hence, the name multisystemic). Treatment may focus on cognitive and/or behavioral change, communication skills, parenting skills, family relations, peer relations, school performance, and/or social networks.

residential care facilities, to help children and youths stick with their medication regime. In a hospital setting, the clinical staff has the option of providing non-consensual drug treatment if, for instance, it is the physician's opinion that it is necessary to do so when a patient is having a psychotic episode. However, the clinical staff we spoke to in hospitals indicated that it was hardly ever necessary to force a patient to take his or her medicine, since the patient can almost always be brought around to do so voluntarily. In contrast, when we asked public safety officials to explain why parents were complaining to us that children placed at NBYC had fallen off their meds, the investigators were told that NBYC has no authority to "form 1" an individual as a doctor might in hospital, that the courts severely limited the custodians right to force children to take their meds, and that all too often, in the opinion of custodial staff, correctional residents transferred from a hospital setting were on such a cocktail of prescription drugs that they were barely communicative.

It is recommended that NBYC revise its practices and, in consultation with provincial mental health services, implement policies for the pharmacological treatment of residents on a prescribed psychotropic drug therapy program that will ensure that youths in custody under a medication regime are able to follow it in accordance with their doctor's advice. It is further recommended that the Department of Health, regional health authorities and the minister responsible for coordination of child and youth services, develop a strategy in consultation with all stakeholders to ensure that effective drug prescription practices are implemented in all child and youth residential placement settings.

30. Shackling, handcuffing and strip-searching of children and youths with mental health disorders

It is recommended that the New Brunswick Youth Centre immediately suspend the practice of shackling, handcuffing and strip-searching children and youths with serious mental health conditions and the protocol requiring the video-taping of this process. It is further recommended that the Department of Public Safety and the Department of Justice consult with the Department of Health and the minister responsible for the coordination of child and youth services to establish new protocols and guidelines for the safe transportation, detention or isolation of children and youths with serious mental health conditions, and for children and youths generally, when they are placed in the care of the Department of Justice or Youth Correctional Services.

31. Education and promotion to prevent abuse of vulnerable youths in custody

It is recommended that the Department of Public Safety should devise an educational program aimed at youths in custody and their care-givers about their rights while in custody, and the procedures to follow when they believe their rights have been violated. All correctional staff should be trained with respect to advising youths regarding the recourses available to them. This should be done in consultation with the minister responsible for coordination of child and youth services and jointly with the Office of the Child and Youth Advocate. This is necessary to ensure that the rights of youths, and

particularly vulnerable youths, are protected from the possibility of abuse and have available to them all avenues for redress.

32. *Ending the co-location of adult and youth populations at NBYC*

When I referred above to the danger of placing vulnerable youths directly in harm's way, I, of course, had in mind the terrible abuse that Nicholas suffered at the hands of his jailor. But there are many risks present in a correctional facility despite our best precautions. One area where child advocates have been successful has been in promoting, as an international legal principle,¹⁸ the standard that adult and youth correctional populations should not be mixed. Notwithstanding these requirements, owing to the overpopulation of our adult correctional facilities in New Brunswick, the New Brunswick Youth Centre now houses adult offenders on a regular basis, at times, more adults than young offenders. They are kept in separate cottages, and strict protocols are in place to avoid any mixing of these two correctional populations. In my view, this is not enough. Many studies have demonstrated the increased risk of delinquency and re-offending which occurs when young offenders are mixed with adult offender populations.¹⁹ The current practice in New Brunswick is an affront to the promise of proactive measures and to the philosophy of care that was meant to permeate the NBYC. It is recommended that the minister of child and youth services and the Minister of Public Safety develop short-term and long-term plans to put an end to the placement of adult offenders in the provincial facility designed for young offenders.

33. *Alternative measures for youth-at-risk and youths with highly complex needs*

Everyone in the youth criminal justice system has assured us of a professional commitment to take young offender legislation at face value and to explore meaningfully all possibilities to divert youth-at-risk from the criminal justice and correctional system. It is difficult however to reconcile the outcomes in the cases we have reviewed in this investigation with that stated commitment or with the provisions of the *Youth Criminal Justice Act*, subsection 39(5) which state that: "a youth justice court shall not use custody as a substitute for appropriate child protection mental health or other social measures". We have the principles down pat. We're not doing a good job however of putting them into practice. Regarding "other social measures" not everyone is as adept as the next person at thinking outside the box. One of the experts whom we met was relating her experience with diversion practices in Ontario and remembered asking a judge about a promising, but errant, youth: "But, seriously, Judge, couldn't you just sentence him to hockey"?

¹⁸ *Convention on the Rights of the Child* adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, Article 37. See also the Senate Standing Committee's report Children: the Silenced Citizens, April 26, 2007, Recommendation 8.

¹⁹ Petrosino A, Turpin-Petrosino C, Buehler J. "Scared Straight\ and other juvenile awareness programs for preventing juvenile delinquency. *Cochrane Database of Systematic Reviews* 2002, Issue 2. Art. No.: CD002796. DOI: 10.1002/14651858.CD002796.

Regarding youths with complex needs, the mental health court in Saint John has had some success in diverting youths with mental health issues from the traditional judicial-correctional system. It would be beneficial for these alternative court processes to be available more broadly throughout the province and designed with the particular needs and challenges of youth in mind. As for youths sentenced to NBYC, it is recommended that the Department of Public Safety review its policy with respect to institutional charges to assess the effectiveness of such charges upon individual youth in their care.

It is recommended that the minister responsible for child and youth services establish, with appointed representatives from the judiciary, the Department of Justice, the Department of Health and the Department of Public Safety, a task force to review alternative measures currently in use within the justice system and to extend the adoption of identified best practices to divert youth-at-risk and youths with highly complex needs from the criminal justice system. Specifically, this group should review, following recommendations from the current Legal Aid Review, means of improving the legal representation of youth in all instances, and develop a pilot project for a youth mental health court based on the Saint John mental health court project.

Chapter 5 - Tailoring educational services for youth with complex needs: *Benjamin's story*

Every story should have a happy ending, and our investigation had its silver lining, too. Benjamin's story also began with a search for an appropriate residential placement. While we were able to convince departmental officials of the need for a placement outside the province, the facility in Nova Scotia that we identified as appropriate gave preference to residents of that province. Accordingly, its officials eventually turned down the recommended placement. As it turned out, this was a good outcome, because it forced intervention team members in this youth's hometown to devise a made-in-New Brunswick solution that was supportive of the child's family, was multi-disciplinary, and proved that, where the will exists, service integration can work very well and deliver benefits to the child.

Not all the cases reviewed in this investigation, however, have such positive educational outcomes. For the most part, our investigation has confirmed that youth-at-risk are very often marginalized by the educational system, and that youths with the most complex needs usually fall off the radar of educational services in this province. As the only government department whose primary focus is children and youth, the Department of Education, and our public school system, can play a very meaningful leadership role in making the province a place where children come first. The Government's response to the Mackay Report underscores its commitment to this focus on child welfare and the equal right of every child to an education through our public school system. In our view, however, fulfilling this commitment to equality in education requires something more than a one-size-fits-all approach; it requires recognition that, in some cases, mainstreaming is not an appropriate short-term or mid-term solution. Specialized

educational services for children with highly complex needs are very costly, whether in the classroom or outside the school setting, but they must be delivered in every case, and renewed efforts are needed to make sure that these very challenging cases are not abandoned by the formal educational system. Proper investment in educational services, in an integrated service delivery setting, is the best means of ensuring that children with complex needs can also reach their full potential and thereby minimize cost consequences to the province down the line. Benjamin's story makes this point very well.

Benjamin's story

“People, not programs, change people.” Dr. Bruce Perry, Child Psychiatrist

When Benjamin's mother became pregnant with him, she and her husband couldn't have been happier. Perhaps every parent feels this way, but, for this couple, the news was even greater. Having dealt with infertility for years, this baby was their “one-time baby”.

Beginning with when he was a baby, Benjamin was very active and needed close supervision. ADHD was suspected. By Grade One, he was on Ritalin, and then Dexadrin. By the time he reached Grade Three, he was taking antidepressants for migraines. This, according to his mother, changed him. He began to have outbursts, and would scream and stay awake at night. His parents felt the neurologist treating him didn't believe their descriptions of his behaviour were accurate. Whenever they expressed concerns about their young son being on antidepressants, he suggested that, if they didn't agree with the medication, they should not give it to him. Knowing the kinds of behaviour this would trigger, the parents were at a loss to help their son. The neurologist also told them Benjamin's behaviour was learned, and he blamed their poor parenting skills. This began the family's visits from one doctor to the next, to pediatricians, psychiatrists, and general practitioners, each of whom offered a different diagnosis and prescribed different medication regimens.

When Benjamin started exhibiting difficult behaviours in Grade Three, the school assigned an interventionist to his classroom. The role of such a person is to observe the child in the classroom and to give suggestions to the teacher on how to handle the child's behaviour. The interventionist can also remove the child from the classroom if he or she is too disruptive. This allows the teacher to continue with the rest of the group, and the worker to do some one-on-one work with the child. Involving an interventionist is meant to be a short-term measure, the goal being quickly to restore the situation. In Benjamin's case, the interventionist taught him techniques to calm himself when he felt pressure building inside him. He taught him the different “me's”—the loud “me,” the quiet “me,” etc.—and how to identify which “me” he was at, and how to get himself to a different “me.” By the end of the year, Benjamin was doing well and passed his grade with no difficulties.

Grade Four, with Benjamin now nine years old, turned out to be more difficult. He had different interventionists in his classroom, but by now his illness had surfaced dramatically. His behaviour had become so erratic that, according to the school, he was

“totally disruptive to the whole building.” He cried, yelled, lay down in the middle of the classroom, left the classroom, sometimes left the school entirely. . Whenever they were unable to manage his behaviour, the staff put him in a room by himself, where he was left to scream for up to two hours before his parents were called. At times, the school used a closet/storage room for this purpose—the staff didn’t know what else to do with him. The school principal admitted to screaming back at Benjamin once and suggested this was what Benjamin needed, since it stopped the screaming. The child’s mother was horrified: her view was that Benjamin had stopped screaming because he was petrified, not because this was a “good technique” to use with him.

It was obvious that no one understood what Benjamin’s behaviour meant. A psychiatrist recommended that he go to school only three hours a day, because a full day appeared to be more than he could handle. The school wanted to transfer nine-year-old Benjamin to the Learning Centre, a place mostly for teenagers who couldn’t cope, or who were in trouble with the law. The parents vehemently opposed this idea.

They were desperate for help. Some professionals were beginning to talk about early-onset bipolar disorder. Visits and stays at IWK became more frequent. Because this facility is located in Nova Scotia, managing Benjamin’s case in emergency situations at home became difficult.

One morning, while Benjamin was in Grade Four, his parents received a call asking them to come to the school immediately. When they arrived, the classroom had been evacuated. Benjamin was standing in front of the blackboard writing the same numbers over and over. He was incoherent and having a psychotic episode. The parents picked him up and carried him outside. On the way out the door, the mother was told she needed to be back by two o’clock for a meeting to discuss Benjamin’s behaviour. The parents took Benjamin to an emergency room, and he was promptly admitted to hospital. Although both parents were beside themselves with worry and horror, Benjamin’s mother returned to the school for the meeting. She met with the school psychologist and insisted she and her husband did not want Benjamin penalized and removed from the school. The psychologist supported her position and told the staff they needed to keep Benjamin in school.

In December of that year, Benjamin was diagnosed with bipolar disorder. He was hospitalized until the following February. After his discharge, the treating psychiatrist, convinced Benjamin’s bipolarity was an isolated episode, weaned him off his medication. In March, Benjamin was back in school. He lasted only two weeks before having another major episode. His new psychiatrist put him back on his medication, which stabilized his behaviour. The school, feeling not equipped to deal with the boy, told the parents he did not belong there. The parents insisted and tried to bring Benjamin back. His mother returned to his class, Benjamin in tow, in the hopes of being able to reintegrate him. Ben was so scared that he hid in the corner of the classroom during the whole visit. The parents, feeling tired of fighting and emotionally depleted, finally gave in and enrolled their son at the Learning Centre.

Benjamin has a mental illness. He is of normal intelligence. As a matter of fact, he has always performed well academically. Each time he missed a lot of school, he caught up in no time on his return and passed each grade without great difficulty. Consequently, he understood how his behaviour appeared to his classmates. He had no friends and always thought the other kids hated him. Not once when he was away from school for long periods of time, and usually hospitalized, did his classmates make a card for him or send him get-well wishes. He knew this was unusual because other kids in his class had been ill, and the whole class made cards. When he was in school but had been put out into the hallway, one staff member told his mother she would come along and give him a hug to reassure him. She was instructed to stop doing that, because he might think this attention was a reward for having a temper tantrum. Not surprisingly, his family felt there was no understanding about Benjamin's mental illness and were very hurt by the rejection of him.

For these reasons, his parents decided they would try a new school for Grade Five. At this school, Benjamin went for two hours in the morning, came home for a rest, and then attended the Learning Centre for two hours. He did very well until March. He struggled for the rest of the year, but again managed to pass.

In Grade Six, his parents enrolled him in middle school. Because he now had a formal diagnosis, he had a full-time teacher's assistant. He had a wonderful teacher, who happened to have two brothers with bipolar disorder. She was very accepting of Benjamin, and she was instrumental in educating all those working with Benjamin about bipolarity. Benjamin got sick for a short time but, all in all, had a great year.

Grade Seven progressed along until the following spring. By this time, Benjamin had tripled his weight (partly due to medication). The mental health nurse and the parents felt something was "brewing" with Benjamin. One day, when he and his mother were visiting the nurse at her office, he had a major crisis and severely assaulted his mother. He was taken to the hospital by ambulance, but, according to his mother, there was ambivalence about admitting him, partly because of a question of where to put him in the hospital. Should he go to pediatrics (after all, he was still a child), or should he, because of his violent behaviour, be placed in a psychiatric bed (with adults). Eventually, he was admitted to pediatrics, where he remained for two weeks. Although under supervision, he managed on one occasion to get out on the roof-top playground, where he climbed the plexiglass wall, planning to jump because he thought he could fly. A nurse rescued him just in time. He was discharged to home and parents who were extremely worried about how they would manage his behaviour. Because staff at this school understood what bipolar disorder was, he received drawings and get-well wishes from his classmates. When he came home, some of them even visited. Benjamin commented to his mother, "You know what, Mom? I think they like me."

The mental health nurse and the parents were trying to put together a team to work with, and support, Benjamin and the family. The visits from one specialist to another continued (one of the issues was the turnover rate of these specialists, in some cases staying in N.B.

only a few months). So far, the Department of Family and Community Services had refused to become involved.

In the fall of 2005, when Benjamin was 13 and in Grade Eight, he had another violent outburst. The mother locked herself in the bathroom to ensure her physical safety. She called the emergency after-hours service at FCS. By the time, the call was returned, several hours later, Benjamin had calmed down. The social worker advised the mother to call the police next time. It was becoming clear that a different kind of treatment plan was necessary to meet Benjamin's needs, and ensure his and his parents' personal safety. FCS opened a child protection file on the family.

Feeling they had no choice, the parents once again turned to IWK. They were convinced at this point that their son needed specialized treatment, which was beyond their capacity to provide. Since the parents could not get services in New Brunswick, they were ready to move to Halifax for the sole purpose of getting their son the care he needed. In the next few months, three referrals were made to specialized programs. Benjamin was rejected in all three because it was felt he did not meet eligibility criteria.

By this time, the Office of the Ombudsman had become involved in the case. At the same time, and as a result of this prompting, FCS asked its local office in Benjamin's area to provide services to the family. Since the family did not meet eligibility criteria for a child in need of protection (his parents refused to turn over guardianship of their son to FCS), the only option was for the family to be given services under the Community-Based Services for Special Needs Program (although Benjamin did not, and still doesn't, meet eligibility criteria for this program either). While a search for a placement was still under way, the mental health nurse, the social worker from FCS, and the parents struggled to develop a plan to help Benjamin while keeping everyone safe.

Benjamin was too ill to go back to school until January, 2006. His Grade Eight teacher was very supportive and helped build him up to full-time classes, with the help of a full-time teacher's assistant.

On the home front, a human resource counselor was hired to stay with Benjamin four hours a day, five days a week. The structure, social skills and anger management training provided by the human resource counselor helped stabilize the situation. The parents recruited a family to provide respite care one weekend a month, paid for by FCS. It also appeared that the right balance of medication had been found. For the first time in years, the parents felt that, with all the professionals involved, perhaps they could keep Benjamin at home and manage his illness. Those professionals, meanwhile, came to the conclusion that, because of a lack of specialized resources to serve this boy, they had put in place a "team" that might have been what was needed, at least for the time being.

The next step for Benjamin was high school. His parents and his psychiatrist wanted to hold him back in Grade Eight to allow him fully to catch up. The school was pushing to move him on to Grade Nine. When he visited his psychiatrist in June, everyone was so impressed by how well he had done academically that they agreed he needed to move on.

In September 2006, Benjamin started high school. He had a full time teacher's assistant. According to his mother, he still has no friends. "It's a small town" she says, "word spreads quickly. He can't get a break." This is one of the most difficult parts for Benjamin and his parents.

In the fall of 2006, Benjamin had a relapse. However, all the support systems put in place by the mental health nurse and the special needs social worker carried him and his family through this crisis. He continued his schooling with a full-time teachers' assistant, and, at Christmas, he visited Disneyland with his parents for one week, without any difficulty.

In September, 2007, he started Grade Ten and is doing very well. Because of his mental illness, Benjamin has tremors, and, as a consequence, his handwriting is unstable. The parents, school, and district have been advocating for a laptop for Benjamin to write literacy and provincial tests, but the Department of Education has refused this request many times, allegedly because it is not policy. The school has been accommodating to Benjamin, giving him a little extra time on tests, and allowing him to go into a private room to write them. Benjamin is also allowed to dictate his answers, and an adult writes them out on paper. But everyone agrees that the use of a laptop would make things much easier. The school has also scheduled his core courses in the morning, when he is well rested and more receptive. Otherwise, he follows the same curriculum as others. Since the fall, Benjamin has been spending his lunch hour at school. He's been integrated into the cycling club, where a Grade Twelve student took him under his wing and assists him when they go out on rides. When asked what has worked for Benjamin in the education system, his mother replies, without hesitation, that having a supportive teacher's assistant has helped tremendously. When Benjamin gets behind on things, like copying notes off the board, the assistant will back him up, making sure he has all the information he needs. The communication with the parents has been excellent. They are informed of all the assignments, so there is continuity between the school and the home. The school insists that all of Benjamin's teachers be present at meetings. They are all willing to learn from the parents about how best to handle Benjamin. There is no competition between the adults in Benjamin's life, only cooperation and understanding. The parents are always only five minutes away when he becomes agitated, or when the staff find he needs extra support. When the school district is asked what makes this situation work, their collective response is: "A whole group of very concerned people coming together to work for Benjamin."

Benjamin would like to go to culinary school after he graduates and become a chef. He is already researching the best schools. His parents are convinced he will succeed.

After my staff met with the mental health nurse who works with the family, she wrote the following in a letter to my office:

I believe that the success for Ben was that there was a commitment that agencies would work together to find innovative programming which actually cost significantly less financially than the initial plan for residential treatment, but, most importantly, kept Ben with the people who love him most and within his home community. I do not think we can even begin to know the cost emotionally, psychologically, and financially to a family

when they have to make the decision to send their child away for appropriate programming.

Perhaps what is most important is for us to start focusing more on client needs in a holistic manner and move away from “criteria” focused care. When we focus on satisfying criteria to access a program, we seem to work very hard to “exclude” individuals, leading to unnecessary pain, alienation, and suffering for those who struggle with a “difference” and their families. Ben’s case may be an “exception” but maybe it should not be. In fact, I suspect that there may be a number of situations that would be identified as “exceptions” and in need of similarly creative and seamless services from a number of government agencies.

I know we acknowledged resources may need to be increased but I would suggest that it may be most important to change our orientation toward children and their needs, breaking down walls between agencies, and expecting creative activity and programming. Otherwise, plugging in more resources without the change in perspective seems unlikely to change very much.

A whole team has been built around this family to ensure Benjamin remains with his parents, in his community. His symptoms are under control most of the time, and he has made, and continues to make, great strides in many areas. Government officials say this service delivery model is the exception and suggest that perhaps it should remain an exception. I beg to differ.

I agree with the mental health nurse’s assessment of this situation: this service delivery model is creative, child-centered, and goes beyond program criteria. It has challenged different departments and professionals to work together. It has supported the primary and most important players in the scenario, Benjamin’s parents, so that they could fulfill their parental responsibility towards their son. Each department has gone beyond its respective “program eligibility requirements” to service this family and has made it work. The departments must be commended for that. I believe every family with a child or youth presenting some of the same challenges as Benjamin and the other youths described in this report deserve the same level of service.

* * *

There is an admirable commitment to principle in an educational system that leaves no child behind and that puts into practice the notion that there is room for every child in the classroom. The fact is, however, that many children are not learning apace in inclusive educational settings and may need more specialized or individualized educational services. We cannot insist upon inclusion for the sake of inclusion, any more than we can afford to do so because it’s *all* we can afford. If individualized educational services are required to help a child achieve his or her potential, then that is the approach we must take, even if it is, at times, more costly. Moreover, if inclusive educational models are to work for the benefit of children with highly complex needs, then they must integrate the support systems of social services and health services and the family to succeed.

Our review of these several cases suggests that many children with highly complex needs have been abandoned or lost by our educational system. A renewed specialized focus is needed to meet the educational needs of these pupils in their varying residential placements. These specialized services could be managed at a provincial or regional level. Teachers and educational services staff must be educated around mental health issues so that pupils in need can be identified, understood and referred, not suspended.

34. *A multidisciplinary approach to inclusive education*

Our analysis of the issues in the area of educational services reinforces the recommendations outlined above in respect to service integration with health, social services, and correctional services, since better coordination of effort will go a long way to minimize problems. Benjamin's story demonstrates very well that, through coordinated efforts, even students with very complex needs can succeed in an inclusive educational model. Every effort had been deployed to place Benjamin in a specialized educational program out of province. Finally, when all the approvals were obtained, his parents accepted over time that his placement in Nova Scotia would be delayed indefinitely, despite assurances and encouragement from his physicians there, for the simple reason that "there will always be a Nova Scotia resident with equal or greater needs." In the end, being turned down by the program in Nova Scotia was the best thing that could have happened to Benjamin, because it forced, albeit out of desperation, his care-givers here to devise their own solution to meet his educational needs in a manner that engaged the strong supports available within his own family and the professionals within his immediate circle of care.

This is how inclusive education is supposed to work. It requires a willingness to tailor programs to the child's needs and a multidisciplinary approach. The way to reach these goals is not, however, the way this family had to do it: out of desperation, and feeling their way as they went along. It must be built into the educational system. The newly adopted guidelines of the Human Rights Commission on accommodating disability in educational services are a helpful resource to district administrators in this respect²⁰. The work done elsewhere in Canada, the U.S. and Norway with respect to multisystemic therapy is also helpful.²¹ Finally, educators confronted with increasingly aggressive or disruptive behaviour on the part of pupils must be equipped to intervene immediately and effectively to reprove such behaviour, as studies have shown that doing nothing will only exacerbate the conduct disorder.²²

²⁰ <http://www.gnb.ca/hrc-cdp/e/Guideline-Accommodating-Students-Disability-New-Brunswick.pdf> October 15, 2007

²¹ Littell JH, Popa M, Forsythe B. Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD004797. DOI: 10.1002/14651858.CD004797.pub4.

²² Mytton J, DiGuseppi C, Gough D, Taylor R, Logan S. School-based secondary prevention programmes for preventing violence. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD004606. DOI: 10.1002/14651858.CD004606.pub2.

It is recommended that the Department of Education renew its efforts to promote and model effective multidisciplinary approaches to inclusive education and that it renew its efforts to intervene immediately to correct violent or aggressive misconduct by pupils.

To illustrate what we are proposing in this section and earlier sections of the report, we have developed a chart which can be found in Appendix III and entitled 'Integrated Complex Case Diagram (proposed process)'. It maps out a path by which complex cases would be identified quickly within the four departments working with youth, referred appropriately and receive specialized services. This structure, accountable through the Minister of Child and Youth Services, would ensure that all youth are visible and accounted for at all times in all systems, leaving no one behind. Services would be coordinated between the different departments, through the aegis of the Minister responsible for such service integration.

The proposed process builds upon the success of the Youth Treatment Program process and suggests consolidating and expanding this process in order to cover all cases of complex needs and act pro-actively with regard to Youth-at-Risk. A revised and expanded role is also proposed for the Atlantic Provinces Special Education Authority (APSEA), as outlined below. Departments of Public Safety, Education, Health and FCS would create complex case manager positions so that children with the most complex needs could be supported throughout their formative years by experienced case-managers, providing greater continuity in care and better service integration.

One of the Province's goals must be to catch problems when they arise and prevent them from getting bigger. The integrated approach outlined in Appendix III must aim in every case to treat children and youth in their own community. They should not lightly be referred to a provincial program only to be placed and treated elsewhere. Cases should be referred to provincial YTP only if local expertise (social workers, nurses, psychologists, probation officers, regional complex case managers, clinical coordinators) are unable to provide adequate care.

35. Expanding the Youth Treatment Program

One of the multidisciplinary efforts among the departments of health, education, public safety and family and community services that has yielded positive results in some cases is the Youth Treatment Program (YTP). This program works at the local and provincial level to refer cases of youths with complex needs to a multi-departmental committee that will develop an integrated treatment plan. The initiative is largely led by Family and Community Services. One of the shortcomings of the program has been the uneven participation of other departments or agencies, including school districts, in the process. The program is also only available to work on a limited range of diagnoses i.e. youth with behavioral and conduct disorder. We recommend that the Youth Treatment Program, or a process similar to it, without duplication, be expanded to cover a broader range of diagnoses and that district authorities ensure that multi-departmental committees be established in each district to refer appropriate cases to the provincial YTP committee. (See the Integrated Complex Case Diagram (proposed process) in Appendix III)

36. *Educating children with complex needs who are no longer in the mainstream*

We recommend that the Department of Education devise a new, dedicated focus on children with complex needs, children who, for whatever reasons, are no longer in the mainstream system. We must stop pretending these students are not there or are so exceptionally few that they can be safely ignored. We also have to stop telling ourselves, and everyone else, that inclusive approaches are in every situation the most effective. What these students need is for a teacher to find them and look after their educational needs wherever they may be. They may be in detox centres, in hospital, in a correctional facility, or at home and unable to attend school for an interim or extended period. But their educational services must not be halted or interrupted unnecessarily.

The educational system has a statutory obligation towards every pupil and needs to track each child and coordinate the education services wherever the child is. At no time should a child or youth be off the educational system's radar. Unfortunately, our investigation has confirmed that this is what routinely occurs when children are placed in a hospital or in some other institutional setting. At RHC, for example, Nicholas's teacher—a unilingual francophone trying to help him prepare for his GED in math and English—is paid for by the hospital. The Department of Education is not involved at all. Similarly, NBYC expends over a quarter of million dollars in educational services each year to young offenders at the youth correction centre. However greater involvement and oversight by district officials regarding these educational services to pupils at NBYC would make it easier for these kids to reach their educational goals following release.

37. *A special education authority for pupils with complex needs*

Individual schools and districts should be able to recommend a highly complex needs student to a provincial committee or Special Education Authority. This authority could be funded separately through the Department of Education to deliver educational services to the child's home or residential setting (hospital, group home, youth residence), without interruption from one placement to another, based upon an individual education plan oriented towards the child's curricular goals and, subsidiarily, towards his or her successful reintegration in the public school. The fact is, the educational needs of youths like those profiled in this report can require extensive supports and accommodations, ones that can easily overwhelm district budgets or be overlooked, given the needs of the many. As indicated in the Integrated Complex Case Diagram (proposed process), successful integration of these pupils into the educational mainstream will invariably require partnering with mental health and social services officials. That type of coordination in highly complex cases is better handled through a special authority.

The Department of Education should explore the possibility of devising a regional delivery of such services jointly with other provinces, with the assistance of the Atlantic Provinces Special Education Authority (APSEA), or upon the basis of a service delivery model such as theirs.

The Atlantic Provinces Special Education Authority is an inter-provincial cooperative agency established in 1975 by joint agreement among the ministers of education of New

Brunswick, Newfoundland, Nova Scotia, and Prince Edward Island. The agreement provided for the creation of the APSEA and authorized it to provide educational services, programs, and opportunities for persons with low-incidence sensory impairments from the time they are born until they reach the age of 21. This includes children and youths who are, hard of hearing, hard of hearing-blind, blind, or visually impaired, and who are residents of Atlantic Canada. The APSEA agreement is the only one of its kind in Canada, and, as such, may serve as a model for service delivery at a regional level.

38. *Measured inclusion in the child's best interests*

During this investigation, there has been significant discussion around the creation of alternative classrooms in some districts. While parents have been demanding them, the interest is no doubt related to the level of individualized attention and programming that their children receive in this setting. I believe it is possible to carve out such opportunities for special needs pupils while respecting the educational system's focus on inclusion. One danger to guard against is, in fact, an institutionalized segregation of special needs students from their peers, which could diminish opportunities for peer-to-peer learning, or, worse yet, lead to stigmatization of one peer group over another. These are very real and ever-present dangers when dealing with young children.

It is recommended that Government invest in more individualized educational services, most likely off-site, but also in individualized laboratory settings within schools, to pupils with the most complex needs. This investment, along with coordination of services within mental health services and Family and Community Services for a broader number of children and youths, should be aimed at reducing the demand and need for more alternative classrooms in the school districts.

39. *Alternative educational settings for youth-at-risk*

At the same time, I recommend that the Department of Education give serious consideration to the possibility of piloting other alternative educational programs and settings for youth-at-risk.

Outdoor education, education through the arts, and vocational education programs are all gaining a resurgence of interest in educational circles these days. Establishing a residential school with a variety of such programs, not a reformatory, may be a helpful means of keeping youth-at-risk in school and focused on their learning, rather than disrupting classrooms in more traditional educational settings.

40. *Cross-training teachers and school staff with mental health and social services*

It is recommended that the minister responsible for services to children and youth develop training programs where teachers and educational services staff can learn alongside mental health employees and social service employees with a view towards:

- Establishing professional contacts within a region among public servants who provide services to children and youth;

- Informing all interveners with respect to the array of services available to assist children, youths and their families;
- Improving the level of knowledge and awareness around varying mental illnesses and how they impact a child’s learning, socialization and behaviour; and
- Developing strategies and programs to better integrate and coordinate efforts in providing services to children and youths, particularly those with highly complex needs and youth-at-risk.

Chapter 6 – Supporting families of youth-at-risk and children with complex needs:
Samuel’s story

Throughout all the individual stories in this report, with one regrettable exception, I have witnessed remarkable accounts of families striving to overcome the challenges of mental illness in youth. The families came from every walk of life, and from very differing levels of means, but their stories were remarkably similar. They were exhausted. They had given everything they could, often at considerable sacrifice to their careers, their health, and their other children, but they were anxious and willing to give more. The recommendations in this chapter should perhaps have been presented at the very outset of the report, since supports to these families are at once the moral imperative that sustains much of the other recommendations and a necessary next step in the critical path for improving child welfare in this province. I felt, however, that the recommendations would make more sense after having presented all the stories gathered from the youths and their families. The one story that was most tragic, and which best illustrates the important role that families could play, if better supports were available, is Samuel’s story.

Samuel’s story

Samuel, an only child, was the pride and joy of his parents. By all accounts, he had a happy childhood and normal development. He lived with his parents in a small coastal community of New Brunswick where everyone knows your name—even moreso, in this case, because his father was well-known. Samuel was a good-looking adolescent, had lots of friends, and was succeeding well in school.

Around the age of 16, his parents noticed something different and unusual about Samuel’s behaviour. A succession of visits to different specialists followed. Samuel was eventually diagnosed with paranoid schizophrenia; his father describes a moment of relief when, at last, they knew what was wrong and had a name for his “condition.” But this was not the end of the story. Rather, it was the end of a quiet and satisfying life for this family, and the beginning of 10 years of torment, spent trying to get their son the care he needed.

After the diagnosis was made, and the initial feeling of relief, the parents began having questions about what this diagnosis meant, what the next step was, what kind of care to provide for their son. Getting information on their son's illness was difficult. There was no process in place, at least not in this case, where specialists sat down with the parents and explained to them what lay ahead. Samuel was seeing his psychiatrist and was being prescribed medication to help control his symptoms. Because of his age, he had the right to meet with his psychiatrists alone, and professionals were bound by confidentiality, even in regards to the patient's parents. Samuel also had the right to refuse to take his medication. No one could force him to do so, unless they were able to demonstrate that he was a danger to himself or someone else. It became difficult for his parents to help him. They were disappointed that it appeared a serious incident had to occur before Samuel could receive help, and that no emphasis was put on prevention. Samuel was also disappointed. He said to his parents one time: "In order to get help I'm going to have to commit an armed robbery".

Samuel's father relates how their son's mental illness changed their lives. Because of his mental illness, Samuel, unlike his friends, could not pursue post-secondary education. In fact, because of his illness, he had to abandon his high school studies when he needed just four credits to graduate. He stayed home while his parents continued to work. Samuel's mother had to change jobs so that she could be at home with Samuel at a certain time of the day. Having a normal family life was very difficult. Everything revolved around Samuel and the managing of his illness. Special precautions were taken to keep Samuel inside the house for his safety. Both parents would call home frequently, as often as six times a day, to speak to Samuel and check up on him. When he answered, they could breathe a sigh of relief. When the phone rang more than a few times, they worried, wondering, "Why isn't he picking up"? If he didn't answer, one of them went home to see why, expecting the worst. Eventually, the stress became enormous on the parents, and, because Samuel was not taking his medication, his situation deteriorated. Having to monitor Samuel 24 hours a day, his father finally decided to abandon his career. He took an early retirement from his job to stay home to care for their adult son.

During the 10 years Samuel dealt with schizophrenia, he was admitted to hospital 14 times, sometimes by force, accompanied by the police. Each time, his parents were there to support him.

One day Samuel decided to go to the library on the university campus not far from his home. His parents always encouraged him to try to find new interests. He left early in the morning with his backpack and arrived before the library opened. He decided to wait at the front door. Someone in an adjacent building thought he looked "suspicious" and called the police. Samuel was quickly surrounded by police officers, who handcuffed him and took him to the station. When he went to pick him up, his father found a terrified young man stunned by the turn of events, because he had done no wrong and had not intended harm to anybody. His parents never blamed the caller for this. They are just very sorry that mental illness scares people so much.

Another time, police were called when Samuel heard that a childhood friend was now teaching at the school they attended when they were younger. Samuel had always been fond of her and decided to drop by and bring her flowers. What Samuel had not yet encountered, as a young adult dealing with schizophrenia, was the stigma attached to mental illness. Much to his surprise, the police were called because some people at the school thought Samuel represented a threat. He was charged following this incident and was eventually admitted to the Restigouche Hospital Center for a 30-day assessment, after he was found unfit to stand trial. Samuel's father said he was relieved at the time. He thought, "Now that he is in the system, he will get the help he needs"—the kind of specialized help the parents couldn't provide.

Samuel adjusted well to RHC. He was less isolated than he was at home. He would socialize with staff and go on outings with other residents. But, again, Samuel experienced the stigma attached to living in a mental health institution. He would relate to his parents how he and the others went on outings, riding in a blue bus that had RESTIGOUCHE HOSPITAL in big letters on the side of the bus, as though, said Samuel, the authorities had to make it obvious that the group was from the mental health hospital. But the family took these things in stride and remained focused on making Samuel as healthy as possible. Thirty days after his admission, Samuel's psychiatrist told the review board he didn't consider his patient to be a threat to himself or others. Samuel was returned to the care of his parents.

Samuel's psychiatrist informed his parents that he was eligible for a disability pension from the province under the income assistance program. He also told them that Samuel could apply for a tax credit with Revenue Canada. Although the parents were pleased to learn this, they wondered why it took so long for anyone to inform them of this. (Samuel had actually been eligible for six years.)

A few years after his diagnosis, Samuel had no friends and very few contacts outside of his immediate and extended family. With the money he was getting from the province, he could treat himself to a pizza on Friday nights and buy books for himself.

Although he was schizophrenic, Samuel, like most young adults, still wanted his independence. When he decided to try living in a residential home in the city, his parents supported him. He soon realized this setting was not for him. Moreover, he would refuse to take his medication while living there. He would call his parents, crying over the phone about how difficult it was for him. He lived at the residence for five or six months. When his parents took him back in (his father states the alternative would have been the streets) he did not hesitate to move back home.

In February, 2006, Samuel received a letter saying he owed the government \$3000 in overpayments. Because he was still living at home, he was eligible to receive less than he had been getting. Moreover, his monthly check would be reduced by \$140. As a young man with paranoid schizophrenia, taking his medication irregularly, this claim for overpayment became a major stress in his life. According to his father, Samuel obsessed

about things like this continuously. His parents, never wavering in support for their son, decided to bring a request in front of the Family Income Security Appeal Board.

In his request for a hearing, the father wrote:

Since receiving notice from the Department of Family and Community Services, I took upon myself to conduct some research as it relates to the cost incurred by the taxpayers for the care of someone such as Samuel when housed in GROUP HOMES. As per the attached e-mail message dated 13 March 2006, you will note that the cost associated to a level 3 is \$107.48 per day which amounts to \$3269.18 a month compared to \$427.50 when the same level 3 resides with his parents who provide the same level of care as group home operators. Some have also suggested that the parental care when available is better for the patient, which is also supported by research data. If one is to consider the personal expenses, this will leave parents with \$317.50 to house, feed and care for their loved one compared to \$2951.68 given to total strangers. I don't believe I need to elaborate further to suggest that parents such as my wife and I and people such like ourselves are being grossly discriminated against by the simple fact that our only link to a person such as Samuel is a genetic one. The amount left every month along with the amount provided by the Federal Government through tax credits does not come close to the amount that is required to care for people such as Samuel.

...I do not suggest...that my wife and I ...receive \$3269.18 a month to take care of our son. After all God gave us this child and we morally intend to take care of him as parents should do....The present regulations and its policies do not recognize people such as my wife and myself. The system along with the people responsible to make it fair and equitable do not care, clear and simple. It is quite evident that being responsible parents we are knowingly or unknowingly being denied decent support, acknowledgement and basic respect.

The day they appeared in front of the appeal board, Samuel was frightened. As a paranoid schizophrenic, dealing with government officials caused him to become agitated and stressed. For the hearing, his father wanted his (the father's) brother present for support, but the chairman ruled that, if Samuel's uncle was present, the father would have to leave. At the hearing, the father felt the board did not listen to him. Later, he said the experience was typical of the way government officials had treated him and his family over the years. He did not blame the civil servants; he believes it is impossible to legislate attitude, partnership and transparency.

In June, 2006, the appeal board finally sent its decision to Samuel. The recommendation was as follows:

After giving careful consideration to all the evidence presented at the hearing, the Board concludes the Department of Family and Community Services acted within the guidelines of the Family Income Security Act and Regulations.

However, the entire Board was in sympathy of [Samuel] and his parents. The Board is limited and regretfully, cannot cancel or deal with the overpayment.

However, the Board strongly recommends the complete review of [Samuel's] case and that [his father's] presentation be brought before the Minister as soon as possible.

[Samuel's father] made it very clear that this is not just about his son, but about thousands of others like Samuel and parents that may not be as fortunate as far as finances, determination and faith in God. Therefore, we further recommend that [Samuel's father] be allowed to speak out and represent his son and many others like his son, as well as their parents. [Samuel's father's] wish is to speak to someone at the Minister or Deputy Minister's level.

By September, word had still not come from the government. Samuel had become obsessed with this issue. He checked the mail three times a day. He wanted to know when the minister or her officials would call concerning his case. That afternoon, as his father worked outside the house, Samuel became very agitated. In an effort to help him, his father called the mental health helpline for advice, but it was the mother who eventually calmed him down, something at which she had always been effective.

The parents had plans to go out for the evening, and Samuel assured them he would be fine alone. When they returned, the house was in total darkness. They thought Samuel had gone to bed. A few minutes later, his father discovered Samuel's body. He had taken his life.

When my investigators met with Samuel's father, he said the following about Samuel: "He was more aware of our mortality than his own. I think he committed suicide because he was afraid of being a burden to us. He thought we didn't have a life. But we did. We had a life. But it was dedicated to our son."

Samuel was buried on September 5, On September 16, his father received a telephone call from the then-Minister of Community and Family Services. The Liberal government was elected on September 19. Three days after the election, Premier Graham called Samuel's father. According to the father, the premier promised that, when he was sworn in, he would strike a committee to review this province's approach to mental illness. On October 25, the father received a letter from the new Minister of Community and Family Services. She offered her condolences and outlined the things her Government is proposing: a review of the current social assistance rates, and the establishment of a provincial strategy on disability issues.

Samuel's parents have tried as best they can to put their lives back together after losing their only child. Their dream is to have residences where people dealing with a mental illness could stay and be truly happy. They regret the fact that all of Samuel's friends abandoned him when he was diagnosed. "The isolation and the stigma is what killed Samuel."

* * *

I have shared this story with all the detail and all the raw emotion that Samuel's father shared with my investigators because I believe it is a compelling call to arms. Just as the criminal justice system has been forced to pick up the pieces from the fall-out of a mental

health system in disarray, parents and family members of mental health service consumers have borne a very isolating and unfair burden in the years since de-institutionalization. I believe the Government has voiced its commitment to do things differently and better. I believe the Government was in earnest when the minister proposed to undertake a review of social assistance rates and development of a new strategy on disability issues. However, it is clearer than ever in my mind, following the investigation over the past year into these several complaints, that a thorough overhaul of our strategies for youth at risk and youths with highly complex needs is required. In that reform process, the parents and families of these children and youths must be lead players in the process and beneficiaries of our reforms.

Parents in the several profiles of this report have done whatever they felt was required, and they were capable of doing, to support their children. When it has entailed physical separation, sometimes because of having experienced abuse at their children's hands, they have not turned their backs, but have turned the other cheek. They have redoubled their efforts to seek better, more adequate supports. They have changed their lives and career expectations to better the quality of life for their child. They have had to balance parental obligations to the child with highly complex needs against other parental obligations, often in very trying circumstances. When all this is weighed in the balance, the rhetoric and policy arguments in favour of respecting the private sphere and maintaining a legal standard that requires families, and parents, in particular, to shoulder their own financial burdens and look after their own, rings very hollow. It has, instead, the tone and nature of a self-interested mantra that the able-minded repeat to themselves to mask the indignities forced by society on those with mental health challenges, children and youths included.

I recommend that Government take positive measures to support the families of children and youths with highly complex needs, including: the establishment of mobile crisis teams; better orientation services to families following diagnosis; on-going program support to families following removal of a child from his or her home; legal recognition of the parental and familial role into early adulthood and beyond; and an end to the practice which penalizes parents for caring for their disabled children in their own home.

41. Mobile crisis teams:

Currently, the advice given to parents, when the behaviour of a mentally ill youth reaches a crisis situation, is to call the police. Even in situations of crisis, children are often placed on waiting lists while parents struggle to care for them. We recommend that Government establish, through mental health services in the regional health authorities, mobile crisis teams to intervene on an emergency basis in the family home. Professionals trained in de-escalation techniques could attend to the families' needs, assess the situation, and provide the immediate and near-term follow-up required. We need to create supportive environments for parents who choose and want to care for their children at home instead of penalizing them.

42. *Preferring family-based approaches:*

If this investigation has strongly convinced me of anything, it is that a child's place is in the home, in his mother's and father's care, or in another family-based setting, provided that adequate supports are available. The review of the seven cases in this study suggests that better and earlier supports to families in the home could have proven much more beneficial to the children in question than the ill-fated and disruptive series of provisional placements in hospital, secure custody, group home and foster home that followed in almost every case. A recent review of clinical studies in this area confirms that family-based interventions are very successful and do actually divert many youths from the correctional system²³. A residential option should be considered only when the child's needs exceed the family's and the community's capacity to care for them either on a transitory basis or a full-time basis. I recommend, therefore, that Government reinforce its commitment to family-based approaches and interventions by adopting guidelines that require social services and mental health services to explore reasonable family supports in preference to residential placement options.

43. *The right to parent children with serious mental health conditions*

Earlier in Chapter IV, I shared my dismay at hearing from so many parents that their child had to commit a crime before he or she could access services. Another troubling refrain is from the many parents who have told my investigators about the hard choice to which they were placed: either to provide for their child's needs with inadequate supports within their home or to relinquish their parental rights altogether in order to place their child in the Minister's care. I cannot imagine a more difficult decision for any parent, and

²³ Woolfenden SR, Williams K, Peat J. Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. *Cochrane Database of Systematic Reviews* 2001, Issue 2. Art.No.: CD003015. DOI: 10.1002/14651858.CD003015. The authors conclude, as per the study's abstract, as follows:

Main results

Of the nine hundred and seventy titles initially identified through the search strategy, eight trials met the inclusion criteria. A total of 749 children and their families were randomised to receive a family and parenting intervention or to be in a control group. In seven of these studies the participants were juvenile delinquents and their families and in only one the participants were children/adolescents with conduct disorder who had not yet had contact with the juvenile justice system.

At follow up, family and parenting interventions significantly reduced the time spent by juvenile delinquents in institutions (WMD 51.34 days, 95%CI 72.52 to 30.16). There was also a significant reduction in the risk of a juvenile delinquent being re arrested (RR 0.66, 95%CI 0.44 to 0.98) and in their rate of subsequent arrests at 1-3 years (SMD -0.56, 95% CI -1.100 to - 0.03). For both of these outcomes there was substantial heterogeneity in the results suggesting a need for caution in interpretation. At present there is insufficient evidence that family and parenting interventions reduce the risk of being incarcerated (RR=0.50, 95% CI 0.20 to 1.21). No significant difference was found for psychosocial outcomes such as family functioning, and child/adolescent behaviour.

Authors' conclusions

The evidence suggests that family and parenting interventions for juvenile delinquents and their families have beneficial effects on reducing time spent in institutions. This has an obvious benefit to the participant and their family and may result in a cost saving for society. These interventions may also reduce rates of subsequent arrest but at present these results need to be interpreted with caution due to the heterogeneity of the results.

I cannot understand why the Province would require any person to be placed in such a dilemma.

This investigation, however, bears out the fact that time and again parents in New Brunswick have called social services for help to have their child placed in a secure, nurturing environment with the supports he or she needs and they have learned that in order to receive appropriate treatment and placement services, they have to turn over guardianship of their child to the Minister. In other words they have to give up temporary or in some cases permanent custody of their child, terminating all parental rights; otherwise the placement is not possible.

Many parents will eventually reluctantly sign over their child's custody to the Minister in order to access placement services, convinced as they do so that they are acting out of love and in their child's best interest.

The parents we have spoken with who found themselves in this situation expressed regret and continue, many years later, to second-guess themselves wondering whether they did the right thing. They felt that they should not have to relinquish their child to the authorities merely to get specialized services to meet the unusual needs of their child. They were fulfilling their parental responsibility more than ever by seeking the needed services, yet they had to turn over the custody of their child. They felt guilty, ashamed, helpless, scared, angry and sad.

In this respect, the current system is unconscionable and must change. Other Canadian provinces are confronted with the same legislative impasses, but that doesn't make it right. The province of New Brunswick can show leadership by correcting this dilemma and recognizing that parents have a right to parent children with serious mental health problems with the State's support. Mentally disabled children for their part have a right to specialized services, consistent with their needs and a right to a family. They don't have to trade one off against the other. This situation has been denounced by many parents' groups across Canada, and by several government officials. If we are to fully engage, include and empower families as the care-givers and service-providers of first choice, if we are serious about embracing family-based approaches and interventions, this humiliating and paternalistic practice must change.

There will always be situations when it is absolutely necessary and appropriate for the Province to intervene and remove a child from the parent's custody. When parents abuse or neglect their children the authorities must bring them into the Minister's care. These practices should continue in all appropriate cases. But in cases where the children or youth in question are dealing with a mental illness that go beyond the parents' and their community's capacity to provide essential care and services, and where it is clear that these children are not in need of protective care from their parents' actions or lack of care, parents should not have to relinquish all parental rights merely to access services. A distinction needs to be made here.

I am therefore recommending that the Government of New Brunswick develop a service delivery system that provides medical, therapeutic, rehabilitative, residential and mental health services to children when child protection concerns are not present. Families should not have to become child protection cases to access the services their children require.

44. *Post-diagnosis supports to families:*

As outlined in Chapter 2, better orientation services are needed for families following their child's mental health diagnosis. In many respects, this speaks to the need to integrate services. Integrating services may yield better results in terms of public health education efforts and other post-diagnosis supports to families. However, communities, non-profit agencies, and professional associations all play an important role in this area, as well. Parents need to know what they can expect, what the next step is, and how to navigate the system. Parents should receive follow-up support, someone to check back with the family when the diagnosis is made and perhaps to connect them with a support group. It is recommended that Government establish effective partnerships with community stakeholders, such as the Canadian Mental Health Association and Chimo, to develop improved post-diagnosis supports to families of youth-at-risk and youths with highly complex needs.

45. *A focus for life and hope*

One of the constant concerns of parents of children with highly complex needs, of which Samuel's case is too stark a reminder, is: what will become of my child when I'm gone? In a context of de-institutionalization and family- and community-based care, it is important in the treatment plan of a child with highly complex needs always to consider the long-term view. The cases reviewed show that, for each of the cases studied, none of the New Brunswick-based interventions seemed focused on more than the immediate crisis. If anything, the problem was most often seen as, "How can we best facilitate the next placement"? We also heard concerns about the extent to which youth-in-care may manipulate behaviours whenever the mood for a change in residential service options struck them. In contrast, the constant focus of all the intervention team members that we met in Maine, who were assisting New Brunswick residents living there, was entirely on life-long learning and incremental progress towards communication, life-skills, or quality-of-life goals. The view was very much towards the long-term, and the residents there seemed to have two things going for them that Nicholas and Jasmine were lacking at RHC. They had hope and purpose. We recommend that the minister responsible for services to children and youth take measures to ensure continuity of care in treatment teams assigned to work with youths with highly complex needs, and that treatment plans for these youths be developed with a view towards their long-term and life-long needs.

46. *Maintaining the parents' active involvement*

Every effort has to be made to maintain contact and active involvement of the parents in their child's life. It is not a weakness on the part of the parents if they are unable to care for their child at home. One of the goals of a regionalized structure for community-based residential care is to facilitate the maintenance and development of positive and healthy relationships between a child or youth in need and his or her parents. This recommendation is consistent with earlier ones about the preferential offer of supports to families and using residential care options as a last resort, and preferably only as a transition. In most cases, however, even when residential care outside the family home is the most appropriate placement, parents can continue to be significant care-providers if the right supports are in place. In any case, support should be available not only to youths, but to their families, as well, when a residential placement is made outside of the extended family unit.

47. *Financial support for parents who choose to care for their children at home*

The crux of Samuel's parents' battle before the Income Assistance Appeals Board was to get some measure of assistance for the investment and care they were providing. Like many parents of disabled children, Samuel's parents had to make the very hard choice of sacrificing career aspirations and their higher earning potential in order to care for their child at home. Very often, this is the best type of care available, and it is what doctors recommend for a child, but it can come at the price of significant financial, emotional and health costs for parents. The same family doctor may have one type of advice for the child, and separate advice for a mother or father. Oddly enough, our income assistance policies exacerbate this tension. They allow for significant investments to be made for youths, or disabled adults like Samuel, who live as wards of the state in institutional settings, but virtually no financial support is available for parents who care for their children at home. Specifically, regulations forbid disabled youths or adults from hiring parents or siblings as care-givers. The result is that caring and qualified care-givers are very difficult to find, and siblings and parents are often forced into poverty in order to care for a child who is disabled. In other parts of Canada, similar regulations have been struck down as offending human rights codes, as discrimination on the basis of family status and on the basis of disability²⁴. Parents in New Brunswick have not been able to have similar cases heard here, since the New Brunswick Human Rights Code does not prohibit discrimination on the basis of family status.

Whether that law is ever changed or not, this investigation suggests clearly that new approaches are needed to end the cycle of poverty that too often follows a mental illness diagnosis, and that parents who choose to care for their child at home should receive a proportional level of support commensurate with services that they are providing at home rather than seeking institutional care. It is recommended that Government end the practice of refusing financial supports to siblings and parents who provide care at home to disabled children who would otherwise be eligible for institutional care.

²⁴ *Hutchinson v. B.C. (Minister of Health)* 2004 BCHRT 58

Chapter 7 - Closing the gap: eliminating age discrimination in youth services

I conclude with one final chapter regarding the gap in services to New Brunswick youth. There is not a specific youth profile to share. If I began to illustrate this point with examples from the cases I have seen this year, the list would be too lengthy. A number of the cases illustrated in this report reflect the concern and adjustments parents and young people experience when the child receiving social services turns 16. But the gap in service affects many more children and youths than those with highly complex needs. Every child and youth receiving social services is affected by the arbitrary cut-off that defines children as people under 16 years of age; as they near their 16th birthdays, these children are routinely refused a host of social and other services.

It is difficult to determine exactly how the law allows this disadvantage to children or youths aged 16 to 18 years, let alone why the law is written in this way. On its face, the *Family Services Act* provides a complete range of services to families and to children, in particular, from birth, and indeed from before birth, up to the age of majority. The minister's authority to intervene in favour of children under the statute is very broad indeed. The term "child" is defined as follows:

"child" means a person actually or apparently under the age of majority, unless otherwise specified or prescribed in this Act or the regulations, and includes

- (a) an unborn child;
- (b) a stillborn child;
- (c) a child whose parents are not married to one another;
- (d) a child to whom a person stands *in loco parentis*, if that person's spouse is a parent of the child; and
- (e) when used in reference to the relationship between an adopted person and the person adopting or the relationship between a person and his birth mother or birth father, a person who has attained the age of majority;

but, for the purposes of making a determination under Part VII, does not include a person who has been married;

The Act further defines the term "child in care" as follows:

"child in care" means any child within an age group prescribed by regulation who has been placed under protective care or any child who is in the care of the Minister under the terms of

- (a) a custody agreement;
- (b) a guardianship agreement;
- (c) a custody order;
- (d) a guardianship order; or
- (e) a supervisory order;
- (f) Repealed: 1996, c.75, s.1.

There are then numerous provisions under the Act which speak to the minister's powers in relation to child protection, most of which provide that the minister's charge regarding

a “child in care” ends upon agreement (in the case of a custody arrangement), or upon the marriage, death or adoption of the child, or “when the child reaches the age of majority.”

The caveat comes, however, in the wording of the *General Administration Regulation* under the Act, N.B. Reg. 81-132. The regulation qualifies the definition under the Act as follows:

2(2) For the purposes of Part III of the Act

"child" means a person actually or apparently under the age of sixteen, and includes a disabled person actually or apparently under the age of nineteen.

Subsequently, section 13 of the Regulation, restricts the legislative scope of the Act as follows:

CHILDREN IN CARE

13(1) Subject to this section, the Minister shall not take a child into care who is actually or apparently sixteen years of age or over except where the child is a disabled person.

13(2) The Minister may extend a custody agreement in accordance with subsection 48(3) of the Act with respect to a child sixteen years of age or over.

13(2.1) The Minister may, for the purposes of subsection 49(5) of the Act, continue to provide care and support for a child who

(a) is enrolled in an educational program, or

(b) is not self-sufficient by reason of a physical, mental or emotional disability.

13(3) The Minister may apply to the court for an extension of

(a) a supervisory order under subsection 54(2) of the Act,

(b) a custody order under subsection 55(2) of the Act, or

(c) a protective intervention order under subsection 58(4) of the Act,

with respect to a child sixteen years of age or over.

13(4) The Minister may enter into an agreement with a representative of the Crown in right of another Province, or a representative of any other government, or with any other person or agency approved by the Minister to accept the transfer of all or part of the parental rights and responsibilities in respect of a child sixteen years of age or over who is subject to any order referred to in subsection 62(1) of the Act.

13(5) The Minister may make an application to the court for an order under paragraph 51(1)(a) of the Act where a child who has been placed under protective care attains his sixteenth birthday before the application is heard.

For the sake of completeness, I also reproduce here the definition of “disabled person” taken from section 1 of the Act, as follows:

“disabled person” means one who, because of physical or mental impairment, including congenital or genetic abnormality, suffers absence or reduction of functional competence which substantially limits his ability to carry out normal daily activities;

and also the relevant provisions of the regulation-making authority as follows:

143The Lieutenant-Governor in Council may make regulations

...

(c)prescribing groups of persons, according to age or need, eligible to receive social services under this Act;

(d)prescribing age groups for the purpose of the definition of “child in care”;

Part III of the Act is, of course, that part of the statute which deals with child and adult protection services. The effect of the provisions under the regulations, according to departmental practice, is to deny child protection services to children who turn 16. Typically, at that age, child protection files are closed. Exceptions, however, have been made in cases of exceptional risk or need. Generally, children in care who turn 16 have the option of continuing in the minister’s care. The Act provides also for a medical examination committee who may determine who is a disabled person within the meaning of the Act. Since the test prescribed by the Act is one of functional competence, it is quite possible that a youth who is determined to be not criminally responsible, and thus not competent to stand trial due to a mental incapacity, could nonetheless not be a “disabled person” for the purposes of child protection services. Finally, there is a separate regulation which governs the offer of residential care services in community placement residential facilities, but residents in these facilities, according to the definitions in the regulations, must be adults²⁵.

It is a general principle of law that the executive branch of government cannot adopt regulations which have the effect of invalidating the legislative provisions that govern their application. Thus it is very unusual for the Legislative Assembly to define a term in the statute and then have Cabinet adopt a regulation to say that the word means something less. It seems to me that if the Legislature’s intent is only to provide child protection services to children under the age of 16, then the law should clearly say so, rather than seeming to promise the opposite.

In fact, I have several serious concerns with 1) the manner in which the Department of Family and Community Services has interpreted and is applying these provisions; 2) the legal validity of these provisions; 3) their constitutional validity; and 4) whether New Brunswickers should accept such a law without amendment if, in fact, it is valid and being properly administered.

During this investigation, I heard from many sides that the law was inexcusable, and should be changed. The reasons it hadn’t been changed already varied from the lack of better approaches elsewhere, to the lack of political will, to the cost consequences of

²⁵ See section 1 definition of “resident” under the *Community Placement Residential Facilities Regulation - Family Services Act*, N.B. Reg. 83-77: “resident” means an adult requiring social services who resides in a community placement residential facility.

providing equal services to youths aged 16 to 19 years. It is perhaps preferable, then, to focus on the policy imperatives for maintaining this regulatory framework, rather than scrutinizing the legality or validity of its current form. I do not want to engage in a detailed legal analysis of the provisions set out earlier, but I find it helpful, before turning to the policy considerations, to list the following concerns:

- Under the current provisions, I question the reluctance and hesitation of child protection services to maintain involvement in cases such as those profiled in this report. If, in fact, there is authority in the regulations to extend child protection services in the case of disabled youth, why have so many parents complained, expressing concern and fear that the minister's involvement in the provision of services and care to their child will end?
- Generally, where rights are affected, the expression of those rights and the general limitations placed upon them by the law should find expression in a statute, not in a regulation or sub-regulatory instrument. This raises a serious question as to whether the regulations under the *Family Services Act* are properly adopted.
- Very important rights are set out in this statute, but the effect of the regulation is to defeat these rights with respect to a vulnerable and disenfranchised segment of the population: youths in need of protection between the ages of 16 and 18. This raises questions as a matter of administrative law and legislative drafting regarding the legal validity of the regulation. Can Cabinet adopt a regulation that defeats the Legislature's intent?
- The general question just raised can be rephrased and questioned also from the perspective of the Act's specific regulation-making authority. The definition of "child" and the provisions of part III of the Act clearly contemplate that child protection services should be available to youths up to the age of majority. The regulations clearly provide a cut-off at age 16. Ostensibly, the regulation-making authority for section 13 of the General Administration Regulation is found in paragraph 143 c) or d) of the Act and limits the definition of child under the Act based upon the rider contained therein: child means a person under the age of majority "unless otherwise specified or prescribed in this Act or the regulations." The question I have is whether the Act gives Government sufficient latitude in these provisions to say that the term "child" means *in the Act* something less than the *Act* says it means.
- The impact of the regulation is to deny services to a vulnerable group within society on the basis of a prohibited ground of discrimination. This necessarily raises important questions regarding the validity of the regulation with our provincial *Human Rights Code* and with the *Canadian Charter of Rights and Freedoms*, particularly the equality provisions of section 15 thereof, and the guarantees of section 7 to "life, liberty and security of the person".
- Age discrimination cases have had only relative success before our courts and tribunals. The Human Rights Code provides exceptions to age requirements that are set out in legislation. Courts interpreting the Charter have insisted, particularly in relation to age-based legislative criteria, that, to be discriminatory, the legislative provision must constitute an affront to human dignity. There is much debate as to whether it is appropriate to extend the Courts' human dignity analysis

to every case of discrimination, but I find it helpful for our purposes to recall what the Supreme Court of Canada stated in *Nancy Law v. Canada*, the case which initially determined that an affront to human dignity was an important element in proving discrimination:

Human dignity means that an individual or group feels self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment. Human dignity is harmed by unfair treatment premised upon personal traits or circumstances, which do not relate to individual needs, capacities, or merits. It is enhanced by laws, which are sensitive to the needs, capacities, and merits of different individuals, taking into account the context underlying their differences. Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society. Human dignity within the meaning of the equality guarantee does not relate to the status or position of an individual in society *per se*, but rather concerns the manner in which a person legitimately feels when confronted with a particular law. Does the law treat him or her unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law?

Turning, then, to the policy considerations, I remain concerned as Child and Youth Advocate whenever social workers and public officials indicate to me: “We would like to be able to assist this child, but, unfortunately, the law prevents us from doing so.” This is the quandary in which youths aged 16 to 18 years of age find themselves whenever they need to access social services. Beyond the provisions outlined in respect of child protection services, youths in this age bracket are disadvantaged when it comes to applying for housing assistance. They are for instance, at times, told by social services that because they are not of the legal age to contract they cannot enter into a lease arrangement. Similarly, if they leave home and no community residential care facilities are open to them because of their age, they often cannot obtain a fixed address, and, without a fixed address, they cannot apply for income assistance. Their eligibility for income assistance would factor in their age and the ability and obligation of their parents to provide care, which, if they have fled home as a result of conflict within the home, may not work to their advantage.

Late adolescence is a difficult stage in life at the best of times. Our social welfare laws and regulations do very little, however, to improve the lot of youths caught between childhood and adulthood.

There may be some legitimate policy reasons for this state of affairs, but they are not apparent from the Act or the legislative record. Some may be of the view that, given the relative autonomy that youths in this age bracket often achieve, if they want to assert their autonomy from an early age, they had better be able to make their own way. In this view, the intentional under-funding of the social safety net provides better incentive for youths to remain in their parental or foster home and in school. None of the people I have consulted has defended this view. Even if it had any merit, the adoption of a strict policy stance in these matters, without any accommodation for genuine cases of risk, hardship and neglect, is hardly defensible. Social policy in an advanced liberal democracy like

ours can surely do better for our youth than leave them fending for themselves in the school of hard knocks.

It is critical for Government to consider the several recommendations put forth in this report jointly with the need for a significant additional investment of resources to correct this historic imbalance between social security programs available to vulnerable children and vulnerable adults on the one hand, and, on the other, those available – or unavailable, as the case may be - to youths in the age gap in between. While the demands of youths with highly complex needs may be resource-intensive – in comparison to the relatively small number of individuals who may benefit— correcting the discriminatory gap in services for youths aged 16 to 18 will also prove costly. This investigation has convinced me however that the economic costs of leaving either youth constituency hanging are far greater.

Moreover, if government dithers with these reforms, it is likely the courts will intervene to protect the rights of vulnerable youths in both categories. It would, of course, be preferable by far to decide as a society to correct these injustices and move forward together on the path of self-sufficiency, and thereby reap the benefits that proper planning and rationalization of our programs and services could bring. In the end, however, in the absence of significant social policy and law reform in the near term, judge-made solutions would be by far preferable to the status quo.

48. *Closing the Gap*

It is recommended that Government take immediate steps to cease the discriminatory impact of current regulations creating a gap in services to youths aged 16 to 18 years of age. I recommend further that amendments to the *Family Service Act*, and regulations thereto, be brought about as soon as possible to end the denial of social services to vulnerable youth.

Conclusion

Law reform and program reform are urgently needed in this province in order to provide an equal playing field for New Brunswick children and youth. Youth-at-risk in the 16-to-18 year age group are unfairly and expressly disadvantaged, by our laws and social programs. Children and youths with highly complex needs are too often overlooked.

The problems outlined in the individual cases reviewed in this report are not new. Though startling and troubling, they come as no surprise to people who work within the system. The same issues have been raised many times in the past, by all departments involved.

I have attempted, in the recommendations set out in this report, to provide a road-map for the process of social transformation required. It is my firm conviction that these reforms are a necessary, though by no means sufficient, condition to the program of self-

sufficiency to which the current Government is committed. A self-reliant society is necessarily one that looks first to the needs of its children and youth. All the children must be accounted for, all their needs considered and addressed; otherwise, we cannot reach our goal.

The transformation can only occur, however, if there is a strong political will to ensure that children come first. Many governments, past and present, have committed themselves to this principle, but children's rights need more than lip-service. A concrete demonstration of this political will and a necessary catalyst and guarantor of the social and administrative transformation required would be the creation of a minister responsible for child and youth services, based upon models in Ontario and elsewhere.

The principal task and function of this minister would be to oversee the integration of all public services to children and youths. I recommend that Government undertake this task with method and determination; that it develop ways of brokering disputes over spending and breaking down resistance to information-sharing.

The areas of reform which I recommend to Government's urgent attention are intended to address the critical shortage of residential options for Youth-at-Risk and youths with complex needs and, as a necessary corollary of these efforts, to focus on the de-criminalization of youths with mental health disorders. It only makes sense to spend our dollars on proactive preventative measures to support our youth, rather than spending even more through court services and correctional services. Correctional methods are reactive, rather than preventative, they are costly, and they are not designed to treat the needs of Youth-at-Risk and youths with mental health disorders.

Finally, this re-investment in youth mental health services and social services must be coordinated with the principal institutional supports to children and youths: schools and families. It is my clear and central recommendation that a child's place is in a stable and loving family environment, however that family may be defined. Government must give priority to this relationship in all its interventions with children and youths. For its part, the public school system is the principal ally and support to parents in meeting their child's educational, physical, social and developmental needs. In moments of crisis, emergency, mental health and social service interventions are needed and are to be preferred to traditional public safety measures. All measures to support the family must be exhausted before alternative placements are considered, having always the child's best interests foremost in mind. Residential services options must remain a solution of last resort. Optimally, residential care services will be accessed only provisionally, as a transition through crisis and significant changes in the family unit. Supports to residents and their families are critical at these times.

Some of the recommendations set out in this report can be implemented without significant new investments. In many instances, it may be a case of redirecting our resources and energies. It is likely that a number of the recommendations, if successfully implemented, will strengthen families and communities and result in a lesser burden on the state. Admittedly, a number of recommendations will have significant cost

implications to Government. In some respects, however, the demands of fairness and equality are such that we have no choice but to make these investments.

As this investigation was largely premised on case studies, it is essentially meant to raise awareness. Much work remains to be done in terms of identifying and reaching out to the number of youths affected. Contacts with officials suggest that the cases profiled here are only a sampling from among many, that they are representative of other, more troubling cases of kids falling through the cracks. I remain deeply concerned by these admissions. Much more work is required to trace the true picture and status of children and youths in this province: how many children and youths are dealing with homelessness, with neglect, or with mental illness? How many are in the care of the minister, in the correctional system, or still living with their families? In every case, how are their educational needs being met? The Government needs to exercise leadership around these issues, to provide better reporting and engage all of society in these important child welfare matters.

I remain hopeful that, despite the many priorities which this Government has set, it will respond favourably to these recommendations. There is no immediate pay-off in the ballot box in looking after the needs of the disenfranchised, but my experience in politics tells me that it is, in fact, to make a difference in matters such as these that most elected officials seek political office. That is why I hope these recommendations may serve as a catalyst for a political and societal consensus, to move the province resolutely forward, with the support of all political parties, the press and civil society, in matters of child welfare.

Child welfare advocacy can be troubling and disquieting, but it is rarely tiresome. It energizes and motivates all of us. Antoine de Saint Exupery, author of *The Little Prince*, captures this sentiment very well in the concluding paragraphs of his novel *Terre des Hommes*. The hero of this piece was a postal service pilot in the early days of civil aviation who was returning home by train in post-war Europe after another close scrape with death. His gaze wanders through the crowded railcar to the couple and child in front of him. He is struck by the grace of the child huddled against his parents' worn and haggard forms. He reflects that this could be Mozart as a child, a rare golden fruit, a beautiful promise of life, like one of the "Little Princes" of stories of old: "When by mutation a new rose spring forth in a garden all the gardeners pitch in. We isolate the rose, we cultivate the rose, we favour the rose. Alas, there are no gardeners of men."

But we have a choice. We don't have to leave any child, least of all those with the most complex needs, to the doldrums of revolving and disconnected systems of state care. We can be instead the gardener or nurturer that sustains a child to adulthood. If anything, this investigation has confirmed the difference that parents, but also individual public servants, can make in advancing, or denying, a child's welfare. I believe we have to celebrate the people in Benjamin's life, the social workers who went to bat for William, for Gabriel and Jacob, to obtain for them the level of care they are now receiving.

Each of us has an important role to play in the lives of children in our families and in our communities. This report's title, *Connecting the Dots*, comes from a child's game that allows a child to make an image and discover the world around him. It focuses us on how our mind works and on the challenges we face when our cognitive abilities are challenged. It is also a reminder of the need to work together for the benefit of children and youth and an invitation to connect, or reconnect, with the children and youths in our lives.

This investigative report is therefore an opportunity for each of us to reflect upon how well we fulfill that role, and what more we can do individually. However, by acting together in society—and the recommendations in this report are merely possible first steps in that direction – we can make an even more appreciable difference in child welfare in this province and help set the stage for truly transformational change.

APPENDIX I

TABLE OF RECOMMENDATIONS:

Responsibility	Recommendations
Political direction and accountability	
Office of the Child and Youth Advocate	1. <i>An active presence, accessible to children and youths:</i> It is recommended that the Office of the Child and Youth Advocate continue and enhance regular staff visits to children in care and children in custody and in other institutional and residential settings to an increasing range of residential settings whenever possible on a weekly or similarly regular basis.
Office of the Child and Youth Advocate	2. <i>Monitoring services to children:</i> It is recommended that the Office of the Child and Youth Advocate conduct regular monitoring of services to children and youths being delivered by the Province of New Brunswick through either public or private operators; this may include social audit functions, such as regular requests to authorities for numbers of children in care, in custody, in hospital settings, or on special education programs, and year-over-year comparisons of expenditures in relation to such services.
Department of Public Safety Department of Family and Community Services	3. <i>Privileged access to electronic records:</i> It is recommended that designated members of the Child and Youth Advocate’s investigative staff be provided with direct access to youth correctional records or child protection records, for monitoring purposes and to facilitate timely delivery of advocacy services on behalf of children. For greater certainty, this privileged access should be provided by law, through amendments to the <i>Child and Youth Advocate Act</i> , the <i>Family Services Act</i> and, if necessary, the <i>Youth Criminal Justice Act</i> .
Office of the Child and Youth Advocate	4. <i>Legislated oversight of children in group homes and transition homes:</i> It is recommended that the <i>Child and Youth Advocate Act</i> be amended to ensure that the oversight functions and mandate of the Advocate expressly include services to children and youths in privately operated group homes, youth transition homes, foster homes or other institutional settings where they may be placed.

<p>Government of New Brunswick</p>	<p>5. <i>A minister responsible:</i> It is recommended that the Government of New Brunswick appoint, from among its senior ministers, a minister responsible for child and youth services, with a legislative mandate to ensure the integration of services to children and youths across all government departments and agencies.</p>
<p>Minister, Child and Youth Services</p>	<p>6. <i>The minister’s mandate and authority:</i> The minister’s mandate should include:</p> <ul style="list-style-type: none"> • fostering a child-centred approach to the delivery of public services in order to meet the needs of children and youths; • the development of agreements within, and among, departments to further this approach through joint funding of programs and services and information sharing; • the authority to enter into agreements with other provinces and levels of government to enhance service delivery to children and youths; • administrative responsibility for the various agencies, committees and programs established to achieve the integration and coordination of service to children and youths. <p>It is recommended that care should be taken to resource adequately the service integration and coordination function, while respecting the spending power and investments required by the stakeholder departments and agencies of government.</p>
<p>Government of New Brunswick</p>	<p>7. <i>Nurturing child welfare advocacy as a civic virtue:</i> It is recommended that the Government of New Brunswick actively promote volunteer, professional and community-based investments in child welfare, recognizing the Province’s overarching responsibility in matters of child welfare, but balancing this consideration with the value-added component that not-for-profit agencies, professional associations, municipalities and others can offer in building strong, caring communities for children and youths.</p>

Service integration	
Minister, Child and Youth Services	8. <i>A child-centred service delivery model:</i> It is recommended that the Minister of Child and Youth Services establish guidelines and training programs for all front-line staff to move public service providers away from a system of exclusion through criteria-based programs to a system of service delivery premised on the assessment of a child's needs.
Minister, Child and Youth Services	9. <i>Legislating resource-sharing in child welfare matters:</i> It is recommended that the Minister of Child and Youth Services be granted the authority to order a financial contribution or payment of services by a given department in cases of disputed access to services in order to expedite service delivery objectives. The minister should also have the authority to claim certain extraordinary expenses against the consolidated revenue so that the increase of child and youth services is not borne at the expense of other public programs within a given department.
Minister, Child and Youth Services	10. <i>Legislating interdepartmental coordination in child welfare matters:</i> It is recommended that a steering committee of the deputy ministers of Education, Health, Public Safety and Family and Community Services be struck to meet quarterly and report to the Minister of Child and Youth Services. The latter should be assisted in this task by an executive director reporting to him directly and acting as secretary to the deputy ministers' committee.
Minister, Child and Youth Services	11. <i>Legislating information sharing in child welfare matters:</i> It is recommended that a legislative framework be put in place to ensure the flow among departments of information concerning a child receiving government services. While protection of a child's privacy is an important right, the obligation to share information with other public service providers who may need it to benefit the child is a paramount concern.
Minister, Child and Youth Services	12. <i>Technology-enabled information-sharing in child welfare:</i> It is recommended that the Minister of Child and Youth Services establish a study group to report on the most appropriate means of sharing information among departments, including consideration of the

	<p>potential use of electronic health records by child welfare interveners and the possible establishment of a joint electronic records management system for children and youths in need. Following this study, the minister must implement measures to ensure that the free flow of information among government agencies in the interests of a given child's welfare becomes the actual practice and not merely the policy of government.</p>
Minister, Child and Youth Services	<p>13. <i>A single entry point for information and service access for families:</i> It is recommended that Government invest significant new resources into the development of open, public health information systems to assist and guide parents and families through the array of programs and services that may assist their child following diagnosis of a mental health condition. The partners in this process should include regional health authorities, mental health service managers, the mental health patient advocate, the Child and Youth Advocate and the Canadian Mental Health Association.</p>
Community-based residential care	
Minister, Child and Youth Services	<p>14. <i>A provincial centre of excellence for youths with highly complex needs:</i> It is recommended that Government establish a provincial centre of excellence for youths with highly complex needs. This centre of excellence should be located in a provincial community and mandated to recruit and retain expert services in child and adolescent psychiatry, developmental psychology, audiology, speech pathology and other support services in matters of child welfare.</p>
Minister, Child and Youth Services	<p>15. <i>A provincial centre of excellence for Youth-at-Risk:</i> It is recommended that Government establish a separate provincial centre of excellence for Youth-at-Risk. The centre should be established jointly with a willing partnership of community agencies in a given locality within the province and be mandated to develop and pilot innovative approaches and best practices in the field of youth welfare services.</p>
The Department of Family and Community Services	<p>16. <i>Supporting the role of youth transition homes:</i> It is recommended that the Department of Family and Community Services develop a program to guarantee stable core funding to youth transition homes and to</p>

	assist community organizations elsewhere in the province on a regional basis to establish similar homes in order to meet the housing needs of young men and women who might otherwise be living on the streets.
The Department of Family and Community Services	17. <i>Investing in youth transition home staff and information sharing:</i> It is recommended that youth transition homes be assisted in recruiting and retaining specialized staff to meet their client needs and that the staff within these homes be included within the circle of care of the youths placed with them, and that the flow of information from public records that may assist in the care of these young people be facilitated in the child's best interests.
The Department of Family and Community Services	18. <i>A transition home cluster for youths with complex needs:</i> It is recommended that the community selected as the provincial centre of excellence for children and youths with highly complex needs must have available an appropriate number of residential homes that can be made available as staff model special care homes and that a dedicated cluster be developed to provide housing and shelter for up to eight youths with highly complex needs on a transitional basis. The units must all be independent of one another and allow for a two-to-one staffing complement involving qualified care-givers who are permanent employees.
The Department of Family and Community Services	19. <i>Staff training for group homes and youth transition homes:</i> It is recommended that the Province of New Brunswick invest significantly in on-going training, clinical support, and better wages for group home and youth transition home staff with demonstrated competencies.
The Department of Family and Community Services	20. <i>A clinical framework as first responders:</i> It is recommended that a strong clinical framework and adequate supervisory support be put in place to respond promptly and adequately to group homes, especially after hours.
The Department of Family and Community Services	21. <i>Improved funding for autism strategy and for community autism centres:</i> It is recommended that Government renew its investment in the autism intervention strategy in a manner consistent with the needs identified and that the proportion of funding directed to supporting the community autism centres in the province be increased.

	<p>Furthermore, it is recommended that Government consider re-directing its investment in training programs towards more broad-based or on-line training components to assist care-givers, field-workers, nurses, teachers and teacher assistants as opposed to merely developing more autism support workers.</p>
<p>Minister, Child and Youth Services</p>	<p>22. <i>Continuity of care and stable relationships:</i> It is recommended that Government make it a priority throughout the public service to provide child-centric service and continuity of care and to promote development of stable relationships around youths with mental health disorders, particularly youths with highly complex needs.</p>
<p>De-criminalizing youths with mental health disorders</p>	
<p>Minister of Child and Youth Services</p> <p>The Department of Health</p>	<p>23. <i>Engaging regional health authorities as sponsors of change:</i> It is recommended that the Minister of Child and Youth Services take measures to ensure the participation of all regional health authorities in the service integration efforts undertaken, as they will be lynchpin participants in this process.</p>
<p>Minister of Child and Youth Services</p> <p>The Department of Health</p>	<p>24. <i>Regionalised child and adolescent psychiatric and mental health services:</i> It is recommended that the Department of Health, the Minister of Child and Youth Services and the regional health authorities develop a phased plan for the establishment of child and adolescent psychiatric services and mental health services in each regional health authority, thus ensuring prompt access to services by children and youths in their health care region.</p>
<p>The Department of Health</p>	<p>25. <i>Making regional health authorities accountable for post-discharge care:</i> It is recommended that increased responsibility be given to the regional health authorities for the post-discharge care of children and youths with mental health disorders as the best means of ensuring them the guaranteed access and continuity of care that they deserve, given their vulnerability and disenfranchisement. Regional health authorities, working in partnership with communities and family physicians, should replace public safety and child protection workers as the first responders for youths with complex needs.</p>

The Department of Health	26. <i>Designation of facilities as approved observation sites under the Criminal Code:</i> It is recommended that, in the design and development of these regional facilities, care should be taken to meet the appropriate standards so that the facilities where the units are located can be recognized as a hospital within the meaning of the <i>Criminal Code of Canada</i> and designated by the Minister of Health as hospitals for assessment purposes under the <i>Code</i> .
The Department of Health	27. <i>Recruitment of mental health professionals:</i> It is recommended that the Department of Health and the regional health authorities collaborate to ensure that we can retain qualified and experienced child and adolescent psychiatrists, psychologists, and other mental health professionals and that the staff recruited have adequate incentive to commit to work in this province over the long term.
The Department of Health	28. <i>More research into drug therapy versus counseling and other therapies:</i> It is recommended that the provincial centre of excellence for children and youths with highly complex needs develop partnerships within the province and with national research agencies and funding partners to support research that will help advance our knowledge of the benefits and risks associated with the use of psychotropic drug therapy for our children, and regarding its prevalence in our society as compared to counseling, psychological therapy and other interventions.
The Department of Health Minister, Child and Youth Services	29. <i>Implementing effective drug prescription practices in all youth placements:</i> It is recommended that the Department of Health, regional health authorities, and the Minister of Child and Youth Services take adequate measures, including recourse to legislative measures, if necessary, to ensure that all children in care and all children in custody receive the drug treatment program prescribed by their physicians, and it is further recommended that a strategy be developed to encourage families and youths themselves to follow the drug treatment program prescribed for their mental health condition.

The Department of Public Safety	<p>30. <i>Shackling, hand-cuffing and strip-searching children and youths with mental health disorders:</i> It is recommended that the New Brunswick Youth Centre immediately suspend the practice of shackling, hand-cuffing, and strip-searching children and youths with serious mental health conditions and the protocol requiring the video-taping of this process. Additionally, it is recommended the Department of Public Safety and the Department of Justice consult with the Department of Health and the Minister of Child and Youth Services to establish new protocols and guidelines for the safe transportation, detention, or isolation of children and youths with serious mental health conditions, and for children and youths generally, when placed in the care of the Department of Justice or Youth Correctional Services.</p>
The Department of Public Safety	<p>31. <i>Education and promotion to prevent abuse of vulnerable youth in custody:</i> It is recommended that the Department of Public Safety devise an educational program aimed at youths in custody and their care-givers about their rights while in custody, and the procedures to follow when they believe their rights have been violated. This should be done in consultation with the Minister of Child and Youth Services and jointly with the Office of the Child and Youth Advocate. This is necessary to ensure that the rights of youths, and particularly vulnerable youths, are protected from the possibility of abuse and to make available to them all avenues for redress.</p>
Minister, Child and Youth Services The Department of Public Safety	<p>32. <i>Ending the co-location of adult and youth populations at NBYC:</i> It is recommended that the Minister of Child and Youth Services and the Minister of Public Safety develop short-term and long-term plans to put an end to the placement of adult offenders in the provincial facility designed for young offenders.</p>
Minister, Child and Youth Services The Department of Justice The Department of Health	<p>33. <i>Alternative measures for Youth-at-Risk and youths with highly complex needs:</i> It is recommended that the Minister of Child and Youth Services establish, with appointed representatives from the judiciary, the Department of Justice, the Department of Health, and the Department of Public Safety, a task force to review alternative measures currently in use within the justice system and to extend the adoption of identified best practices to divert Youth-at-Risk and youths with highly</p>

The Department of Public Safety	complex needs from the criminal justice system. Specifically, this group should review, following recommendations from the current Legal Aid Review, means of improving the legal representation of youths in all instances and develop a pilot project for a youth mental health court, based upon the Saint John mental health court project.
Tailoring the educational system to the needs of children with complex needs	
The Department of Education	34. <i>A multi-disciplinary approach to inclusive education:</i> It is recommended that the Department of Education renew its efforts to promote and model effective multidisciplinary approaches to inclusive education and that it renew its efforts to intervene immediately to correct violent or aggressive misconduct by pupils.
Minister, Child and Youth Services	35. <i>Expanding the Youth Treatment Program:</i> It is recommended that the Minister of Child and Youth Services expand the Youth Treatment Program (YTP) to cover a broader range of diagnoses and that the program be staffed with a dedicated representative from each department; district authorities must ensure that multi-departmental committees are established in each district to refer appropriate cases to the provincial YTP committee. Regional health authorities, youth correctional authorities and Family Services regional offices must ensure local participation as well.
The Department of Education	36. <i>Educating children with complex needs who are no longer in the mainstream:</i> It is recommended that the Department of Education devise a new dedicated focus on children with complex needs who, for whatever reason, are no longer in the mainstream system. Its purpose would be to ensure that these pupils continue to receive educational services, regardless of their placement status.
Minister, Child and Youth Services The Department of Education	37. <i>A special education authority for pupils with complex needs:</i> It is recommended that the Minister of Child and Youth Services and the Minister of Education consider establishing a Special Education Authority to coordinate services to pupils with highly complex needs at the provincial level and possibly at the regional level. This should be done in partnership with, or along the model of, the Atlantic Special Education Authority.

The Department of Education	38. <i>Measured inclusion in the child's best interests:</i> It is recommended that Government invest in more individualized educational services, most likely off-site, but also in individualized laboratory settings within schools, to pupils with the most complex needs. This investment, along with coordination of services within mental health services and Family and Community Services for a broader number of children and youths, should be aimed at reducing the demand and need for more alternative classrooms in the school districts.
The Department of Education	39. <i>Alternative educational settings for Youth-at-Risk:</i> It is recommended that the Department of Education give serious consideration to piloting other alternative educational programs and settings for Youth-at-Risk. Outdoor education, education through the arts, and vocational education programs are all gaining a resurgence of interest in educational circles these days. Establishing an alternate-site school with a variety of such programs, not a reformatory, may be a helpful means of keeping Youth-at-Risk in school and focused on their learning, rather than disrupting classrooms in more traditional educational settings.
Minister, Child and Youth Services	40. <i>Cross-training school staff with health and family services staff:</i> It is recommended that the Minister of Children and Youth develop training programs where teachers and educational services staff can learn alongside mental health employees and social service employees with a view towards: <ul style="list-style-type: none"> • Establishing professional contacts within a region among public servants who provide services to children and youths; • Informing all interveners with respect to the array of services available to assist children, youths, and their families; • Improving the level of knowledge and awareness around varying mental illnesses and how they impact a child's learning, socialization, and behaviour; • Developing strategies and programs to better integrate and coordinate efforts in providing services to children and youths, particularly those with highly complex needs and Youth-at-Risk

Supporting families of Youth at Risk and children with complex needs	
The Department of Health	41. <i>Mobile crisis teams:</i> It is recommended that mental health services in the regional health authorities establish mobile crisis teams to intervene in emergencies at the family home. Professionals trained in de-escalation techniques could attend to the family's needs and assess the situation and the immediate and near-term follow-up required.
The Department of Family and Community Services The Department of Health	42. <i>Preferring family-based approaches:</i> It is recommended that Government reinforce its commitment to family-based approaches and interventions by adopting guidelines that require social services and mental health services to explore reasonable family supports in preference to residential placement options.
The Department of Health	43. <i>Post-diagnosis support to families:</i> It is recommended that Government establish effective partnerships with community stakeholders, such as the Canadian Mental Health Association and Chimo, to develop improved post- diagnosis supports to families of Youth-at-Risk and youths with highly complex needs.
The Department of Family and Community Services	44. <i>The right to parent children with serious mental health conditions:</i> It is recommended that the Government of New Brunswick take measures to protect the right of mentally disabled children to access services without having to sever the familial ties that unite them to their parents. Specifically it is recommended that the Province develop a service delivery system that allows the Minister to provide medical, therapeutic, rehabilitative, residential and mental health services to children and youth when child protection concerns are not present, without the parents having to turn over the legal temporary or permanent custody of their child to the Minister.
Minister, Child and Youth Services	45. <i>A focus for life and hope:</i> It is recommended that the Minister of Child and Youth Services take measures to ensure continuity of care in treatment teams assigned to work with youths with highly complex needs and that treatment plans for these young people be developed with a view towards their long-term and life-long needs.
Minister, Child and Youth Services	46. <i>Maintaining the parents' active involvement:</i> It is recommended that the Minister of Child and Youth Services take measures to ensure that programs across

	<p>government make every effort to mend, maintain and promote contact and active involvement of the parents in their child’s life. It is not a weakness on the part of the parents if they are unable to care for their child at home.</p>
<p>The Department of Family and Community Services</p>	<p>47. <i>Financial support for parents who choose to care for their children at home:</i> It is recommended that Government end the practice of refusing financial supports to siblings and parents providing care at home to disabled children who would otherwise be eligible for institutional care.</p>
<p>Closing the Gap: Eliminating age discrimination in youth Services</p>	
<p>The Department of Family and Community Services</p>	<p>48. <i>Closing the Gap:</i> It is recommended that Government take immediate steps to ease the discriminatory impact of current regulations that create a gap in services to youths aged 16 to 19 years of age. I recommend further that amendments to the <i>Family Service Act</i>, and regulations thereto, be brought about as soon as possible to end the denial of social services to vulnerable youths.</p>

Appendix II
Connecting the Dots:
List of Interviewees and Contributors

Parents:

Benjamin's mother
Samuel's father
Nicholas's mother and father
Jasmine's mother
William's father
Jacob's mother

Youth:

Nicholas
Jacob
William
Gabriel
Benjamin

Treatment Facilities

Spurwink
Restigouche Hospital Center
Child and Adolescent Psychiatric Unit
PEEL Children's Center
Stan Cassidy Rehabilitation. Center
Chrysalis House

Professionals

Sandra Barton, social worker
France Allain, social worker
Patricia Deitch, psychiatric nurse
Denis Jalbert, social worker

Organizations

Fredericton Emergency Shelter
Community Autism Center Inc.

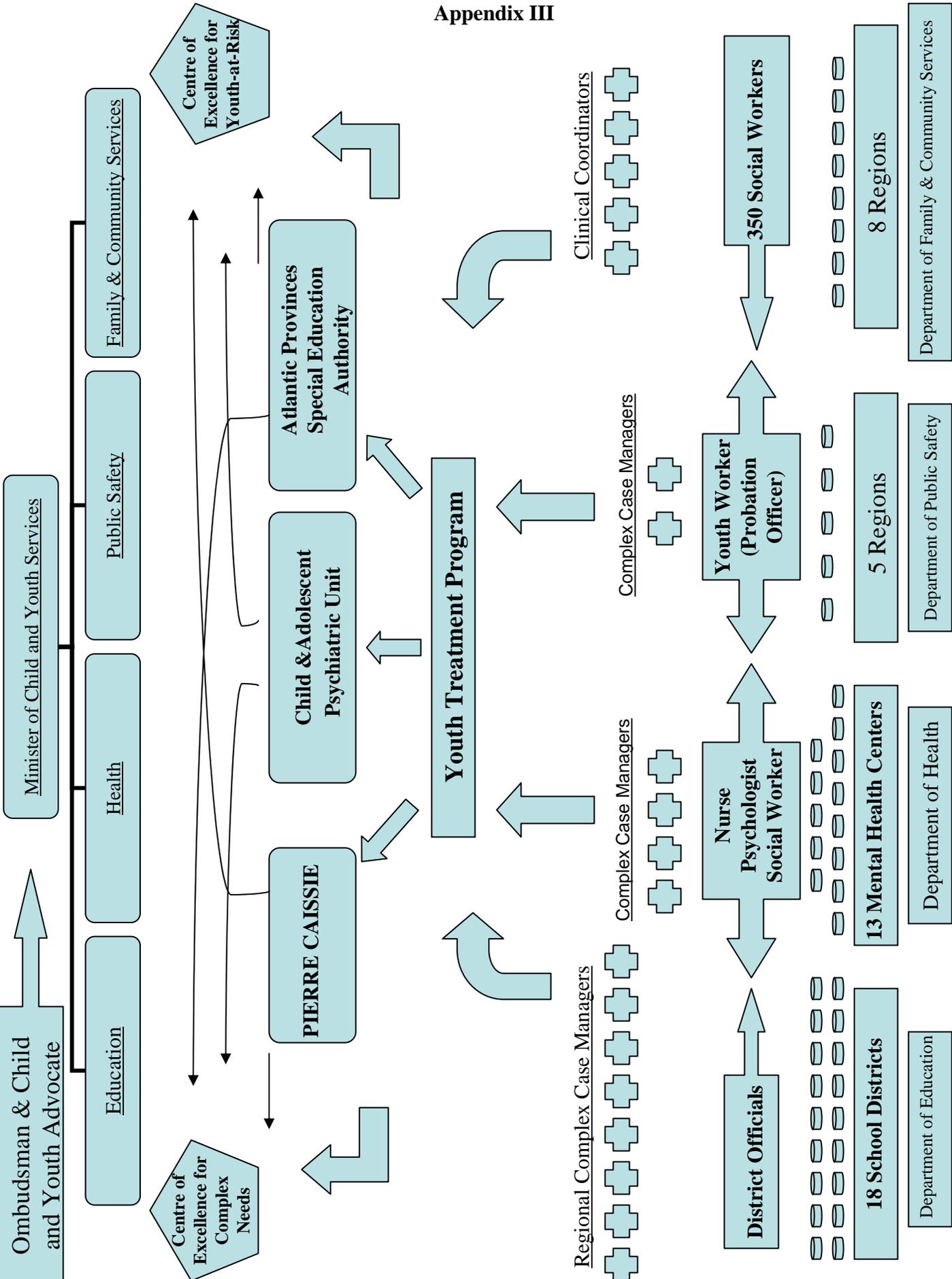
Government Officials:

Barbara Whitenect
Yvette Doiron-Brun
Joan Mix
Gina Atkinson
Brian Kelly
Bob Gerard
Len Davies
Mike Boudreau
Gina St-Laurent
Ian Walsh
Faye Morehouse
Bob Eckstein

Researchers

Nicole Létourneau (Canada Research Chair
in Healthy Child Development at UNB)
Susan Reid (Centre for Research on Youth
at Risk)
Hélène Albert, École de travail social, U.
de Moncton

Appendix III



Appendix IV

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