JUST SIX QUESTIONS

RESEARCH SUMMARY

"Safe with Intervention" — The Report of the Expert Panel on Deaths of Children and Youth in Residential Placements

Key Details

KEY WORDS
Youth in Care, Child Protection, Indigenous Youth, Black Youth, Suicide, Culturally Centered, Intervention, Mental Health, Intergenerational Trauma

POPULATION GROUP
Indigenous Youth, Racialized Youth, Youth In and Leaving Care, Youth Living in Rural and Remote Communities, LGBT2SIQ Youth, Youth Workers

RESEARCH ORIGIN
Ontario

SOURCE
Government

"Ontario's most vulnerable young people, those with multiple needs in complex environments, need a system that is intentionally designed to provide wholisitic, early, ongoing and prevention-focused care and treatment that works for them, their families and their communities — and they need it now" (p. 2).

1. What is the research about?
In the first six months of 2017, five young people died while in the care of a Children's Aid Society or Indigenous Child Wellbeing Society. Majority of the youth were Indigenous and all had struggled with mental health issues. An expert panel was assembled to investigate the deaths. Ultimately, the panel reviewed the deaths of 12 young people who died between January 1, 2014, and July 31, 2017. Of the 12 young people, eight were Indigenous and one was Black. All the young people were in care in residential placements at the time of their death. The panel highlighted significant structural barriers and limited access to resources for youth belonging to these groups.

2. Where did the research take place?
This review took place in Ontario. The panel consulted with youth with lived experience and youth workers in Kenora, Thunder Bay, and Toronto.

3. Who is this research about?
The report focused on Indigenous youth placed in care and removed from their home communities. The panel reviewed services offered to young people to determine the degree to which youth needs are being met.

4. How was the research done?
The report details the work of an external panel put together by the Office of the Chief Coroner. The panel used mixed investigative methods. Over 100,000 pages and records were reviewed, including coroner's reports, post-mortem reports, toxicology reports, and internal organizational documents. Additionally, the panel met with families of the young people (nine of the 12), in addition to interviewing young people with lived experience and 10 staff who had worked directly with the 12 young people. The panel summarized the individual experiences of the 12 young people, aggregated findings, and presented recommendations for action.

5. What are the key findings?
In their review, the panel found that despite complex histories and the high-risk nature of these young people's lives, interventions were minimal and sometimes non-existent. Additionally, minimal efforts were made to incorporate key identity elements into care received (e.g. Indigenous, Black, and LGBT2SIQ identity). Overall, the report found that youth were not living in settings that promoted continuity and hopefulness for the future.

Several issues and challenges were identified:

a) Over-Representation of Indigenous Youth in Care
Eight of the 12 young people were Indigenous and from First Nations communities in Northern Ontario. These young people and their communities were deeply impacted by colonization, residential schools, and intergenerational trauma.

b) Society Involvement and Placements
Many of the young people were removed from their home communities and placed far away from their families. This contributed to isolation. Additionally, youth workers and caregivers were not always prepared to or able to support young people with complex and challenging needs.

c) Mental Health Care
All 12 of the young people struggled with mental health challenges. In most cases, mental health care was fragmented, crisis driven or altogether non-existent. Additionally, there were significant inequalities in mental health care availability in northern First Nations communities.

d) Service Systems
The panel highlighted lack of coordination, information sharing, and integration between services accessed by young people.

e) System Oversight
The panel found that many residences, both licensed and unlicensed, may not have been regularly inspected. This impacted compliance with regulatory standards, which in turn impacted young people's care.

The report concluded with a series of **recommendations** for future actions:

i.) Call for the Government of Canada and the Government of Ontario to provide equitable, culturally, and spiritually safe and relevant services to Indigenous young people, families, and communities in Ontario.

ii.) Call for the Ministries of Children, Community & Social Services, Education, Health & Long-Term Care, and Indigenous Affairs to identify and provide core services and support integrated systems of care for young people and their families across a wholistic continuum.

iii.) Call for the development of wholistic approaches to the identification of, service planning for, and service provision to high-risk young people (with or without child welfare involvement), continuing through age 21.

iv.) Call for the implementation of system improvements and increased accountability through measurement, evaluation, and public reporting.

v.) Call for the enhancement and strengthening of quality placements for young people in care.

6. Why does it matter for youth work?
The report raises important issues for service providers and stakeholders in Ontario's youth sector. It meaningfully engages youth with lived experience and advocates for changes where the rights and needs of youth are understood and respected. Additionally, it highlights the importance of using comprehensive frameworks and models to address the needs of youth in care.

Office of the Chief Coroner. (2018). *Safe With Intervention: The Report of the Expert Panel on the Deaths of Children and Youth in Residential Placements.* Toronto, ON: Author.

FIND IT ONLINE
http://www.mcscs.jus.gov.on.ca/english/Deathinvestigations/OfficeChiefCoroner/Publicationsandreports/SafeIntervention.html