Tabled by the Minister of Child, Youth and Family Services 2013-12-04

1.0 EXECUTIVE SUMMARY

Part of the legacy of Zachery Turner, the subject of a judicial review following his murder by his mother, Dr. Shirley Turner, has been to illuminate the delivery of child protection services in Newfoundland and Labrador. This report is an evaluation of the clinical services being provided to children, youth and their parents. It is based on a review of 400 files from across seven program areas that resulted in an assessment of the clinical services. Further the report recommends how to build the system to alleviate the limitations.

The child protection system, like many of the children that it serves, has been the victim of neglect over many years. Prior to the review of the life of Zachery Turner, the system had received no new funds for over a decade; it was working under legislation that had been in place for fifty years; there had been no ongoing training provided for social workers or managers in recent memory; and it was unable to attract staff to sustain adequate levels of human resources.

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The *Deloitte Organizational and Operational Review* completed in March of 2007 concluded that:

> *"No one would suggest that the CYFS program in Newfoundland is operating in an ideal environment today. All would agree that there are significant shortcomings."*

The report goes on to identify five inter-connected elements of an ideal work environment, all of which must be in place to create a well functioning system. These elements are: strategy, structure, process and tools, people and organizational culture.

The delivery of child protection services is a high-risk business. To be successful it requires well-trained and supported staff working with a clear purpose, in a culture that supports and recognizes their work, equipped with the knowledge, skills and resources necessary for success.

The child protection system as the *Clinical Services Review* found it can be compared to a vehicle and driver that have embarked on a long journey over rough terrain and under grueling environmental conditions without any attention being paid to the need for tune-ups, oil changes, new tires or rest for the driver. Sooner or later something is bound to fail, be it the vehicle or the driver or both.

Under such circumstances it is no surprise that a tragedy such as the one that befell Zachery Turner occurred. What is surprising is that there have not been more such tragedies.

1.1 WHAT WAS THE PURPOSE OF THE CLINICAL REVIEW?

Given the desire of Child, Youth and Family Services (CYFS) to make appropriate investments to improve the child protection system, the *Clinical Services Review* was pursued in order to develop recommendations that would assist in directing the planning and implementation of any needed additions or changes in policies, programs, standards, practices and methods of service delivery. This was achieved through the following process:

- A review of recent reports and materials including the *Turner Review and Investigation (October 2006)* and the *Deloitte Organizational and Operational Review (March 2007).*
- The design of data collection instruments for seven service areas (family services; protective intervention program including cases screened out of service; children in care and custody; child welfare allowance; caregiver homes; youth services, both residential and non residential).
- Review of 400 case files.
- The collation and analysis of the collected data in conjunction with both a Working Group and an Advisory Committee.
- The development of observations, findings, conclusions and recommendations regarding clinical services.
- The final report includes recommendations for policies and procedures; service models and tools; training and development; quality improvement practices and programs; and structural reform and leadership.

1.2 WHAT ARE THE KEY FINDINGS?

The achievement of an acceptable standard of clinical services is being undermined by the following systemic barriers:

- **Workforce instability** that results in service discontinuity that is compromising the welfare of children. This is seen in casework where there are repeated worker changes; contacts with clients that are significantly below what is necessary for maintaining a clinical relationship to support client change; lack of planning with clients; incomplete or missing client records; low levels of compliance with current service standards.
- **Sufficient leadership and resources** to focus on a realistic set of goals and tasks related to a clear vision of child protection. The current system is working under a conflicting array of purposes and a vision in which child protection is virtually

invisible. As a set of high-risk activities, child protection services require a concerted and sustained focus on key activities, risk indicators, service targets and client feedback. The profile of the child protection needs to be heightened and more systematic attention paid to indicators of quality at all levels of the system.

- **Legislation, policies and procedures** that fail to adequately position the safety, protection and well-being of the child as paramount.
- **Lack of training and professional development** at all levels of the system to support a professional and competent service response.
- **Lack of timely and accurate data** about the work being done and how information about that work can be used to plan for services to children.

1.3 WHAT ARE THE KEY RECOMMENDATIONS?

This review was positioned to closely examine the system through its clinical work - that is the work that directly affects the safety and well-being of the province's children. The clinical perspective examined such factors as the timeliness of response to complaints that children were in need of protection; the thoroughness of assessments of family needs, strengths and risk factors; the frequency of contact with clients; adherence with department policies and procedures; the development of plans of service.

This vantage point also provided a view of how other systems support the achievement of protecting and safeguarding children. As described by the *Turner Review and Investigation:*

> *The shortcomings that contributed to Zachary's death did not originate at the front line level. [They are] systemic problems pervasive at all levels, provincially and regionally...*

The picture that has emerged is a troubling one with few of the essential components of an ideal work environment as described by the Deloitte Review.

Recommendations from the *Clinical Services Review* are focused on the following areas:

- **Leadership:** The need for a mandated leadership team with sufficient resources and time within which to undertake the necessary reform of the child protection system.
- **Legislative Reform:** The current legislation requires review and updating in several areas in order to achieve greater clarity of purpose with a more child-centered focus.
- **Stabilization of the Workforce:** There is an urgent need to stabilize the province's workforce through the development of a coordinated, province-wide recruitment

and retention program. Such a program will recognize the risks inherent in child protection work as the most difficult form of social work practice. Workforce stabilization will require incentives, both financial and other, in order to attract, support and keep people on the job.

- **Training and Development:** The development of a comprehensive training and development program which includes both mandatory and specialized components. The training should be focused on the development of core competence required to deliver clinical services. At a minimum the training should include orientation and basic training for new staff and review and refresher opportunities for experienced staff. Training should address the core competencies identified by the *Clinical Services Review* including risk assessment, planning, comprehensive assessment, client engagement, documentation and clinical supervision.

- **Quality Improvement:** Development of a quality improvement program that will utilize the baseline data extracted from this project and develops strategies for improving on the results. Accurate and timely information regarding casework and flow, human resources and financial resources is essential to the development of such a program.

- **Management of Complex Cases:** A system for the management of complex cases is needed. This should include the routine review of certain types of cases according to an agreed-upon format. Findings and recommendations coming out of these reviews should be aggregated and utilized to make service improvements.

- **Policy and Procedure:** Work already undertaken to develop the *Child, Youth and Family Services Policy and Standards Manual* should be continued in order to develop greater clarity regarding requirements and expectations for service delivery Methods must be developed for ensuring that staff are knowledgeable about the contents of the *Manual* and that supervisors are ensuring that review and monitoring of requirements occurs. A system for the ongoing review and revision of the *Manual* and a communications plan is required.

- **Workload:** An accurate picture of the workload and the current work needs to be ascertained. From this, workload benchmarks must be developed and implemented to direct staff recruitment, management and assignment of work.

- **Documentation:** Current standards of documentation are a serious concern throughout all of the programs. Attention needs to be given to the implementation of formats, file organization and timeliness for the system. This should be complimented by training on use of the case file as a clinical tool.

- **Infrastructure and Information Technology:** Accurate, timely information and training on how it is to be utilized to set targets, monitor and evaluate service goals is basic to system improvement. This will promote a system view and reduce the reliance on often faulty anecdotal information.

The priorities listed above will require a concerted and sustained focus of strong leadership over several years in order to achieve the improvement of the child protection system that is urgently required. If this report is received as another that can be responded to with a patchwork of "quick fixes" it will fail to make significant improvement and be viewed as a disincentive to those working in the system.

The lives of children in Newfoundland and Labrador depend on this.