REPRESENTATIVE FOR
CHILDREN AND YOUTH

News Release

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LONG WAITS FOR MENTAL HEALTH SERVICES PERSIST DESPITE TRAGIC DEATH OF FIRST NATIONS TEEN

VICTORIA – Lack of timely access to mental health services contributed to the suicide death of a First Nations teen in 2013 and is continuing to place Aboriginal children and youth at risk, says a new report released today by British Columbia's Representative for Children and Youth.

A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth tells the story of a 16-year-old boy who left school one morning, walked into a nearby forest, and took his own life. Chester – a pseudonym used to protect the privacy of his family and community – was an intelligent teen from a close-knit family who was described as *"sweet and easy to like"* by his teachers. But despite exhibiting signs of serious mental health issues, Chester received very little in the way of assessment or services from the organizations that might have helped him. And little has changed since his death, the report concludes.

"One might think that when faced with a tragedy such a teenager taking his own life, providing treatment for mental illnesses for Aboriginal children and youth would become a top priority for government, but that has not happened in British Columbia," Representative Mary Ellen Turpel-Lafond said. "In May 2013, we lost a bright and creative young man who should still be here. Three years later, wait lists for services in this youth's area – close to an urban centre – are still on-average 270 days, or nearly nine months. This is nothing short of cruel and is tantamount to abandoning children in crisis."

The lack of proper assessment and services for Chester was partially a result of miscommunication and lack of follow-up between service providers that created the perception of extremely long wait lists for treatment through Aboriginal Child and Youth Mental Health (ACYMH) services as well as a false sense that the teen was already receiving the supports he needed. But not enough has changed since Chester's death to ensure that other youth and their families won't find themselves in the same situation.

"What is it going to take to get government to listen and make the changes that are needed to the child and youth mental health system?" Turpel-Lafond said. "Aboriginal Child and Youth Mental Health services are grossly under-supported and under-staffed in B.C. and the continuing wait lists are tangible evidence. How many more children do we have to lose before government will take action?"

The report finds that the delegated Aboriginal Agency (DAA) serving Chester's area was functioning well below acceptable standards, and was not being properly supported by the Ministry of Children and Family Development (MCFD). According to staff interviewed by the Representative's investigators, the DAA was unable to properly serve youth such as Chester, in part because it was concerned with getting its records in order for an MCFD audit and a subsequent quality review.

"This DAA had been struggling for years with little aid from the ministry, which is required by law to support it," Turpel-Lafond said. "Actions taken by MCFD did not adequately address the lack of capacity in the DAA until well after Chester's death and it remains unclear whether these issues have been resolved in a sustainable manner."

The report makes five recommendations. First, in the immediate term, the Representative calls for MCFD to appropriately resource mental health services for Aboriginal children and youth so that wait lists can be reduced. This aligns with a recommendation made by the Select Standing Committee on Children and Youth in its January 2016 report, *Concrete Actions for Systemic Change*, calling for children and youth with mental health issues to be assessed within 30 days and treated within the next 30 days.

Over the longer term, the Representative recommends the creation of a proactive lead agency for the provision of Aboriginal child and youth mental health services. This agency should be formed by partnership between the federal and provincial governments, the First Nations Health Authority, DAAs and other service providers.

In addition, the Representative recommends that the Ministries of Education and Health, along with MCFD, work to ensure that children and youth are not excluded from school because of mental health challenges, and that child and youth mental health services are co-located in schools where possible.

Further, the report recommends that before the provincial government explores devolution of child welfare services to First Nations, it establish a clearly articulated plan to ensure child safety, develop a workable and effective infrastructure, appropriately fund it and ensure competent, independent leadership is in place.

Finally, *A Tragedy in Waiting* recommends that MCFD immediately develop a strategy to provide collaborative support for DAAs that are failing to meet performance standards.

"There has been much talk about reconciliation and placing children at the centre, but so little has been done to make improvements that it is impossible to say the system has progressed at all since Chester died," Turpel-Lafond said. "Children are waiting and waiting and waiting. Even now, some children in Chester's region are waiting as long as 12 months for services in a major urban area. This is essentially a denial of service. Quite simply, we must do better."

The full report can be viewed here: http://www.rcybc.ca/tragedyinwaiting

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