COMMISSION OF INQUIRY INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF PHOENIX SINCLAIR

Commission Disclosure 0208

MANITOBA OMBUDSMAN

Report Regarding the

Progress on the Implementation of the Recommendations "Strengthen the Commitment"

April 1, 2008– March 31, 2009

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EXECUTIVE SUMMARY

This is our second report on the implementation of the recommendations in *Strengthen the Commitment,* our 2006 report containing over 100 recommendations designed to improve the administration of the child welfare system in Manitoba. All the recommendations were accepted by the Province. Our office has been following up on the progress of their implementation. Some foundational issues identified in our 2006 report have not yet been completely resolved and implemented throughout the system, for a variety of reasons. There are also some areas that appear to be moving more slowly than we had anticipated.

Upon accepting the report, the Minister of Family Services and Housing announced that ... *public accountability for the action on the recommendations will be enhanced with report cards on action taken to be released by... the ombudsman on the review of the child welfare system for the fiscal years 2007/08 and 2008/09.*

A copy of the *Strengthen the Commitment* and the 2007/08 progress report can be found on our website at www.ombudsman.mb.ca.

We have limited the focus of our 2008/09 progress report for the period April 1, 2008 to March 31, 2009 to ten areas. This will be our last progress report in this format. However, we will continue to review the child welfare system in conjunction with our monitoring of the implementation of recommendations made by the Children's Advocate in the child death review special investigation reports.

The primary objectives of the system, the protection of children and preservation of families, reflect our core values and beliefs as a society. The public does not often hear about the good work done by the system or about the dedicated professionals who work tirelessly to provide services required to promote the safety and well being of children and families in Manitoba. Unfortunately the child welfare system usually only comes to the attention of the public when a tragedy occurs, particularly when that tragedy relates to the death of a child. The 2006 review was one of several prompted by such a tragedy.

In our 2006 report we raised concerns about the high level of staff turnover in the agencies. Almost all of the people we spoke to during the 2006 review in collateral service areas raised this issue. We noted that "*a significant number of youth in care reported that they were not aware that there is anyone else available at the agency they can speak to other than their primary social worker. Some of those youth reported that they were unable to reach their*

social workers and that their social workers did not return their phone calls. Furthermore a small number of those interviewed reported that they do not know who their social worker is."

We reiterate that it is essential that staffing in the child welfare system be stabilized. Vacant positions throughout the system need to be filled as soon as possible with permanent staff rather than with staff who are in temporary or term positions, secondments or in acting status appointments. This stability is required to ensure that there is consistency and continuity in front line service delivery as well as in foundational policy work, both of which are critical to the child welfare system. Only with a full staff complement and a strong foundation will improvements and enhancements to child welfare service delivery be achieved in a way that is responsive to the needs of the system.

CHILDREN'S ADVOCATE CHILD DEATH REVIEW SPECIAL INVESTIGATIONS

The Children's Advocate's Enhanced Mandate Act, was proclaimed on September 15, 2008. This legislation transferred the responsibilities for conducting "section 10" reviews of the deaths of children, from the Chief Medical Examiner to the Children's Advocate (OCA). The reviews are now referred to as Child Death Review Special Investigations.

The scope of the investigations has been expanded to allow the OCA to examine the standards and quality of any publicly funded social services, mental health or addiction treatment services that were provided to the child, or in the opinion of the Children's Advocate should have been provided, and make any recommendations she finds necessary.

Expanding the scope of the reviews to include collateral agencies permits recommendations to be made to all systems that have, or should have, provided services to the child, rather than being solely focused on the child welfare agency or authority.

We are satisfied that our recommendations in this area have been implemented. We will follow up on the recommendations made in each special investigation report. We will also ensure that systemic issues identified through this process are addressed and the outcomes of our review process are reported on publicly through our annual report.

As of March 31, 2009 we had received 7 special reports. (To date we have received twenty one reports from the Children's Advocate.) We note that many of the recommendations made in these reports relate to issues that were raised in our 2006

review such as staff turnover in agencies, standards not being followed and risk factors for children that are beyond the control of the child welfare system. We will request responses from the system to the recommendations and comment fully on issues that may emerge from future recommendations.

OFFICE OF THE STANDING COMMITTEE (OSC)

The Office of the Child and Family Services Standing Committee has been established, however due to a considerable turnover of staff and vacant positions we feel that it is too early to comment on whether this structure will accomplish all the objectives that were highlighted in *Strengthen the Commitment.*

FOUNDATIONAL STANDARDS

Agency standards have been revised or developed in many areas including Services to Families, Child Protection, Children in Care and Foster Homes. However, Facility, Authority and Branch Standards remain incomplete. We have been advised that future work on developing Standards will be through the Inter Authority Standards Work Group with an emphasis on the content, impact, measurability and applicability of any standards being paramount.

Our position, strongly stated in *Strengthen the Commitment*, was that establishing, publishing, disseminating and training on all foundational standards was a critical first step that needed to be taken by the child welfare system. A clear understanding of the expectations for service delivery by front line staff is essential throughout the province. While it is necessary to have strong foundational standards in place, they will only be effective if front line staff follow them.

STANDARDIZED RISK ASSESSMENT

We continue to view standardized risk assessments as a critical component of any model of service delivery to ensure the safety of children. A risk assessment instrument is currently being tested in the field. We await the outcome and approval of the final version of the risk assessment tool by the Standing Committee.

CHILD AND FAMILY SERVICES INFORMATION SYSTEM (CFSIS)

Standing Committee continues to work with Agencies in remote communities that still have problems with electronic connections to CFSIS. Connectivity issues relate not only to the ability of workers to input data to the system but also to the critically important need for every worker to be able to retrieve information from the system in a timely manner to deal with child protection issues.

We were advised that the federal government has never funded Information Technology in First Nations communities and therefore there is still only one computer per site, provided by the province. This means that there may be one computer available for up to eight staff in some sites.

Another issue that needs to be resolved is the ratio of support resources to users. Although the number of CFSIS/Intake users has increased, the level of support resources has not. As well, there is currently only one CFSIS/Intake trainer who is available to train all new users province-wide.

The enhancements that have been and continue to be implemented in CFSIS have focused on ease of use, broader accessibility, and reducing risk to children. However, the benefit of the system in reducing the risk to children will not be realized until all agencies are actively and correctly using the system. These issues were raised frequently in our discussions with front line staff regarding the use of CFSIS.

AUTHORITY DETERMINATION PROCESS (ADP)

The reality of service delivery in some remote communities is that there is only one agency providing service. The client can choose a different Authority to oversee the services that agency provides to the family, but the direct service is still provided by the agency located in that area. While this process offers a "choice" of Authority, the reality for families is that the ADP may not produce the anticipated result, or take into consideration the actual significance of that choice, for the family.

The Child Welfare System has not accepted our recommendation that the ADP be completed by staff other than front line staff (Intake). Given that, it is even more important to address the questions and concerns that have been raised by front line staff and provide an appropriate guide to the ADP that is easy to use and comprehend.

Given the format and language of the June 2007 65 page draft guide currently in use, it may not be as helpful as the frontline workers would like. Pending receipt of the finalized version and planned accompanying pamphlet, our review of the June 2007 draft finds that this document does not fully address the concerns that were initially posed by our office.

INTRODUCTION

PURPOSE OF THIS REPORT

It is important that the public be informed of the progress being made in the critical area of child welfare service delivery to children and families. This is our second report on the implementation of the recommendations in *Strengthen the Commitment,* our 2006 report, for the period April 1, 2008 to March 31, 2009. Last year we reported on the progress made on the implementation of the recommendations as of March 31, 2008. A copy of each report can be found on our website at www.ombudsman.mb.ca

This will be our last report in this format on the implementation of the *Strengthen the Commitment* recommendations. We will continue to monitor the progress of administrative improvement in the child welfare system as we review the implementation of the recommendations made in the child death review reports by the Children's Advocate. We will report on systemic issues based on our findings from those reviews.

We have limited the focus of our 2008/09 progress report to the following ten areas:

- The Child Welfare Secretariat (now the Standing Committee Office);
- Child Death Reviews;
- Transfer of Responsibility for Protection Hearings;
- Use of Voluntary Placement Agreements;
- Foundational Standards/Protocols/Directives;
- Standardized Risk Assessment;
- Child and Family Services Information System (CFSIS);
- Authority Determination Protocol (ADP);
- Designated Intake Agencies (DIAs); and
- All Nations Coordinated Response Network (ANCR).

BACKGROUND

In March 2006, the Minister of Family Services and Housing asked the Ombudsman, the Children's Advocate and the Executive Director of Tikinagan Child and Family Services to conduct a review of the opening, closing and transfer of cases in the child welfare system. The report was to be concluded in September, 2006.

The report, titled *Strengthen the Commitment*, was submitted to the Minister on September 29, 2006 and contained over 100 recommendations designed to improve the administration of the child welfare system in Manitoba. On October 12, 2006, the Minister announced that the government would work with the General, Métis and First Nations Authorities towards the implementation of the recommendations in it and two other reports related to child welfare, and committed $42 million over the course of the next three years to do so.

CHANGES FOR CHILDREN

On October 13, 2006, the Minister announced the launch of Changes for Children, an action plan to implement more than 220 recommendations made in the reviews of the child welfare system, including those made in *Strengthen the Commitment*.

The Minister also announced that "*public accountability for the action on the recommendations will be enhanced with report cards on action taken to be released by.....the ombudsman on the review of the child welfare system for the fiscal years 2007/08 and 2008/09*".

When the Changes for Children action plan was announced by the Minister in a news release in October 2006, the implementation was focused on three priority areas: workload relief, training, and prevention. Workload relief and front-line support, prevention and early intervention, and training were areas designated for funding of $37 million over three years.

Changes for Children was based on a blueprint for change that framed the response to the reports on "*key themes that address the substance of the recommendations in the external review reports*".

The Child and Family Services Standing Committee has issued a report on the *Progress on the Changes for Children Initiative* for Winter 2008/09 which can be found at www.changesforchildren.mb.ca This details the progress that has been made in many areas of the system. Our progress report this year has focused on areas we believe are foundational to the reforms that are presently taking place.

PROGRESS REPORT 2008/09

OUR PROCESS IN MONITORING THE IMPLENTATION OF THE RECOMMENDATIONS

We have met with the staff team from the Office of the Standing Committee (formerly Changes for Children staff team) on a number of occasions to discuss and obtain updates regarding the progress made to date on the implementation of the recommendations in the *Strengthen the Commitment* report. As well, there have been regular meetings with Standing Committee to discuss or clarify specific recommendations, in particular our follow-up on the child death review reports.

We requested information from Standing Committee and the Office of the Standing Committee over the period from April 1, 2008 to March 31, 2009. Additionally, we reviewed the notes of the meetings that were held with Standing Committee and the staff team, and others involved in the process of implementing recommendations and making changes within the system.

We met with the Children's Advocate and the Child Death Review Special Investigations team regarding the child death reviews and staff from the Branch regarding the process for follow-up on the recommendations from the reviews.

We met with staff from the General Authority's Youth Engagement team. We reviewed the revised standards as they were completed.

In relation to CFSIS, we attended the Information Matters project team's Foundation Validation Workshop and also participated in the Foundation Validation follow-up workshop. This provided us with a summary of the feedback that had been obtained from staff representing all the Authorities.

Our office has access to CFSIS which allows us the opportunity to review some of the changes as they were made. CFSIS also has a bulletin board which periodically reports updates and changes to the system.

We have met with staff from various agencies this past year, however we have not sought feedback from front line social workers in child welfare agencies and this report therefore does not include a review of the impact of the implementation of recommendations.

FORMAT OF THE REPORT

In preparing this report, we summarized the information gathered from service providers, recipients and other individuals and organizations who provide services to children and families involved with the child welfare system, which formed the basis of our recommendations in our initial report *Strengthen the Commitment*. We have highlighted the key issues that formed the basis for the recommendations and summarized them.

We have shared a draft of this progress report with Standing Committee and received their feedback.

In most sections of the report, we included "Our Comments" which reflects our observations and feedback on the child welfare systems' implementation activities for April 1, 2008 – March 31, 2009 as they relate to the intent of the recommendations made in our 2006 report.

We have also included a section titled "Status" and a status key to provide a snapshot of our view on the progress of implementation to date. A glossary is also included, for ease of reference that outlines the acronyms utilized in this report.

APPRECIATIVE INQUIRY

In our ongoing reviews we are interested in hearing from young people who are affected by the Child Welfare System. A question that is not often asked of them is what is working well for them in the system.

Appendix A of this report contains a report titled "In Their Own Words". This report was generated by using an appreciative inquiry model to determine positive experiences that young people from all four authorities had while in foster care.

A graduate student from the University of Manitoba Social Work program researched this model of inquiry, designed and conducted the interviews, and wrote the report. The study involved interviewing young people between the ages of 14 and 21 who were in foster care, or had recently been in foster care. The study was conducted through the Manitoba Ombudsman's office as part of our follow-up to the *Strengthen the Commitment* review of the child welfare system. The report provides information on appreciative inquiry, information about the interviews, and recommendations for change. It is our understanding that most of the young people found this experience quite interesting and enjoyed the chance to tell their stories to an interested listener.

I believe that the positive information it contains will provide useful information to service providers in the system, and foster parents in particular, about what young people believe some of the best practices might be for welcoming them into foster homes in a way that assures that they will feel wanted and valued.

STATUS KEY

No Information – no information available to us at this time
In Progress – resolution has begun but is not yet completed (there is an anticipated end date)
Ongoing – requires continuous work. Resolution has started but there is no anticipated end date
Dependent on Other Action – some other activity is required before resolution to this issue can begin
Completed – no further action required

GLOSSARY OF ACRONYMS

Aboriginal Justice Inquiry-Child Welfare Initiative **AJI-CWI**
All Nations Coordinated Response Network **ANCR**
Authority Determination Protocol **ADP**
Child and Family Services **CFS**
Child and Family Services Authority **Authority**
Child and Family Services Information System **CFSIS**
Child and Family Services Standing Committee **Standing Committee, SC**
Child Welfare Secretariat **CWS**
Child Protection Branch **CPB**
Designated Intake Agencies **DIA**
Differential Response **DR**
Family Services and Housing Integrated Services Team **IST**
Fetal Alcohol Spectrum Disorder **FASD**
Fetal Alcohol Syndrome **FAS**
Fetal Alcohol Effects **FAE**
Healthy Child Manitoba Office **HCMO**
Integrated Service Advisory Group **ISAG**
Integrated Service Delivery **ISD**
Intersectoral Partnership Project **IPP**
Indian and Northern Affairs Canada **INAC**
Joint Training Unit **JTU**
Manitoba Family Services and Housing **FSH, the Department**
Manitoba Government Employees Union **MGEU**
Office of the Children's Advocate **OCA**

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Office of the Chief Medical Examiner **CME**
Office of the Child and Family Services Standing Committee **Office**
Quality Assurance **QA**
The General Child and Family Services Authority **General Authority**
The Metis Child and Family Services Authority **Metis Authority**
The First Nations of Northern Manitoba Child and Family Services Authority **Northern Authority**
The First Nations of Southern Manitoba Child and Family Services Authority **Southern Authority**
The Child and Family Services Act **the Act**
The Child and Family Services Authorities Act **the Authorities Act**
Voluntary Placement Agreement **VPA**

1. Office of the Child and Family Services Standing Committee (OSC)

Creation

Standing Committee serves as an advisory body to the Authorities and government, and is responsible for facilitating the provision of services under *The Child and Family Services Authorities Act.* The members of Standing Committee (SC) are the Chief Executive Officers of each Authority and the Executive Director of the Child Protection Branch. They are responsible to represent the views and interests of their individual entities at SC for contribution to a common goal. This achieves the goal that the structure will allow for diversity within a consensus model.

When created, there were no staff positions allocated to Standing Committee, although it received support from both the Child Protection Branch and Strategic Initiatives in the Department of Family Services and Housing (FSH) on an *ad hoc* basis.

In our report "Strengthen the Commitment", we stated our belief that the structure of Standing Committee did not allow it to achieve seamless delivery of child welfare in the province. As the Authorities have many of the responsibilities that were formerly those of the Director of Child Welfare we recommended that an office to support the work of Standing Committee be developed to ensure a coordinated direction for foundational work in the child welfare system, regardless of the Authority involved.

At the direction of, and as governed by Standing Committee, this office would be responsible for implementing provincial minimum programs that would shape the case management model, quality assurance framework, differential response, policy development, training, communication, computer systems, Winnipeg intake agency, Authority Determination Protocol (ADP) and foundational standards. Enhancements to the provincial minimums and foundational programs would be the responsibility of each Authority, which could incorporate culturally appropriate practices and programs relevant to it, or its agencies.

We felt that the structure should strengthen the governance model created by the Aboriginal Justice Inquiry-Child Welfare Initiative (AJI-CWI) by enhancing the capacity of the Authorities. As well, the structure should allow for the longer term AJI-CWI goal of devolving more responsibilities to the jurisdiction of the four Authorities from the Executive Director of the Child Protection Branch.

The Standing Committee did not agree with the model recommended and expressed concern that it was a regressive step that would re-centralize functions within the child welfare system, thus losing ground that had been achieved through the AJI-CWI process.

An alternative model was developed and agreed to at Standing Committee and meetings were held with our office to discuss and refine the model. A resolution signifying support for the implementation of the model was signed by all members of Standing Committee on January 22, 2008.

In the spring of 2008, the Office of the Child and Family Services Standing Committee (OSC) was established as a permanent resource to Standing Committee (SC). The Métis Child and Family Services Authority (Métis Authority) is serving as the host for this office. This office replaced the Changes for Children staff team.

Structure

To ensure that the OSC would have the necessary critical mass to fulfill its responsibilities, while meeting the need for diversity, it was agreed that it would have staff representing each member of Standing Committee. It was also agreed that it would use a consensus decision making process, where issues are discussed and direction given to the Coordinator of the OSC for work to be completed on behalf of Standing Committee.

At this time, the OSC structure includes three Core Positions - Coordinator, Financial Officer, and an Administrative Assistant. Each Authority has dedicated two analysts and one administrative support person to the OSC for the purpose of carrying out assignments delegated as core foundational work. The staff complement is 15.

Each analyst is employed by his or her Authority, and is responsible to ensure that its perspective is reflected in the assigned work. The analysts' priority is the core foundational work of the OSC but their secondary role is to address Authority issues when practical and/or necessary. The analysts are responsible to keep their Authority apprised of the common work and provide feedback for the OSC when required.

The OSC has advised us of Cross-Authority Committees working with the staff team to achieve a common approach on issues of common interest and importance to all Child and Family Services Authorities. Staff members from each Authority are assigned to these committees for their professional input. The Cross-Authority Committees and the staff team support the operation of the SC in setting agendas, taking minutes, preparing reports and other information

or authority-seeking documents, providing updates/status reports, maintaining the overall consolidated work plan and the work plan of SC, and in providing advice to SC on issues, projects, or future needs/requirements, etc.

Staffing

The staffing of OSC has still not stabilized. Since my last report, the Coordinator of the Office of the Child and Family Services Standing Committee (OSC) was appointed on July 28, 2008, and is filling this position on a secondment basis from FSH.

The policy analyst positions at the OSC have had high turnover and high vacancy rates. In April 2008, only two positions were filled; by July five of the positions were filled; and as of October 2008 seven positions were filled. Even with filling these positions there has been a turnover of staff and as of March 31, 2009 there were still three vacant positions.

With regard to the Authorities and their participation on the Standing Committee, as of March 2009, the Chief Executive Officer of the Northern Authority was appointed on an interim basis only, the former CEO having resigned in August 2008.

During the fiscal year, the CEO of the Métis Authority left on secondment to a position outside the Authority and two other people acted until a third person could be hired on a permanent basis.

Also during the fiscal year, a person was appointed as the Acting Director of the Child Protection Branch, replacing the Assistant Deputy Minister who had filled the position, in addition to her regular duties. That person left the position in December and the position was filled on a permanent basis at that time.

Our Comment

It is essential that positions be filled on a permanent basis to provide stability and consistency for the child welfare system. Without stable staffing the system cannot operate effectively.

Given the present situation, we are not yet able to comment on whether the OSC structure will accomplish all the objectives that were highlighted in *Strengthen the Commitment.*

The Northern Authority leadership agreed with this structure in 2008, conditional on its review in two years (2010).

Status

In Progress

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2. CHILD DEATH REVIEWS

Section 10 of *The Fatality Inquiries Act* required the Chief Medical Examiner to conduct a review when there had been a death of a child who had received child and family services in the previous year. This review was focused on the performance of and identifiable deficiencies in the child welfare system. In *Strengthen the Commitment*, we identified a significant flaw in the process used under *The Fatality Inquiries Act* to review the deaths of children.

Those reviews conducted by staff at the Office of the Chief Medical Examiner (OCME) were thorough, impartial and independent of the child welfare system. However, the findings and recommendations of the OCME were provided only to the department responsible for overseeing the child welfare system. There was no external review of the recommendations to determine whether or not they had been accepted and implemented in a way that might prevent further deaths. The process lacked transparency and public accountability.

We recommended that *The Fatality Inquiries Act* be amended to remove the responsibilities of the OCME that were set out in section 10 and that *The Child and Family Services Act* be amended to include those duties and responsibilities under the mandate of the Office of the Children's Advocate (OCA).

The recommendations made in *Strengthen the Commitment* included expanding the scope of the reviews. We felt that the amendments should ensure that the OCA is provided with access to all records held by government that relate to services provided by government to the child and family, regardless of department. We also suggested that there be increased staffing and travel resources for the child death review function.

We recommended that all reports on the death of a child should receive independent scrutiny to ensure that the recommendations made are implemented, or are given due consideration and the appropriate action taken.

We felt that the oversight mechanism must be separate from the investigative review process undertaken, and could be achieved by following the process in place for determining compliance with recommendations made by judges of the Provincial Court following inquests. In that process, the judge's report is sent to the Ombudsman who reviews the recommendations and then asks the appropriate department what action has been taken to implement the recommendations.

The changes proposed would ensure that the child death review process is an oversight mechanism external to the child welfare system. A published annual report on compliance would make the system's handling of its identified problems a more transparent process.

These recommendations were accepted by government.

The Children's Advocate's Enhanced Mandate Act, was proclaimed on September 15, 2008. This legislation transferred the responsibilities for conducting Section 10 Reviews from the Chief Medical Examiner to the Children's Advocate. The Section 10 reviews are now referred to as Child Death Review Special Investigations.

The scope of the investigations has been expanded to allow the OCA to examine the standards and quality of any publicly funded social services, mental health or addiction treatment services that were provided to the child, or in the opinion of the Children's Advocate should have been provided, and make any recommendations she finds necessary.

Expanding the scope of the reviews to include collateral agencies permits recommendations to be made to all systems that have, or should have, provided services to the child, rather than being solely focused on the child welfare agency or authority.

The investigation method now has a stronger community-based emphasis. 5.5 new staff positions have been added to the Special Investigation Review Unit at the Office of the Children's Advocate. Investigators are encouraged to visit residences, community meeting places, and publicly-funded agencies that had contact with children in care or children and their families who had received services within one year prior to the death. In the past, Section 10 reviews generally relied on file reviews, telephone calls, and some personal interviews.

A committee has been formed to review reports and draft recommendations from special investigations and provide feedback. Committee members come from a wide range of disciplines.

Recommendations from the OCA are still forwarded to the Minister of Family Services and Housing and are assigned to an Authority Relations staff member of the Child Protection Branch to ensure each recommendation is reviewed and addressed. All recommendations relating to agencies and authorities are reviewed by this staff person and when assessed to be complete a recommendation for closure is made to the Executive Director of the Child Protection Branch. The Executive Director will then review the information and sign off that

the file can be closed. If the recommendation is systemic then a further review and sign off is required by the Assistant Deputy Minister, Child and Family Services.

As well, these reports are now forwarded to our office, to monitor implementation of the recommendations. By assigning that responsibility to our office, the new structure assures the public that the monitoring of the implementation of recommendations, with the goal of reducing the likelihood of a death occurring under similar circumstances, is truly independent, impartial and external to the child welfare system and to government.

The Child Protection Branch has committed to provide system-wide reports on progress of all the recommendations on a semi-annual basis in April and October on the government's progress in implementing recommendations arising from Child Death Review Special Investigations. In this way the outcomes of the review process will be transparent and public accountability will be strengthened.

Our Comment

We are satisfied that our recommendations in this area have been implemented. We will follow up on the recommendations made in each child death report. We will also ensure that systemic issues identified through this process are addressed and the outcomes of our review process are reported on publicly through our annual report.

Status

Completed

NOTE:

As of March 31, 2009 we have received 7 Child Death Review Special Investigations reports and:

- **there were 106 child death reviews pending where the death of the child had occurred prior to September 15, 2008 (the date the new legislation came into force).**
- **there were 45 child death reviews pending where the death of the child occurred after September 15, 2008.**

Our office has received 21 reports as of the date of this report. In some of the child death review special investigation reports recently reviewed, the OCA has stated that various agencies have failed to meet program standards when providing services to families. Some of the other standards cited that have not been met relate to using the intake module, file recording, assessment, transfer of files to another agency and case planning.

Some of these reports also refer to risk factors that are beyond the control of the child welfare system. Risk factors such as suicide ideation and gestures, access to intoxicants, gang related beatings at school and in the community need to be assessed and addressed by the child welfare system, and agencies collateral to it, to redress the risk.

7325

3. Transfer of Responsibility for Protection Hearings

One of the factors that we identified as contributing to delays in the transfer of responsibility for protection hearings, is the process prescribed by subsection 28(2) of *The Child and Family Services Act.* When a child has been apprehended and there has been an application to court for a protection hearing, the apprehending agency (usually intake) may apply to court to have another agency (usually the ongoing service agency) substituted for the apprehending agency for the purpose of the hearing.

Designated Intake Agencies indicated that they are responsible for preparing the court documents necessary to complete the transfer and then must serve the parents with those documents. These steps, along with the delays in the court process itself, further add to the length of time it takes to transfer a file to ongoing service.

Based on our discussions with staff, we recommended that there be scheduled meetings among agencies operating in the same region to discuss and resolve barriers to acceptance of cases at transfer and that the requirements for court documentation for a protection hearing be amended to permit a concurrent application for transfer pursuant to subsection 28(2) of *The Child and Family Services Act.*

It was our understanding that the Department of Family Services and Housing worked with Family Law Branch Crown Counsel and Legislative Counsel to develop an administrative transfer process through amendments to *The Child and Family Services Act*, regulation and forms.

We were advised that in 2008, the Court expressed that concerns about the child protection system cannot be addressed by merely substituting an administrative transfer process for the current section 28 process, nor can it be dealt with simply through the Statute Law Amendment process. Accordingly, at this time, the option of amending section 28 to provide for an administrative transfer process is being revisited, and a meeting will occur with representatives from the Court of Queen's Bench (Family Division), the Masters, the Provincial Court, counsel from Civil Legal Services and Family Law Branch, as well as Child and Family Services officials.

We were also advised that at the same time as proposed amendments were being developed to deal with the section 28 transfer process, amendments were developed to simplify Form CFS-22 (Affidavit of Service) of the *Child and Family Services Regulation.* Standing Committee reviewed the amendments with their counsel and social work staff; further amendments were requested by SC, which were incorporated by Legislative Counsel and these went back to the Court for consultation. These subsequent amendments will be reviewed by SC.

Our Comment

The intent of this recommendation was to streamline legal procedures, reduce legal costs incurred by child and family service agencies and provide more timely access to appropriate child and family services. The department has been unsuccessful in its attempts to resolve this issue. It is hoped that continued consultations will result in workable solutions to reducing the delays in transferring files.

Status

Ongoing

7327

4. VOLUNTARY PLACEMENT AGREEMENTS (VPAS)

Part II of *The Child and Family Services Act* allows a parent, guardian or other person with actual care and control of a child to enter a Voluntary Placement Agreement (VPA) with an agency for the placement of the child without transfer of guardianship. There are limits regarding the duration and renewals of such agreements.

A VPA recognizes a parent's need for temporary out-of-home placement of their child, due to special circumstances, while ensuring the parent retains legal guardianship. When a VPA is used for a reason such as out-of-home placement for a special needs child, or where family circumstances require a time limited out-of-home placement and child protection concerns do not exist, then agency workers need to remain cognizant that the parent retains guardianship and should be involved in any case planning for the child.

The interviews conducted with front line staff revealed that often parents of children in care under VPAs are not involved in case planning for their children. This lack of parental involvement is contrary to the principles of the legislation.

In order to access supportive and preventative services to families where mandated agency involvement is not required, and where services are not readily available in the community, workers reported that they were signing VPAs with families to secure funding for these services.

According to Standards, VPAs should not be used in matters where child protection concerns exist, and where the parent is not willing to work cooperatively with the agency. However, some workers admitted to signing VPAs on child protection cases, instead of apprehending the child(ren), in an effort to work with some families. However in doing this, legal requirements associated with child protection matters are not met.

In order to ensure that VPAs were used in appropriate circumstances, we recommended that the Authorities monitor the agencies' use of VPAs.

All of the authorities agreed that the agencies' use of VPAs needs to be monitored. At the time of our last update, there had been a number of reviews underway, including assessment of the use of VPAs. At that time, this issue was to be considered a priority for many of the planned quality assurance activities for 2008/09.

We were informed that as of July 2008 a section regarding Voluntary Placement of Children and a section on Alternatives to Apprehension had been added to the foundational standards manual. These sections clarified the appropriate use of VPAs, how they are to be utilized for child protection issues and voluntary services, and when VPAs are not appropriate. As well, our office was informed that training on these newly added sections had commenced.

The revisions made to the foundational standards manual regarding the Voluntary Placement of Children reflect a clear and comprehensive process for monitoring VPA usage through reviews by the supervisor. A VPA continues to be required to be signed by the Executive or Regional Director of the Agency, or their delegate, and a copy is sent to the Authority. The section regarding "Alternatives to Apprehension" simply referred to Voluntary Placement as being the only alternative.

Our Comment

It is imperative that the Authorities do not lose sight of this matter in the future and that the resolution of the issues regarding the use of VPAs continues to be a priority. This can be achieved through the continual implementation of preventive efforts.

With turn-over and increases in staffing, it is important to ensure that training efforts are also on-going. Frontline staff must be fully aware of the issues regarding VPA usage and how these issues correlate with the legislation with which they must comply. Not only will this approach better address the needs of the client, it will also reinforce best practice methods in accordance with the fundamental principles.

The response to our recommendation has resulted in revisions to foundational standards, including a procedure for monitoring the usage of VPAs and requiring director (or delegated) approval. With proper implementation of this process, it will serve to prevent the same confusion and mismanagement of VPA situations in the future.

Status

Completed

5. STANDARDS

In the simplest terms, standards in child welfare refer to the minimum requirements or expectations of agencies in relation to the services they provide to children and families; and the activities undertaken to provide these services.

As we noted in our 2006 report, standards are the policies that govern the practice of child welfare in Manitoba. At the time of our review, social workers in the field said that there was confusion about the standards. They were unclear which version was the current requirement and how it could be obtained. More concerning was that child welfare workers from across every region of the province felt that they were unable to meet the requirements of the standards. In particular this related to meeting response times for investigation and assessment, and client contact, including seeing children under their care.

At the conclusion of our 2006 review, we emphasized that the completion of the revisions to the foundational standards must be a priority. We felt the Manitoba child welfare system, which had undergone significant change, needed to have a solid and universal framework as a basis for consistent service to children and families from all agencies and across all Authorities.

With the change of child welfare service delivery in Manitoba to the Authority model, the responsibility for the development of the standards that had previously rested solely with the Director shifted to a shared responsibility among the Child Protection Branch and the four Authorities. Based on this new structure, we made the following recommendations:

- That foundational standards (to ensure the safety of children) be applicable in all situations across the province and be completed as a priority.

- That every child and family services worker in the province receive training on the foundational standards.

- That the foundational standards be published on-line and that every agency office and sub-office receives a manual containing the standards.

- That no standard be implemented without the opportunity for meaningful comment from frontline protection workers representing each Authority.

In our 2008 progress report, we reported that the Standing Committee had completed the *The Provincial Standards for Child and Family Services Development Protocol* which would be used for all standards work in the future. The Standing Committee, in its reply to the Ombudsman, stated at that time that it was focused on completing consultations with field staff around 18 new standards and five introductory sections in the areas of:

- services to families (i.e. family support services, voluntary placement, and voluntary surrender of guardianship);
- child protection (i.e. child protection services, legal proceedings, child abuse investigations, apprehension for medical treatment, working with law enforcement);
- children in care (i.e. places of safety, use of hotels);
- foster care standards that relate to resource management, licensing and licensing appeals, child placements, care responsibilities, support and respite, and removing foster children).

In 2009, the Office of the Standing Committee confirmed that there is a standards development working group, comprised of one representative from the Child Protection Branch and one from each of the four Authorities responsible for the current and forthcoming foundational standards. The working group utilizes a consensus model with all members of Standing Committee.

To date there are 18 newly written standards and five new introductory sections. There have been two new standards approved by Standing Committee; *Service Records*, and *Death or Injury of a Child*, and edits have been made to three previously approved standards; *Use of Hotels, Provincial Child Abuse Investigations* and *Licensing and Licensing Appeals.*

Our Comment

The Standing Committee has approved 18 child welfare standards, in core areas fundamental to service to children and families - case management, service to families, child protection, and portions of children in care. Introductory sections, the chapter on service administration and agency operations have also been completed. These newer or revised standards, together with existing standards from 2005 as well as portions of the former Program Standards Manual ("the remnants"), comprise the minimum expectations of practice for Manitoba child welfare workers.

With regard to our recommendation that the foundational standards, (which ensure the safety of children) be revised and completed as a priority, the completion and dissemination of these particular standards from 2008 to 2009 has met the intent of the recommendation.

However, we note that there are critical portions of standards relating to children in care as well as the Facility, Authority and Branch Standards which remain incomplete. Adoption Standards continue to remain in effect under the former Program Standards Manual.

We have been advised that future work on developing Standards will be the responsibility of the Office of Standing Committee with an emphasis on the content, impact, measurability and applicability of any standards being paramount.

While we acknowledge and support these goals, it is also our view that the current package of standards should be complete, in order for the field to have a clear understanding of the expectations for service delivery and to avoid the previous confusion as to which standards apply. While we have focused on the development, distribution and training related to Standards, it is also imperative that once a standard is finalized that it be followed.

The Case Management Standards have been revised and updated over the years. While revisions have been made, expectations regarding worker responsibility in some areas have not changed since 2005, yet the Children's Advocate child death review reports continue to include findings of agencies failing to meet the standards.

Training

In our 2008 progress report, we were advised by the Standing Committee that all of the Authorities and the Child Protection Branch had developed or were in the process of developing training packages on the foundational standards. While we acknowledged that each Authority is responsible for developing additional standards which are specific to their agencies, we questioned the need for Authority specific training on the foundational standards required of all agencies in Manitoba and also highlighted the importance of the timely completion of the standards in order that the training on standards be comprehensive for all workers in the province.

We are pleased to note that the Standing Committee has advised that by November 2008, standards training had occurred in various sites across Manitoba and in Winnipeg. We were advised that agency employees in all capacities and with a range of experience attended the training, resulting in orientation for newer staff and a refresher for more experienced staff.

It is expected that all agencies will have received standards training within the upcoming fiscal year and that Authority spending plans reflect the anticipated workload of this priority.

With regard to the content and standardization of the training, the Standing Committee noted that, upon completion of the amendments to the newly approved standards, each section was reviewed to highlight key expectations and a Power Point presentation was developed in order to present the standards in the most meaningful way to agency workers.

Our Comment

Progress has been made towards ensuring that all workers in the province receive standards training and it appears that this progress will continue throughout 2009 based on the commitment of the Authorities.

DISTRIBUTION AND AVAILABILITY

In preparation for our report last year, the Standing Committee stated that multiple hard copies of the case management standards were provided to every agency. Approved standards are also posted on the department's website and are linked through each of the Authorities websites. When new standards are developed and approved, directives/notices are sent to the Authorities and their respective agencies which are to be shared with staff. Existing and new standards are incorporated within existing training.

Our Comment

Based on the information we have received from the Child Protection Branch and the Standing Committee, this process has continued to date. Our contact with agencies in the future in connection with the child death reviews will provide the opportunity to determine the distribution and availability of the standards package at the line level.

PROCESS FOR STANDARDS DEVELOPMENT

In response to our recommendation that no standard be implemented without the opportunity for meaningful comment by front line workers from each Authority, the Standing Committee approved *The Provincial Standards for Child and Family Services Development Protocol.* We note that one of the key principles of the Protocol states:

> *Those expected to comply with foundational standards should be consulted during development to ensure that standards are user friendly and reflect practice realities to the greatest extent possible.*

In its 2009 update on the process for standards development, the Standing Committee noted that in mid 2008, the first group of standards completed through the Protocol was approved by Standing Committee.

We are aware that each of the Authorities hired consultants to meet with agency staff regarding the draft standards in order to obtain feedback prior to approval by Standing Committee.

Although the Authority and Branch standards are not yet completed, there has been a significant amount of work completed on the standards over the last three years. This work has included developing standards in other areas, clarifying the standards for the field, providing extensive training, and continuing to work on the development of new standards and revisions to existing standards. In order to be able to fully deal with the issues related to standards development the connectivity and funding issues discussed in other sections of this report need to be addressed.

Our Comment

A review of the reports prepared for two of the Authorities noted concerns regarding the ability to obtain meaningful feedback in a short period in particular from rural agencies. The reports also commented that the Protocol required that standards would be developed by a working group made up of representatives from each of the four Authorities and a member of the Child Protection Branch with the focus on a consensus model of developing draft standards for approval by the Standing Committee. Concerns were expressed that the first group of standards were ones that had been drafted solely by the Child Protection Branch and had not been developed under the guidelines of the Protocol.

We commented in our previous report that the Protocol marked a significant shift in the way in which standards development occurs, moving this function from one that was solely driven by the Child Protection Branch to one that is a collaborative Standing Committee driven process ensuring input from front line staff from their agencies.

We note the considerable work and commitment by the Authorities to establish the Protocol to ensure that the process for standards is based on consensus and that real and meaningful feedback from those who use the standards is fully considered. It is essential that this Protocol be followed, and feedback from the Authorities and Agencies obtained, as it is critical for the purpose of effective implementation of the standards.

Status

Ongoing

7335

6. STANDARDIZED RISK ASSESSMENT (SRA)

One of the key responsibilities of child welfare workers, with regard to the children they are mandated to protect, is the necessity to predict the potential or risk of future maltreatment. This is essential in order to make the best decision regarding the course of action that should be taken.

Risk of maltreatment is generally based on an evaluation of the immediate safety of the child following a crisis within the family and a detailed longitudinal consideration of a range of indicators of family functioning. A structured risk assessment tool has been one mechanism for assessing risk used by child welfare workers. Risk assessment tools have been shown to assist in the decision making process regarding the protection of children. They help to provide a consistent perspective and minimize subjectivity. This additional level of accountably can help guard against decision making based on systemic pressures of limited resources, high caseloads and increasingly complex family issues.

In the course of our review in 2006, agency staff and supervisors advised us that safety assessments were being completed in agencies where the intake module was being used. Staff noted that while the safety assessment is a requirement and described in the standards as the beginning of risk assessment, it is based on an assessment of the immediate danger to a child and the current incident.

Many staff noted that a thorough analysis of past history and patterns of functioning is not possible given the time constraints and structure of information to be gathered for the Intake Module. As well there were difficulties with accessing information from other agencies, Child and Family Services Information System (CFSIS) and closed files.

Some agencies commented that while the safety assessment might indicate a safety plan for a child, very quickly matters can change that place a child at risk. The safety assessment cannot be seen as assessing or mitigating overall risk to a child. Agencies indicated in general that there is no commonly agreed upon risk assessment tool that is recommended in the standards and there was a concern that such assessments were not being completed.

Based on our discussions with staff, we recommended that a consistent model or standardized tool for the assessment of risk be implemented and adopted by every agency across the province. We felt that this assessment model should include the consistent and core elements necessary to assess risk as recognized by best practice in child welfare. Above all, any risk

assessment model should allow for the comprehensive and longitudinal assessment of risk to a child, and should not focus solely on immediate safety.

In response to our recommendation, Standing Committee advised us in 2007/08 that it agreed that the adoption of a standardized risk assessment tool would be a fundamental component of the Differential Response (DR) model of child welfare service delivery.

The standardized risk assessment tool is now being finalized and is being piloted by agencies across the Province. The companion strength-based tool has also been completed and is designed to be a complement to the standardized risk assessment tool, which will be an assessment of the probability of future harm. This tool will serve as a useful guide for workers to conduct comprehensive assessments, identify factors that affect child safety, and establish case plans with families.

Best practice models suggest that assessments are inclusive of (but not limited to) risk and strength based approaches when delivering service to children and families. There is consensus from Standing Committee that a strength based tool will also be adopted by all Authorities. We have been advised that phased-in training on the utilization of these tools will commence in September 2009.

Our Comment

We continue to view standardized risk assessment as a critical component of any model of service delivery to ensure the safety of children. We await the outcome of the testing, the approval of the final version of the risk assessment tool by the Standing Committee and its full implementation in all agencies across the province.

Status

In Progress

7. The Child and Family Services Information System (CFSIS)

The Child and Family Services Information System (CFSIS) is the Child and Family Services (CFS) computer information system used by staff to collect and manage data on cases and services provided to families. CFSIS was to be a province-wide electronic system used to obtain information about children and families within the child welfare system. This is especially important due to the transience of many families involved with the system.

The provincial standard requires mandated agencies to use the Child and Family Service Application (CFSA) for all cases transferred as part of the implementation of the Aboriginal Justice Inquiry – Child Welfare Initiative and all cases which have been opened, other than in First Nations communities. The standard also requires mandated agencies to use the Intake Module to open all cases in the province including cases opened on First Nations communities.

In the course of our review in 2006, we found that several agencies were not using CFSIS fully because they did not have the necessary equipment to run the system, they had developed their own system, or their community did not have the technological capacity to allow its use.

In response to our recommendations, the Standing Committee advised us in 2007/08 that the Authorities agreed to complete an agency-by-agency inventory of connectivity issues and provide it to the Department. Once the Authority reports were received, the department would then conduct a technical assessment of the issues and work with the Authorities and connectivity providers to resolve the issues.

We have been informed that progress continues to be made in solving current connectivity problems experienced by some agency offices when trying to utilize Child and Family Services Computer Applications. We have been advised that the involvement of Science, Technology, Energy and Mines (STEM) in decision making related to IT has slowed down the process of resolving these connectivity issues and some agencies are still waiting.

Staff advised that inputting data on CFSIS was time consuming and cumbersome. Some users would circumvent mandatory "windows" when they did not have information available by inputting "dummy" information. Even when information had been entered in CFSIS and was accurate, if another agency opened a file on the same family, the only information available was that a different agency was previously involved. The worker would have to call the agency that "owns the file" to obtain details. This had a profound impact on the time of intake workers who needed to have quick access to information about the family.

As it existed, CFSIS appeared to be an impediment to communication between workers. CFSIS was intended to provide front line staff with more time to work directly with clients. However, it was reported that it caused workers to spend more time on the computer. Also some areas only have dial-up service which significantly increases the time it took to input information on the system. If something interrupted the connection, workers needed to begin the inputting process again.

It should be noted that centres such as Brandon, Dauphin, The Pas and Thompson are served by broad band carriers. Therefore, approximately 75% to 85% of the total provincial caseload is served by agencies that are supported by broad band carriers. The remaining 15% to 25% are supported by dial-up or satellite carriers.

Based on our discussions with staff, we recommended that a province-wide information system should be capable of being used as a tracking system with timely, accurate and basic demographic and contact information. It should have warnings attached for adults/youth who pose a threat to the child or family. If the CFSIS system were streamlined, it would be easier to use, benefiting all agencies. We recommended that the issues with CFSIS be addressed and that staff have access to cases across the province.

We have been advised that there is now province-wide access to all intakes on the Intake Module for designated workers. There is now a new feature in the Prior Contact Check to ensure accurate results are properly displayed and to reduce/eliminate duplicate records.

Other improvements to the system include:

- reduced navigation to case recordings to a single click solution;
- advanced notice and reports of expiring foster home licences;
- new security level – restricted access for highly sensitivity cases;
- recording of medical information for children in care;
- the creation of a 'flag' to identify children in care with high risk medical needs;
- automatic transfer of household information from IM to CFSIS;
- repairs to ensure that Prior Contact Check (PCC) in the Intake Module and CFSIS produce the same results; and
- the ability for workers to record when they have face-to-face contact with their children in care;

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- a trigger for workers when certain conditions occur in their cases. This trigger is known as a File Action Required (FAR) warning. A FAR will occur in the following system determined circumstances: multiple placements, maltreatment, face-to-face visits, unplanned absence, recurrence of service, worker determination; suicide ideation and sexual exploitation; and other.

The flags in CFSIS will address some of the issues related to compliance. The automated risk warnings will cause warnings to be delivered to a worker and supervisor by e-mail on an overnight basis when certain conditions are met within a CFSIS record. The warnings are based on information that is recorded within CFSIS that represent a condition of increased risk to a child in care.

The risk conditions include:

1. 5 or more placements in the last 12 months;
2. 8 or more placements since case first opened;
3. case re-opened 3 or more times in last 12 months;
4. case re-opened 8 or more times since first case opening;
5. alleged victim of abuse;
6. unplanned absence (AWOL);
7. lack of face-to-face visits;
8. sexual exploitations*;
9. suicide ideation*;
10. other*.

*Worker determined – not automated.

When the warning is received by e-mail, the worker is able to confirm or dismiss the warning. The worker is also able to escalate the warning to agency and Authority management. The automated risk warnings provide an early alert to a worker and supervisor, as well as provide a frontline capability to raise the issue to agency and Authority management. Following a warning, the worker and supervisor develop a plan to remedy the condition that created the risk. The worker implements the plan and records the actions within the risk warning part of CFSIS. When the risk is diminished, the worker will close the warning.

In 2008/09, focus has shifted from developing enhancements for CFSIS to looking at rebuilding the system. To that end, a project team was struck called "Information Matters". The Information Matters Project (IMP) team conducting this research was comprised of various child welfare staff from agencies, Authorities and Family Services and Housing, as well as individuals from IBM Canada, who supplied expert consultation in business analysis, change management and information technology assessment.

The consultation helped to answer the question how a modern, computerized case management application could ease the administrative burden on workers while providing better and more timely information and enhancing safety for children.

As the system prepares for the next phase of work to be done in 2009/10, IMP began its inter-phase work in November 2008. The goals of this period were to support the Child and Family Services Authorities to understand the range of findings from the initial phase and to support the Authorities to undertake the appropriate readiness and/or early start activities that focus on work process improvement.

Presentations were made to Standing Committee illustrating the work pressures and bottlenecks that are foremost in the minds of front-line workers and making recommendations identified through the Business Change Impact Assessment, which identified system-level process changes that cross authority boundaries and have the potential to offer benefits to all Authorities.

It is anticipated that the formal process of selecting a new computer system will be completed in 2009/10.

OUR COMMENT

The enhancements that have been and continue to be implemented in CFSIS have focused on ease of use, broader accessibility, and reducing risk to children. However, the benefit of the system in reducing the risk to children will not be realized until all agencies are actively using the system. At the time of our review these issues were raised frequently in our discussions with front line staff regarding the use of CFSIS.

It is our understanding that the majority of connectivity problems with CFSIS have been addressed. Some agencies which were previously not using CFSIS at all are now fully utilizing the database. It needs to be appreciated that connectivity issues relate not only to

the ability of workers to input data to the system, but of critical importance, is the need of every worker to be able to retrieve information in a timely manner from the system to deal with child protection issues.

We were advised that the federal government has never funded Information Technology in First Nations communities and therefore there is still one computer per site as provided by the province. This means that there may be one computer available for up to eight staff in some sites.

Another issue that needs to be resolved is the ratio of support resources to users. Although the number of CFSIS/Intake users has increased the level of support resources have not. As well, there is currently only one CFSIS/Intake trainer who is available to train all new users province-wide who is unable to meet the current demands for training.

Status

Ongoing

8. AUTHORITY DETERMINATION PROTOCOL (ADP)

The Child and Family Services Authorities Regulation (M.R. 183 / 2003 – Part 2) requires that the Authority Determination Protocol (ADP) be completed for every family or person that requires child and family services.

The "authority determination protocol" is a tool that is to be used by a designated intake agency to determine the culturally appropriate Authority and the Authority of service for a person or family. The adult member(s) of the family may choose the culturally appropriate Authority or any other Authority. Only one Authority may be chosen by a family. Exceptions to this are minor persons who are receiving or about to receive Expectant Parent Services, or minor persons who are living in independent living arrangements established and monitored by a child and family service agency.

The ADP is normally completed by way of a face-to-face interview(s) with the adult member(s) of the family. The views of children 12 years of age and older must be considered as part of the interview. The views of children under the age of 12 years may be considered depending upon the maturity and understanding of the child.

The ADP serves to identify the:

1. Culturally Appropriate Authority (CAA) – this is the Authority that most closely matches the cultures of origin of members of the family;

2. Authority of Service – this is the Authority that the adult members of the family actually choose to provide service to them. The Authority of Service may be the CAA or any other Authority.

It is important to understand that the family chooses the Authority of Service but it is this Authority that determines which of the agencies under its jurisdiction will deliver services to the family.

Sometimes, an authority will have a service arrangement with another authority to provide service on its behalf. For example, the General Authority has service arrangements with First Nations Authorities to provide service on its behalf to families that choose the General Authority and reside in First Nations communities. Any time such a service arrangement is in place, the worker is required to inform the adult members of the family about that service

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In most cases, workers at the intake level complete the ADP form with the family at the time that the children have been apprehended by the agency. The Authorities are responsible through their agencies to provide information to families to allow them to make an informed choice regarding the appropriate Authority.

We found that families were expected to make this choice, often based on limited information. Families were not provided with information about the services provided by the agencies within the Authority. In most instances, the intake workers who were providing information to the families did not know what services were available from the agencies providing ongoing service delivery.

Workers reported that completing the ADP form was a time consuming process, the use of which was often misunderstood by families. Subsequently, we recommended that the ADP process be streamlined to the extent possible and be written in language that is easy to understand.

We felt that the ADP process should be completed by staff other than front line workers in order to reduce the administrative functions performed by them.

We also recommended that the ADP process be evaluated to determine how choice can effectively be offered to every family in situations where only one agency provides service.

We were advised that child and family services workers would continue to fulfill this responsibility because it is felt that this is a key part of the intake process and it is important that it be the front line workers that are completing the ADP with the family.

The current Authority Determination Protocol Field Guide remains in draft form from June 2007, and is available to staff as the operational guide to complete the ADP forms. This guide has undergone significant changes.

We have been advised that Standing Committee continues to prioritize the approval of this guide and has sought feedback from their agencies on how best to incorporate this in a final version. We have also been informed that training is now being prioritized by way of an inter-Authority group, with focus on the application of the ADP as well as further interpretations on the draft guide.

Standing Committee has committed to the review of the solicited feedback from staff and will develop a finalized working document within this year.

Our Comment

The June 2007 Field Guide refers to the definition of "choice" as it relates to the ADP process as the following: "The ADP determines which child and family service authority is the most culturally appropriate for a family or person. The adult members of the family or person may choose the culturally appropriate authority or any other authority". It then states that it is important to understand that the family chooses the Authority of Service but it is the Authority that determines which of the agencies under its mandate will deliver services to the family or person.

The realities of service delivery in some geographic areas are that some communities only have one agency providing service. The choice that the ADP provides for families residing in a remote community is somewhat of an illusion. The client can choose which Authority will oversee the services an agency provides to the family. However, the direct service is still provided by the agency located in that community, which may be mandated by a different Authority.

While this process offers a choice of Authority, the reality for families and the service delivery provided by the front line is that the process may not produce the anticipated result, or take into consideration the actual significance of that choice, for the family. Many families do not comprehend the differences between and implications of choosing one authority over the other. In 2006 we found that when this question was posed to staff, they were unable to provide a response.

The Child Welfare System has not accepted our recommendation that the ADP be completed by staff other than front line staff (Intake). Given that, it is even more important to address the questions and concerns that have been raised by front line staff and provide an appropriate guide to the ADP that is easy to use and easy to comprehend.

Given the format and language of the current draft guide which is 65 pages long, it may not be as helpful as the frontline workers would like.

We have since been informed that the Authority Determination Protocol Guide has been rewritten in plain language style and was reviewed by legal counsel. As well, it was reported that the protocol can be found in the standards manual and an existing Authority Determination Protocol (ADP) pamphlet for families is in the process of being updated.

Pending receipt of the most current revised version and accompanying pamphlet, our review of the June 2007 draft finds that this document does not fully address the concerns that were initially posed by our office and therefore, does not achieve all of the recommendations outlined by the formal review.

We await the completion of ADP process training for staff, as well as the revision, finalization and approval of the ADP Field Guide by the Standing Committee.

Status

In progress

9. DESIGNATED INTAKE AGENCIES

The *Child and Family Services Authorities Act* introduced a new system for intake, which requires the Authorities to jointly designate an agency to provide intake and emergency services by geographic region (excluding on First Nation communities). There are thirteen Designated Intake Agencies (DIAs) providing this first level of contact for child welfare services in the province, outside Winnipeg. They are:

FIRST NATIONS OF NORTHERN MANITOBA CHILD AND FAMILY SERVICES AUTHORITY

Cree Nation Child and Family Caring Agency
Head Office: Opaskwayak (DIA Area 5)

Kinosao Sipi Minisowin Agency
Head Office: Norway House (DIA Area 7)

Nisichawayasihk Cree Nation Family and Community Wellness Centre
Head Office: Nelson House (DIA Area 9)

FIRST NATIONS OF SOUTHERN MANITOBA CHILD AND FAMILY SERVICES AUTHORITY

Anishinaabe Child and Family Services
Head Office: Fairford (DIA Area 1)

Peguis Child and Family Services
Head Office: Peguis (DIA Area 10)

Intertribal Child and Family Services
Head Office: Koostatak (DIA Area 6)

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GENERAL CHILD AND FAMILY SERVICES AUTHORITY

Child and Family Services of Western Manitoba
Head Office: Brandon (DIA Area 3)

Child and Family Services of Central Manitoba
Head Office: Portage La Prairie (DIA Area 2)

Rural and Northern Services – Eastman
Head Office: Beausejour (DIA Area 11)

Churchill Child and Family Services:
Head Office: Churchill Regional Health Authority (DIA Area 4)

Rural and Northern Services – Interlake
Head Office: Selkirk (DIA Area 12)

Rural and Northern Services – Northern
Sub-Office: Flin Flon (DIA Area 13)

MÉTIS CHILD AND FAMILY SERVICES AUTHORITY

Métis Child, Family and Community Services
Sub-Office: Dauphin (DIA Area 8)

The Joint Intake and Emergency Services by Designated Agencies Regulation outlines the role and responsibility of the DIAs. The DIAs must provide twenty-four hour intake and emergency services and respond to all referrals or requests for service on a timely basis. In addition, the DIAs must provide child protection services and assess the need for ongoing services.

If a DIA determines that ongoing services are required, it must determine which Authority will be responsible for providing those services in accordance with the ADP and transfer the file to the appropriate agency for ongoing services.

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In the course of our review, we noted that there was a general lack of collaboration and communication among the DIAs and the agencies they serve across the province. In order to provide seamless service delivery to families, there needed to be clear communication, clarification of roles, and compliance with standards as the DIAs transfer service to other agencies.

Accordingly, we recommended that DIA steering committees be established in each region as forums to address service issues of mutual concern, to share information, to collaborate on resources and to promote seamless service delivery among the DIAs and the agencies with which they interact.

Last year we were told that there was an active steering committee in the following DIAs:
- CFS Western
- CFS Central
- Métis Child, Family and Community Services
- All Nations Coordinated Response Network (ANCR)
- Anishinaabe CFS
- Intertribal CFS
- Peguis CFS
- Rural and Northern Services – Interlake

We were also advised that in the following DIAs, a steering committee was in place at the time the DIA was established, but the steering committee was in the process of redevelopment or there are other forums for discussion between the DIA and the other mandated agencies in the area:
- Churchill CFS
- Cree Nation CFS
- Kinaso Sipi Minisowin Agency
- Nisichawaysihk Cree Nation
- Rural and Northern Services - Eastman
- Rural and Northern Services – Northern

In areas where there are no formal Steering Committees in place, we were advised that the DIAs actively work with collateral service providers as required. Working groups are established to address issues as needed.

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Regarding First Nations Child and Family Services agencies, most First Nations communities have local child care committees in place that perform a similar function as a formal steering committee.

This year we were advised that the DIAs of Anishinaabe Child and Family Services, Peguis Child and Family Services, Intertribal Child and Family Services, and Rural and Northern Services – Interlake are part of the same steering committee; however not all these DIAs have actively participated in the past year. The steering committee meets quarterly and has a goal this year of achieving full participation of all its members.

Cree Nation Child and Family Caring Agency and Nisichawayasihk Cree Nation Family and Community Wellness Center now have active steering committees. Kinasao Sipi Minisowin Agency has a local child care committee that meets monthly as needed.

Child and Family Services of Central Manitoba's steering committee has been inactive since June 23, 2008 due to numerous staff changes. They hope to resume regular meetings now that staffing has been stabilized. Churchill Child and Family Services' steering function is carried out through a local child care committee. Rural and Northern Services – Eastman does not have a formal steering committee. It works with collateral service providers as required. Rural and Northern Services – Flin Flon office had their first formal steering committee meeting in June 2009.

Child and Family Services of Western Manitoba, Métis Child, Family and Community Services and the All Nations Coordinated Response Network all continue to have active steering committees. As well the DIAs in First Nations Communities continue to utilize their child care committees to fulfill the steering committee function.

In our 2006 report we had recommended that adequate funding be made available for increased emergency care resources outside the city of Winnipeg, and that these resources be accessible to each DIA.

We are advised that this recommendation is being addressed through:

- The creation of Foster Care Teams;
- The allocation of additional funding.

We had recommended that the DIA after-hours system in the various geographical regions operate with a full complement of staff who are not already employed in social work positions during the day, regardless of whether After Hours operates on an on-call basis or as an operational unit.

We are advised that the Child Protection Branch completed a DIA volume review as the basis for the distribution of the balance of workload relief funds. In 2008/09, $1,902,100 was allocated for workload relief in the designated intake agencies. The $1.9 million was distributed to the various designated intake agencies, including ANCR, the Winnipeg intake agency, through a formula that takes into account the original resource transfers and utilizing costs associated with Crisis Response Unit, Tier 1 & 2 Intake of the ANCR budget, the intake caseloads of the designated intake agencies, and also recognizes higher travel costs in rural and northern Manitoba.

There have been 103.5 positions for workload relief added to the system since 2006. Of those, 41 positions were given to agencies that also have the designated intake function for their region. Of those 41 positions, 24.15 were specifically assigned to intake activities as follows:

Authority	Totals
Northern First Nations Authority	**0**
Cree Nations	0
KSMA	0
Southern First Nations Authority	**12**
ANCR	12
Annishinaabe	0
Peguis	0
Intertribal	0
Métis Authority	**2**
Métis CFS	2
General Authority	**10.15**
CFS - Central Manitoba	1
CFS - Western Manitoba	3.65
Northern Region	1.5
Interlake Region	2.5
Eastman Region	1.5
DIA Workload Relief Total	**24.15**

We were also informed that in March 2009, a proposal for the review of After Hours service provision by mandated agencies was submitted to Standing Committee. The broad objectives of the proposed review are to:

1) quantify the concerns raised in current service provision;
2) conduct an analysis of the existing situation; and
3) identify effective and manageable solutions.

We had recommended that the DIA functions outside Winnipeg and in First Nations communities, be adequately funded to allow for the delivery of the range of support and preventative services prescribed under legislation.

We are advised that this recommendation is being addressed through a variety of avenues. Additional Workload Relief funds were provided to DIAs to hire additional staff, combined with the planning and implementation of a differential response (DR) model in Manitoba which is occurring in three phases. The provincial funding model review work currently underway and the INAC Prevention Focus funding model are also addressing this recommendation.

It is also our understanding that funding to DIAs will form the second phase of the new provincial funding model which is scheduled to begin in 2009/10. In addition, the Federal Prevention funding model has been completed by INAC in consultation with the Authorities, agencies and the Province. We are advised that the federal funding model will provide an additional $21 million in funding to First Nations agencies for prevention services which will act as a resource to families regardless of stage or level of service received.

We were informed by Standing Committee that the Federal Government still does not provide funding for intake on First Nations communities. It is the view of Standing Committee that the Province should fund intake services on First Nations and seek reimbursement from the Federal Government, consistent with Jordan's Principle.

Our Comment

We have not as yet followed up with DIAs on the implementation of the recommendations and the impact on service delivery. Based on the information obtained it is unclear how this recommendation is being met in the DIAs that did not receive any additional staff.

SC has advised that the review of afterhours service provision has been scheduled to commence in fall 2009 and will be undertaken only in the General Authority for its five DIAs.

Phase 2 of Differential Response (DR) comprising Authority specific planning for DR implementation within their respective structures and the development of submissions for planning/development and test/demonstration approaches and sites within a general framework has occurred. The Authority submissions for Phase 2 are comprised of demonstration sites which included a mix of service environments, i.e. DIA and ongoing service agencies.

The effects Differential Response will have on service delivery are also yet to be seen. However, we have been advised that an additional 60 positions were created through increased funding for Differential Response. These positions include a mixture of front line, service assistants, community workers and support staff.

Status

Ongoing

7353

10. ALL NATIONS COORDINATED RESPONSE NETWORK (ANCR)

The intake units across the province are the "front door" to service and their efficient functioning is critical to the child welfare system. In 2005, the Joint Intake Response Unit (JIRU) was established as the primary first point of contact with the child and family services system in Winnipeg.

In February 2007, ANCR(formerly JIRU) was mandated by the First Nations of Southern Manitoba Child and Family Services Authority (Southern Authority). As part of the process for becoming mandated, the agency underwent a complete mandate review of all of its programs and services. One of the recommendations from this review was to have a follow-up review completed to examine the service model of the agency.

Every month, ANCR receives approximately 1200 requests for service to children and families in Winnipeg as the first level of contact for child welfare services in the city. Where there is a need for longer term services for families or there are child protection concerns, ANCR completes the Authority Determination Protocol (ADP) in preparation for transfer of service to one of seventeen different agencies which serve families in Winnipeg.

We have set out ANCR as a topic in this report because of its central importance to multiple agencies providing service in Winnipeg, but also because we were advised by Standing Committee that our review recommendations had been implemented as of ANCR's "live" date in February 2007. It had been our plan to return to ANCR in 2008 to meet with staff to confirm that the intent of our recommendations had been met, based on the actions taken to date.

Our follow-up with the staff of ANCR in 2008 did not occur as we were made aware of a number of specific complaints the Department and the Southern Authority had received with respect to ANCR.

We were advised that the Southern Authority and the Child Protection Branch were proceeding with a comprehensive Quality Assurance Review. We were also informed that the concerns raised would be addressed as one component of the Quality Assurance Review.

As well a number of the Children's Advocate child death review reports had recommendations related to ANCR. One of the recommendations in particular was that there be a comprehensive review of ANCR that includes (but is not limited to) a review of the Agency's funding, workloads, organizational structure and case management practises.

We were advised that a review of the agency's service model, and a human resource audit was planned that would focus on the following three main areas:

- An employee survey to identify and confirm issues and develop recommendations for resolution.
- Recruitment and selection audit to look at selection processes and hiring practices.
- HR Policy Manual review which will include recommendations for improvements.

The Quality Service Review that was planned had three main objectives:

1. To conduct a comprehensive review and assessment of the service functions at ANCR that are delivered by After Hours Unit (AHU); Crisis Response Unit (CRU); Tier 2 Intake; Abuse Services Unit (ASU); and Family Enhancement Unit (FEU).

   Focus was to be on: volume, management, and effectiveness of service delivery within each unit; quality of assessments conducted; and decisions made in regard to closure or transfer of cases both within ANCR and to other agencies.

   The plan was to assess for: service quality and effectiveness in relation to the Operational Plan and in relation to relevant program standards and regulations.

2. Review and assessment of the service relationship between ANCR and its receiving agencies and the effectiveness of the case transfer process.

   Focus was to be on: review of case transfers including length of time to transfer cases to other agencies; quality of documentation in transfer summaries; effectiveness of transfer process in relation to standards and regulations; and communication between ANCR and designated receiving agencies.

3. Report document containing analysis of current services at ANCR and key recommendations for service improvement.

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Our Comment

When concerns or complaints are raised, it has been our practice to give the department or agency involved the opportunity to review the concerns and take whatever action it deems appropriate based on its findings. Given the intention of the Branch and Southern Authority to conduct two in depth reviews at ANCR we determined that it would be more appropriate for our office to monitor the results of those reviews and the implementation of any recommendations made. As of March 31, 2009, we were waiting for the outcome of these reviews.

Once the reviews are completed we will follow-up on the recommendations made to ensure that the concerns that had been raised were in fact addressed. As well based on this follow-up we hope to determine if the intent of the recommendations made in our report *Strengthen the Commitment* regarding ANCR have in fact been met.

Status

Dependent on Other Action

CONCLUSION

The Child Welfare System is attempting to establish a process to ensure that all recommendations made and directed to the child welfare system are followed up on and the identified issues are addressed.

Some basic issues identified in our 2006 report have not yet been resolved and implemented throughout the system. Responses to issues identified seem to be moving more slowly than we had anticipated. Recent reports from the Children's Advocate have identified issues and reiterated recommendations made in the past.

We will continue to monitor the progress of administrative improvement of the child welfare system in conjunction with our follow-up on the child death review recommendations made by the Children's Advocate.

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