

10/25/2006 14:22 FAX 709 896 4741

HUMAN RESOURCES

002

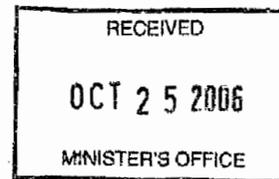


Labrador-Grenfell
Health

CODE # EXE-010620			
C.C. 1.	JA	4.	_____
2.	_____	5.	_____
3.	_____	6.	_____
REGISTRY <input checked="" type="checkbox"/>			

2006 10 24

Honorable Tom Osborne
Minister of Health and Community Services
P. O. Box 8700
West Block, Confederation Building
St. John's, NL A1B 4J6



Dear Minister Osborne:

As you requested, I am forwarding a Report of File Review dated October 24, 2006.

This report prepared by our Directors in Region, Ms. Genevieve Corbin and Ms. Lyla Andrew profiles the high risk child welfare cases in the Labrador-Grenfell Region. While I understand there were challenges inherent in the process, I feel the report will prove valuable in planning our future direction supporting the application of best practices in all areas of Child, Youth and Family Services.

I must highlight that the findings point to a significant human resource deficit in our region and a high level of social distress in our communities. I hope we can work towards addressing these challenges in the interest of better serving the needs of children, families and staff.

Please contact me if you have questions or require clarification.

Sincerely yours,

Boyd Rowe
Chief Executive Officer

BWR/tb

10/25/2006 14:22 FAX 709 896 4741

HUMAN RESOURCES

003



Labrador-Grenfell Health

2006 10 25

Mr. Boyd Rowe
Chief Executive Officer
Labrador-Grenfell Regional Health Authority
P.O. Box 7000, Station C
Happy Valley – Goose Bay
Labrador, NL A0P 1C0

Dear Mr. Rowe:

*Reports of File Reviews
Child, Youth and Family Services
Labrador-Grenfell Region*

Attached are completed file summaries, reports and analysis which were presented to us recently by Directors: Ms. Genevieve Corbin (entire region excluding Innu communities) and Ms. Lyla Andrew (Innu Communities). While our first thoughts were perhaps to integrate the Innu report into a broader regional review, after considerable consideration it is believed that this distinction may serve us well in future planning. Furthermore, Ms. Corbin also separated out Nunatsiavut and Happy Valley data from the region as a whole which will enable us to do further analysis and planning specific to the Inuit communities. This further reflects the cultural diversity and the challenges in service delivery within a multi-cultural region and also recognizes that the Provincial Child, Youth and Family Services legislation which was amended to enable a Director of the Innu communities.

Ms. Corbin profiled 120 high risk cases while Ms. Andrew profiled 87 high risk cases for a total of 207 high risk cases. High percentages of risk factors such as addictions, violence, mental health, and parenting capacity, were found across the case reviews. For example, 84% of the high risk cases in the Innu communities identified addictions as an element. This reflects the degree of social disorganization that exists in many of our Aboriginal communities. Culturally Appropriate Child Welfare Best Practices continue to be a long term vision for these communities and those with responsibility for service delivery.

.../2

10/25/2006 14:51 FAX 709 896 4741

HUMAN RESOURCES

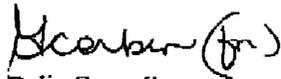
002/002

Mr. Boyd Rowe
2006 10 25
Page 2

I commend Ms. Corbin and Ms. Andrew for the commitment that they have demonstrated to this process of client review. They have raised concerns throughout the process to heighten the level of clarity, but only to ensure that the data that was being collected could be utilized in meaningful ways to improve Child Welfare Practice. The reports contain some valuable analysis and recommendations for next steps. It is imperative that we begin to develop further plans to address some of these recommendations. A close working relationship is required with the province and our Aboriginal Partners to address all these recommendations over time. A specific need of Labrador-Grenfell is to seek expertise with regard to culturally appropriate best child welfare practices for our Innu and Inuit populations. This may require some additional components along with adherence to provincial standards and best practices in Child Protective Intervention Services.

Trusting this is satisfactory.

Sincerely,



Delia Connell
VP/COO Community Services and
Aboriginal Affairs

DC/th

Labrador-Grenfell Regional Integrated Health Authority

**Report of File Review
October 24, 2006**

Presented to:

Mr. Boyd Rowe, Chief Executive Officer

**Ms. Delia Connell, Vice-President and Chief Operating Office,
Community Services and Aboriginal Affairs**

Presented by:

**Genevieve Corbin, MSW, RSW
Regional Director, Child, Youth and Family Services**

And

**Lyla Andrew, MSW, RSW
Director in the Region, CYFS, Innu Zone**

INTRODUCTION

The purpose of this report is to describe findings and to provide recommendations and critical comment specific to a file review requested by the Department of Health and Community Services. Specifically the task which instructed data collection was a four part process which included

- the identification of high risk cases in the region covered by the Labrador-Grenfell Health Authority
- the measurement of compliance with the achievement of program standards
- the identification of outstanding issues
- the measurement of worker caseload

The process of data collection was instructed by the province and included the provision of a template. Staffs were instructed to complete the template in a series of steps which included the participation of the social worker, the manager and the Director in Region. While no specific definition of risk was provided the staff were provided some general instructions which included the utilization of the risk management process and professional judgment. Based upon the lack of clear operational definitions the data derived from the exercise cannot be said to be standardized. The data which informs this report is highly subjective and by extensive interpretive. Further, the data represents a brief snap shot of what is a very complicated and dynamic process. Consequently a cautious utilization of the data is highly recommended. Certainly any attempt to bench mark either within or across regions is not advisable. Early in the data collection process the lack of a clear definition of risk was identified. Concerns were communicated.

The process has provided an opportunity to take a broad brush approach to caseload review which had benefits. Staff were able to quantify the complexity of the client group by identifying the multiple levels of risk which are experienced by the children and families across the region.

The report is presented in two parts, Part A, Section 1, 2, 3, 4 and 5, which is the report of findings for all areas with the exception of the Innu Zone. Part B which is the report of the findings for the Innu Zone.

The findings Part A, Section 1 provides an overview of the total caseload for the region. Section 2 provides an overview of the risk factors which are impacting children, families and communities. Section 3 provides a review of general adherence to the standards which govern the processing of referrals and general case management practices. Section 4 describes outstanding issues and Section 5 describes worker caseload. As noted earlier, the findings give a snap shot of the cases in the region and should be interpreted as a soft measure of risk.

The findings are presented in a series of tables which reflect the categories of interest identified by the Department of Health and Community Services. The tables are formatted to reflect the percentage yes for all cases reviewed and the percentage yes for all protective intervention cases reviewed. A comparative breakdown is provided for the overall region and two of the larger districts, Happy Valley-Goose Bay and Nunatsivut.

The findings do not measure or describe the probability of an adverse event being reduced through the provision of services. The reduction of the probability of an adverse event occurring has been loosely interpreted as a measurement of administrative compliance with standards and the exercise of best practices specifically identified in the template. Again the interpretation is subjective.

10/25/2006 14:22 FAX 709 896 4741

HUMAN RESOURCES

006

PART A**SECTION 1 A – TOTAL REGIONAL CASELOAD
(EXCLUDING INNU ZONE)**

Community	Protective Intervention	Family Services	Youth Services	In Care	Child Welfare Allowance
Cartwright	5	6	3	3	1
HV-GB*	46	6	11	47	11
Southern	56	7	4	2	1
Wabush	90	8	4	4	4
Nain	65	3	7	14	11
Hopedale	44	0	3	21	5
Makkovik	7	1	1	6	0

**SECTION 1 B – TOTAL REGIONAL CASELOAD
(EXCLUDING INNU ZONE)**

Community	Protective Intervention	Family Services	Youth Services	In Care	Child Welfare Allowance
Regional (all cases)	313	31	33	97	33
HV-GB	46	6	11	47	11
Nunatsivut (Nain, Hopedale & Makkovik)	116	4	11	43	16

10/25/2006 14:22 FAX 709 896 4741

HUMAN RESOURCES

007

SECTION 2 – OVERVIEW OF RISK FACTORS**Part A: Risk Profiles Completed**

1. Number of Risk cases profiled: 120
2. Percentage of the cases which were protective intervention cases were 67, 58%
3. Other: Family Services 3%; In Care 29%; Youth Services 8%; CWA 1%

Part B: Types of Assessments Completed

1. Professional Assessments -Total Overall - 98%
2. Professional Assessments - Protective Intervention - 97%
3. Risk Assessment - Total Overall - less than 1% (<1%)
4. Risk Assessment - Protective Intervention - 12%

Part C: Primary Risk Factor	Overall Cases		Protective Intervention			
	Regional		Regional		HV	Nunatsiavut
	#	%	#	%	%	%
Parenting/Supervision	14	11.64	12	18	12	22
Domestic/Family Violence	27	22.5	22	33	28	31
Alcohol Dependency	21	17.5	22	33	24	42
Drug Use	10	0.08	4	6	12	3
Child Behaviour	26	21.7	4	6	0	6
Living Conditions	5	0.04	2	3	0	6
Sexual Abuse	3	0.02	2	3	0.08	0
Neglect	3	0.02	4	6	12	3
Mental Health Issues	15	12.5	11	16	0.04	22
FASD	20	16.7	9	13	0	25
Physical Abuse	3	0.02	4	6	12	3

Part D: Murder	Overall Cases		Protective Intervention			
	Regional		Regional		HV	Nunatsiavut
	#	%	#	%	%	%
Parents Found Guilty of Murder	1	1	0	0	0	0
Parents Charged with Murder	0	0	0	0	0	0

Part E: Violent Crime	Overall Cases		Protective Intervention			
	Regional		Regional		HV	Nunatsiavut
	#	%	#	%	%	%
Parents Found Guilty of Violent Crime	52	43	34	36	36	42
Parents Charge with Violent Crime	56	47	31	46	48	47

10/25/2006 14:22 FAX 709 896 4741

HUMAN RESOURCES

008

Part F: Violence Issues	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Violence Issues	93	78	54	80	76	80
Mother	22	24	9	17	16	17
Father	28	30	20	37	47	31
Both Parents	33	35	20	37	26	45
Child	6	6	2	4	0	3
Other	7	8	5	9	16	7

Part G: Mental Health Issues	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Mental Health Issues	80	67	43	64	56	64
Mother	37	50	18	40	79	20
Father	13	16	9	21	14	30
Both Parents	16	20	11	26	7	35
Child	23	29	10	23	0	35
Other	4	5	2	5	7	4

Part H: Addictions Issues	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Addictions Issues	89	72	48	72	56	81
Mother	25	29	10	21	43	10
Father	12	10	9	20	21	10
Both Parents	41	51	29	60	43	79
Child	8	0.1	4	10	0	10
Other	4	0.04	2	<1	0	10

Part I: Custody and Access	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Custody or Access	17	14	12	18	24	11

Part J: More than two social workers involved in the past 12 months	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
> 2 SW'ers in past 12 months	30	25	23	30	84	0

Most significant risk factors (100% concurrence across the region)

- Alcohol/Drug Use
- Parenting
- Violence
- Mental Health
- FASD

Comments

Section one clearly indicates the degree of social distress in many of our communities. Social issues are extensive and mutually reinforcing. The findings support the reality of caseloads with high clinical complexity.

Specific observations

Section 1 describes clearly the level of risk which staff manage daily in their work. The section clearly describes the dynamic nature of the risk being evidenced. The level and diversity of the risk supports the need for case management practices which include a strong interdisciplinary component.

The findings confirm the need for effective sharing of information across sectors inclusive of police, health and otherwise community services.

The findings confirm the need for the ongoing development and utilization of partnerships across communities to ensure the aversion of adverse events.

The findings support the need for strong interdisciplinary training.

The findings support the need for a high level of competency at the front end of service delivery supported by strong clinical support and partnerships.

The level and complexity of risk identified across the health authority support the need for reduced caseloads. A maximum caseload of ten high risk cases per worker is a recommended standard. Currently caseloads exceed twenty five and are generic in nature.

The level and complexity of risk identified across the health authority supports the need for restructuring of clinical support. Specifically the high complexity and the significant levels of risk identify the need for the formalization of clinical supervision in offices of more than six social work staff.

The level and complexity of risk identified across the health authority supports the need to re-evaluate the role of the community service worker.

10/25/2006 14:23 FAX 709 896 4741

HUMAN RESOURCES

010

Challenges

The interdisciplinary nature of the services required to reduce the probability of an adverse event are for the most part not available in the communities across the Labrador Grenfell Health Authority because of significant recruitment and retention issues.

While Section 2 describes well the efforts of staff to case conference and to consult with the disciplines often those efforts are blocked because of long wait lists and lack of services.

Next Steps

To request that recruitment and retention practices be reviewed specific to the outstanding resource needs of the Child Youth and Family Services Division of the Labrador Grenfell Health Authority.

10/25/2006 14:23 FAX 709 896 4741

HUMAN RESOURCES

011

SECTION 3 - ADHERENCE TO STANDARDS

Part A: Response to Referrals (within 30 days of referral)	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Safety Assessment	19	20	19	30	16	31
Safety Plan	9	8	9	13	4	11
Assessment Investigation Summary	2	2	2	3	4	3
Risk Assessments Completed	2	2	2	3	4	3
Other Assessments Completed	16	13	13	19	8	28
Children Interviewed	64	53	49	73	76	69
Parents Interviewed	67	56	54	81	80	81

Part B: Comprehensive Assessment of Risk	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Safety Assessment	43	36	42	63	64	58
Safety Plan	25	21	24	36	44	28
Assessment Investigation Summary	3	2.5	3	4	4	3
Other Assessments	45	37.5	22	33	32	28
Risk Management Process	3	2	3	4	4	3
Children Interviewed	92	77	48	72	84	58
Parents Interviewed	83	69	56	84	100	69

Part C: Assessment of Families	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Medical & Social Histories	9	8	4	6	0	8
Social History	4	0.01	2	<1	0	3
Other Assessments	41	34	18	27	16	33
Case Conference	30	25	13	19	12	19
Interdisciplinary Consultations	78	65	47	70	88	56

Part D: Case Planning	Overall Cases		Protective Intervention			
	Regional		Regional	HV	Nunatsiavut	
	#	%	#	%	%	%
Family Centered Action Plan	9	0.08	9	13	0	19
Short Term	51	43	39	58	68	50
Long Term	20	17	18	27	68	36
Reviews	11	9			40	28
ISSP Completed	19	16	5	7	4	8
ISSP Not Required	12	10	12	18	44	0
ISSP Not Complete	47	39	25	37	16	53

Comments

For the purpose of this section the protection intervention statistics were regrouped and evaluated to provide a more accurate picture of compliance with the standards. The rationale for the separation out of the data derived from the observation that the policies and procedures outlined in this section pertain more to protection intervention and less to the other areas covered in this report as in for example children in care. The comments were as well informed through a discussion with the program managers.

For the purposes of this review it should be noted that the standards identified are specific to the application of the risk assessment tool. Staff were not trained in the use until very recently. Training began in April, 2006 and is ongoing. To this point approximately 90 % of staff have been trained. To this point staff have not had sufficient time to implement the full scope of the tool. In many cases implementation has been achieved up to step five but not beyond. Excellent progress is being made which is not reflected in the statistical data.

In the absence of the standardized risk management process program managers have developed standards to guide the case management process.

For the purpose of this review it should be noted that program managers are confident that staff are in reasonable compliance with the standards. Program managers cautioned that statistics did not reflect the fact that not all referrals can be supported with reasonable grounds.

Specific Observations

- The file review process has been enlightening to staff and managers and will provide a good foundation from which to identify resource and competency focused needs.
- Approximately 90 % of staff are fully trained in risk and all staff should be trained by the end of October, 2006.
- Members for Custody Review Committees have been recruited and oriented and will begin to review continuous custody files by mid November, 2006.
- A timely response to referrals was noted [98% of referrals actioned within 24 hours]
- Everyone is familiar with the information needed.
- There is a sound awareness of the need for in depth and comprehensive investigations.
- Termination of response priority was identified as appropriate.
- Safety assessments are completed in most cases.
- Multiple interviews with children and parents were noted in most cases.
- Reviews were evidence in a significant number of cases.
- Strong use of interdisciplinary processes was evidenced.
- Excellent use of supplementary assessments given that access to resources is severely limited in many of the communities. [See Appendix A]

10/25/2006 14:23 FAX 709 596 4741

HUMAN RESOURCES

013

Challenges

- Compliance with the completion of a full risk assessment within thirty days of referral is not being met in the vast majority of cases.
- Reviews of plans of care are driven in large part by the court process. Full integration of the review process as in the active engagement around the review of goal attainment is therefore not as integrated as best practice would support.
- Time management is an issue in terms of the completion of risk and general record management.
- Plans for children in continuous custody are not being reviewed as frequently as necessary when placements are stable and therefore reviews are not triggered.
- While every effort is made to develop case plans within thirty days of removal performance is less than satisfactory.
- ISSP's are not being completed as often as is appropriate.
- The case conference is underutilized.
- All managers noted that improvements can be made in obtaining information from other sources.

Next steps

- To ensure consistent monitoring of the implementation of the Risk Management Process.
- To work with the province to identify useful outcome reports which can facilitate the monitoring of successful compliance with the standards.
- To secure funding to support increased contracting out for clinical assessments [i.e. parenting capacity assessments; psychological assessments]
- To review caseload and complexity to support the need for clinical supervision as a dedicated resources.
- To review caseload size and complexity to support need for additional resources.
- To review caseloads with the intent to reduce complexity as a consequence of generic caseloads.
- To share the results of this review with staff for the purpose of identifying specific competency based training needs.
- To request that the risk management process be formally evaluated with a view to determining how we best utilize the process and how we best support staff so they can be successful with compliance.

SECTION 4 – OUTSTANDING ISSUES

Responsibility of the Health Authority

- Manager training required in all areas including human resource management; information management; risk assessment; outcome monitoring; clinical supervision; budget preparation.
- Need to review the management infrastructure [separation out of clinical supervisory accountabilities from program management accountabilities]
- Support fresher training in the Risk Assessment Tool.
- Support the full implementation of the Risk Assessment Tool through technological support services.
- Review of clinical supervision requirements (restructuring management and supervision within the zones)
- Support and advocate for training in the court process.
- Support the competency based training for all social work staff.
- Support training in proper record management
- Support training with police – how to deal with violence in the home
- Enhance budgets to support more external out resourcing for assessment purposes.
- Support the enhancement of human resource and information technology supports for front line staff.
- Work with the province to develop video conferencing capacity for case review, consultation, treatment and training.
- Support enhancements to the foster care program to include dedicated staff and increased rate structures.
- Support the implementation of the Custody Review process
- Support a review of the CWA program
- Support a review of the Community Service Worker program

Responsibility of the Province

- Finalization and dissemination of the policy manual.
- Clarification of best practice specific to 3rd party assault
- Policy development re: family service
- Policy development re: youth service
- Policy development re: critical incident reporting
- Development of outcome monitoring reports.
- Formal evaluation of the Risk Management process and protocol
- Development of standards regarding alternative living arrangements
- Development of video conferencing capacity for case review, consultation, treatment and education
- Development and delivery of competency based orientation (about six weeks)
- Consultation with the School of Social Work regarding the identification of competency based training priorities
- More dedicated resources to foster parents
- Enhance accountability for recruitment
- Full review of the CWA program
- Full review of the Community Service Worker program
- More dedicated resources to strengthen community awareness of duty to report
- Release of memorandum of understanding regarding communications with RCMP and RNC
- Facilitate improved access to tertiary services (Janeway)

Regional level Priorities

- Recruitment and retention
 - Psychologist
 - Social workers
 - Psychiatrists
- Clinical Supervisors
 - Protective Intervention
 - In care
 - Adoptions
- Foster Parents
 - Dedicated resources to support foster parents on a day to day basis
- Capacity Based Training for social workers
 - Risk assessment
 - The assessment and reduction of violence
 - The assessment and treatment of mental health issues
 - The assessment and treatment of dependencies
 - The assessment of parenting capacity
 - The assessment of child development
 - Knowledge specific to court processes and protocols.

SECTION 5 - WORKLOAD

1. Highly diversified generalist caseload. [accountabilities extend across multiple program areas]
2. High complexity of risk [co morbidity – violence; mental health; addictions]
3. Large geographical areas. [multiple and isolated communities]
4. Challenges with communication [across sectors and with different cultural groups]
5. Challenges with travel [one home visit can take a week]
6. Cultural Issues [European and aboriginal mores have to be integrated into assessments]
7. Social workers supported by a generalist program manager. [Generalists managers are responsible for multiple program areas and by extension competing priorities]
8. Timely response to risks compounded by geography. Telephone contact and work through collaterals sometimes required which constitutes heightened accountability.
9. The significant social disorganization experienced by communities impacts ability to reduce the probability of an adverse event. [intergenerational histories of excessive violence; substance abuse and suicide]

PART B**[INNU ZONE - NATUASHISH AND SHESHATSHIT]**

As the Director in Region for the Innu Zone, I want to acknowledge the effort and cooperation of all the frontline staff in this process.

This review was initiated outside this zone and from the outset, I did not fully understand the purpose of the review as it related to the Innu Zone. Therefore it was challenging to oversee the process and provide the necessary support to staff.

Also, I was unfamiliar with the tool that I was provided as the basis for data collection and analysis. I drew heavily upon the experience of my colleague, Genevieve Corbin, CYFS Regional Director for the rest of the Labrador-Grenfell region, and without her assistance in particular, I do not think this review would have been completed to the extent that it has.

The review focus was on high risk cases, and from the beginning, it was clear that the challenge in the Innu zone was to define "high risk". Directors themselves acknowledged that the same case elements might be present in a case that individual Social Workers in different districts and regions could have, and each of those individual Social Workers could define the risk differently and each Social Worker would be right in terms of their own assessment of risk because the context of the workplaces and communities across the province is not the same.

The Innu Zone is unlike any other provincially. The first language of clients is not English. The only language of all Social Workers is English. The history of the Innu in relation to the delivery of Social Services, now Child, Youth and Family Services, is unlike any other provincially, and this review process only served to emphasize this. Therefore the analysis of the data reflects this fact.

SECTION 1 – INNU ZONE: CASE REVIEW STATISTICS**Child Protection Caseload:** [numbers of children]

Sheshatshit	225
Natuashish	118
Total	343

Social Workers [as of review date]

Sheshatshit	4
Natuashish	2

Average Caseload per Social Worker

Sheshatshit	56
Natuashish	59

High Risk Cases [numbers of children]

Sheshatshit	38
Natuashish	49
Total	87

25 % of the total caseload in the Innu Zone is assessed as high risk

41% of the caseload in Natuashish is assessed as high risk

17% of the caseload in Sheshatshit is assessed as high risk

Medium Risk Cases [numbers of children]

Sheshatshit	116
Natuashish	11
Total	127

37% of the total caseload in the Innu zone is assessed as medium risk

51% of the caseload in Sheshatshit is assessed as medium risk

9% of the caseload in Natuashish is assessed as medium risk

Low Risk Cases (numbers of children)

Sheshatshit 71

Natuashish 58

Total 129

38% of the total caseload in the Innu Zone is assessed as low risk

32 % of the caseload in Sheshatshit is assessed as low risk

50% of the caseload in Natuashish is assessed as low risk

Custody Status

40% of the high risk cases are temporary custody

26% of the high risk cases are protective intervention

16 % of the high risk cases are Child Welfare Allowances

13 % of the high risk cases are continuous custody

5% of the high risk cases are youth services and voluntary care agreements

Professional Assessments / Risk Assessment Tool

100% of the case reviews were completed by professional Social Worker assessments.

Risk Factors

Significant risk factors identified:

- unresolved intergenerational trauma
- parental/caregivers' substance abuse
- child's dangerous/disturbing behavior
- parenting capacity
- family violence

Main Risk Factor Identified:

- in 24% of the high risk cases... unresolved intergenerational trauma
- in 22% of the high risk cases....parental/caregivers' substance abuse
- in 18% of the high risk cases ...child's dangerous/disturbing behavior
- in 14% of the high risk cases.... parenting capacity
- in 12% of the high risk cases..... family violence

High Risk Case Elements**Guilty of/Charged With Murder**

- in 100% of the high risk cases, this is not an element

Guilty of/Charged With Violent Crime

- in 40% of the high risk cases, this is identified as a known element
- in 34% of the high risk cases, it is unknown if this is an element
- in 26% of the high risk cases, this is not identified as an element

Mental Health Issues

- in 45% of the high risk cases, this is identified as an element
- in 44% of the high risk cases, it is unknown if this is an element
- in 11% of the cases, this is not identified as an element

Addictions Issues

- in 84 % of the high risk cases, this is identified as an element
- in 12% of the high risk cases, it is unknown if this is an element
- in 4% of the high risk cases, this is not identified as an element

Violence Issues

- in 70% of the high risk cases, this is identified as an element
- in 27% of the high risk cases, it is unknown if this is an element
- in 3% of the high risk cases, this is not identified as an element

Custody/Access Issues [between parents]

- in 99% of the high risk cases, this is not identified as an element

Social Worker Continuity/Consistency [more than one worker primarily responsible for the same case in the last 12 months]

- in 35% of the high risk cases there have been at least 2 changes in Social Workers having primary responsibility for the case

SECTION 2 – OUTSTANDING ISSUES

At the outset of this process we identified challenges with determining “high risk” for Innu children, and because I didn't necessarily know if the statistics gathered by the tool would accurately reflect high risk, I asked Social Workers completing the review to place emphasis on what the tool called “outstanding issues”.

This qualitative data was seen to be as important, maybe more so, than the statistical data.

- The high risk cases captured by this review are for the most part viewed as having multiple risk factors.

We know that high levels of substance abuse, violence and mental health issues are combined in many of the high risk cases. The most prevalent risk factor identified was that of unresolved intergenerational trauma and, in itself, this factor involves many risk elements.

The fact the review focus was on high risk cases only is a concern, as workers felt there were many triggers that could happen at any time which would move a case of medium risk, into a high risk situation, and we have little or no ability to manage this.

- Innu children are absolutely overrepresented in the child protection system and in formal custody arrangements in particular. This is not abating with the continued application of child, youth and family services programs and services. In fact, the increasing numbers of Innu children coming into custody is the way in which we seem to be trying to manage the most high risk situations.
- Risk for Innu children cannot be accurately assessed within an individualized framework.

Healthy Innu culture at one time supported the development of Innu children into responsible, mature Innu adults. However, Innu culture has undergone such drastic change, regardless of the intent, that the damage to social support systems has been experienced by the collective. It is not an individualized pattern of risk. Where risk continues to be seen as being within the family and child, we are going to be limited in our ability to really understand risk for Innu children, as the complexity of risk is in the larger community and cultural context.

- Current practice and the organization of practice resources does not support a focus on structural risks.

The risks for children are fragmented. If we do not create a holistic approach to dealing with structural risks, such as the education and justice systems, Innu children will continue to be overrepresented and disserved by the child protection system.

- Current legislative time frames are too short to allow time for processes aimed at healing and reunification of very damaged individuals and children.

Within a year, a Social Worker is not going to address intergenerational trauma. Parents might seek addictions treatment and be able to maintain food on the table. We are then faced with returning that child when we strongly believe the parent may be so profoundly damaged that the child continues to be at high risk. This is not a situation where blame is assigned to a parent. The analogy has been made that many Innu parents and caregivers have had their legs cut off at the knees, but our expectation is that they get up and run.

10/25/2006 14:24 FAX 709 896 4741

HUMAN RESOURCES

023

- Innu "parenting capacity", while cited as a risk factor, is also an outstanding issue.

What is the benchmark for Innu parental fitness or capacity? How do we begin to address what appear to be major deficits in this regard? Mental health issues are present in almost half the high risk cases, and in the other half of the cases, we don't know if mental health issues are present. However, given our knowledge of the levels of addictions issues and violence in many of these high risk cases, the likelihood is very great that mental health issues are present in most of the high risk cases. Again, we are challenged to access resources to help us understand and deal with these issues.

- In all cases where violence is present we know that the child is at high risk.

We have identified many high risk children as being very emotionally damaged but we feel we have few resources to help us manage this damage, far less try to address the damage. This is an outstanding issue with regard to our ability to find safe placements for these children. Whether it is emotional or cognitive damage, such as that experienced by children with FASD, we are compelled to find safe places for children in our custody to live. Many Innu families have opened their homes but our ability to support these foster families and recruit more, is very limited.

- Many of the children on the current caseload did not earn the high risk rating for this review because at present, they are placed outside the culture within a private foster home system in Ontario.

Arguably these children are safe, so we have managed the risk, but we have removed them from their culture and community of origin and in turn, are fostering the message to them that they can't be kept safe within their own culture, region or province. This is an issue of discrimination that really is outstanding. It is tied to our inability to use resources to create safe placements for Innu children in or near their home communities.

- Social Workers view their work as being crisis driven and feel that as they move from one crisis to the next, they cannot apply their skills to work in processes with extended families and community agencies that would allow them to try and share the management of risks for children. At the same time, we must acknowledge that as Social Workers we are not culturally neutral, and our practice is not culturally neutral. Without acknowledgement of this we inadvertently increase the risk for Innu children.

Suffice to say this review process has opened the door for a much needed examination and understanding of the risks to Innu children's safety and well being. We have to see Innu children in a holistic context of relationships and culture and we will not be able to determine the risks or the best approaches to child welfare practice and Innu children outside of this broad context.

10/25/2006 14:24 FAX 709 896 4741

HUMAN RESOURCES

024

APPENDIX A**OTHER ASSESSMENTS**

Parenting Capacity Assessments
Mental Health Assessments
Special Needs Assessments
Psychiatric Assessments
Contracted Assessments – Dr. Kimberley
Youth Risk Screening Assessments
Independent Reports – Group Home
Youth Services Report
FASD Assessments
Cognitive Assessments
Rainbow Team Pediatric Assessments
Behaviour Management Specialist Assessments
Child Management Specialist Assessments
Charles J. Andrew Youth Treatment Centre
Occupational Therapist Assessment
Labrador Inuit Health Commission Assessment
Doctor's Reports