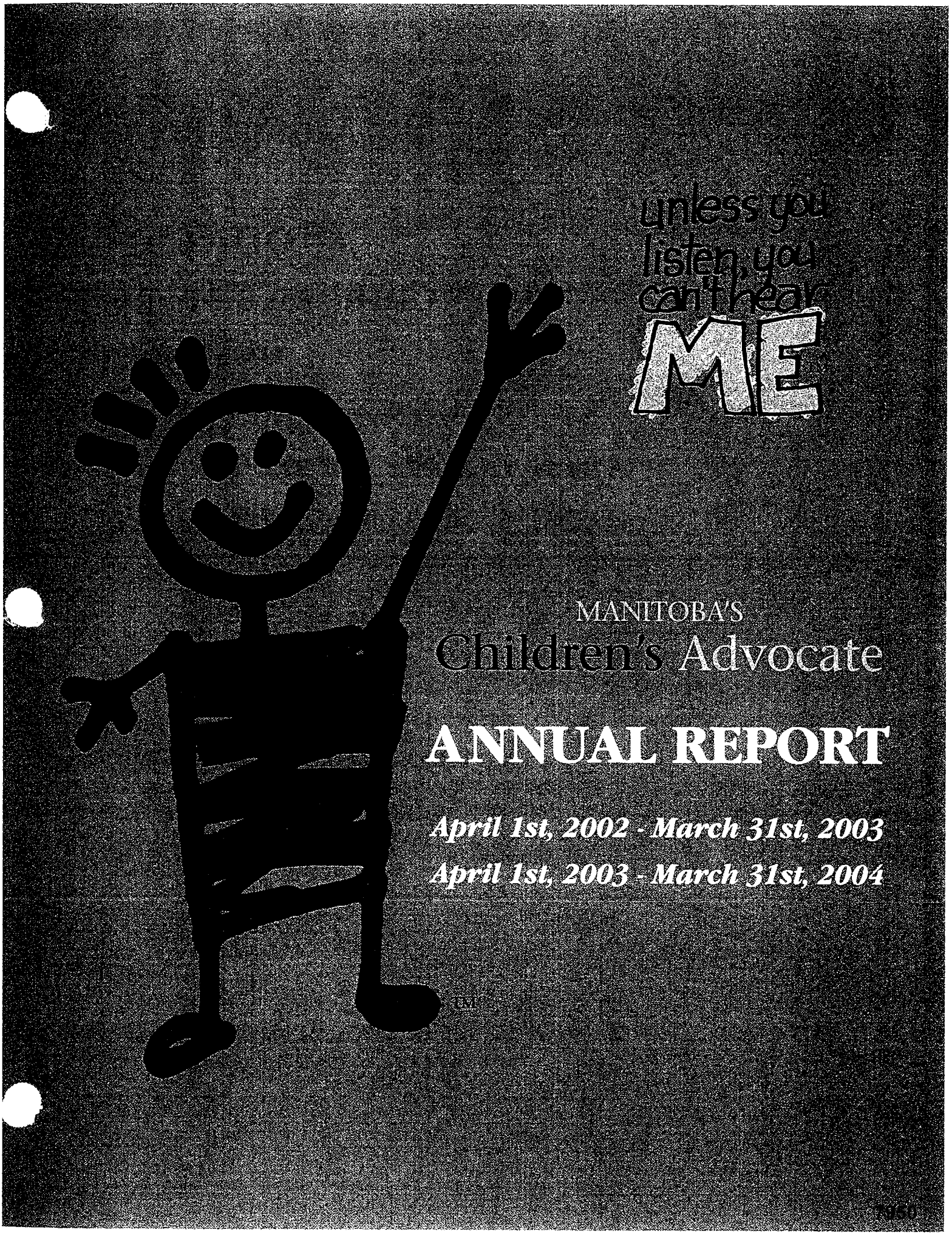
COMMISSION OF INQUIRY INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF PHOENIX SINCLAIR

Commission Disclosure 0218



MANITOBA'S

Children's Advocate

ANNUAL REPORT

April 1st, 2002 - March 31st, 2003

April 1st, 2003 - March 31st, 2004

Annual Reports of the Office of the Children's Advocate of Manitoba

April 1, 2002 - March 31, 2003
April 1, 2003 - March 31, 2004

The Office of the Children's Advocate
102 - 500 Portage Avenue
Colony Square
Winnipeg, Manitoba
R3C 3X1

Phone: (204) 945-1364
Toll Free: 1-800-263-7146
Fax: (204) 948-2278

www.childrensadvocate.mb.ca

The History and Role of the Children's Advocate in Manitoba

The Office of the Children's Advocate (OCA) was created under *The Child and Family Services Act* and proclaimed April 1, 1993. The office operated under the umbrella of the Department of Family Services and the Children's Advocate reported to the Minister of Family Services. In 1996, consistent with legislative requirements, an all-party committee was established to conduct a review of the office with public hearings commencing in May 1997.

On March 15, 1999, in response to recommendations arising from the review, the Office of the Children's Advocate became an independent office of the Legislative Assembly. It currently operates in an arm's length relationship with the child and family services system. It exists to represent the rights, interests and viewpoints of children and youth who are receiving, or entitled to receive, services as prescribed under *The Child and Family Services Act* and *The Adoption Act*. The Children's Advocate is empowered to review, investigate and provide recommendations on matters relating to the welfare and interests of these children. The Children's Advocate prepares and submits annual reports to the Speaker of the Legislative Assembly.

On March 29, 1999, the Lieutenant Governor in Council appointed Janet Mirwaldt as the Children's Advocate on the recommendation of the Standing Committee of the Assembly on Privileges and Elections. Ms. Mirwaldt was re-appointed on March 29, 2002. Her second and final term as Children's Advocate will end on March 29, 2005.

The Importance of Having an Independent Children's Advocate

Advocates challenge the system. They point out current practices, policies or legislation that are not meeting needs and expectations. Advocates work for change ... and change is not always easy for people to accept. Advocacy can create tension, but can improve the system.

Children especially need advocates. They cannot vote. They live in a world where adults make decisions about their lives. They have a voice but they have virtually no legal power to make anyone listen to that voice. Our experiences speaking with children and youth in the child and family services system have shown us they often feel they have no say in what happens to them.

Our mission is to animate their voices and ensure their rights, interests and viewpoints are valued, respected and protected. Our advocacy efforts and services are child-centred, family-oriented and anchored in the community. They are delivered in an ethical, culturally sensitive and respectful manner.

"What's the dilly-yo?
I am sitting here makin' some dough,
When I get on the streets that's when I do my duty-o.
When I first got busted,
My family said I couldn't be trusted.
So I called the Child's Advocate,
And they told my family that I was just a kid.
They also told them it was my last chance
To prove I could dance."

Youth, age 14

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A Message from the Children's Advocate

In accordance with Section 8.2 (1)(d) of *The Child and Family Services Act*, I respectfully submit this document as my annual reports for the fiscal years April 1, 2002 to March 31, 2003 and April 1, 2003 to March 31, 2004.

The two-year period covered by this report has been punctuated by a number of very complex and lengthy reviews. These included a review of allegations that local CFS staff detained several youth in RCMP cells in Pauingassi. At the request of the Minister of Family Services and Housing, we also completed an operational review of Winnipeg Child and Family shelter system. Highlights of both reviews are contained in this document.

While it was necessary and appropriate to complete the two systemic reviews, our experience in completing these projects demonstrated that special measures must be put in place to provide the OCA with additional resources. These resources are needed to meet the demands associated with producing in-depth reviews and reports, while maintaining a high quality of service in our case work. As our efforts are always child and youth focused in the OCA, systemic projects stop when any young person needs our immediate help on individual issues.

Completing these reviews in addition to handling our burgeoning caseloads has taken a great deal of time, effort and dedication on behalf of all members of the Office of the Children's Advocate (OCA). I would like to publicly commend and thank the OCA staff for their outstanding commitment to the children, youth and families we serve.

Requests for our services over the last two years has increased by 53 per cent and with only eight staff we are challenged every day to meet the needs of those we serve quickly and efficiently.

Given increasing requests for our services, we had to make a number of changes to the way that the OCA assessed advocacy service requests and opened cases. In order to prevent the growth of waiting lists for advocacy services, members of this office have made a concerted effort to focus on cases that clearly fall within our mandate and had a direct connection to a CFS agency.

Where possible, we have encouraged the use of alternate avenues to settle disputes by helping children, youth and family to access existing grievance procedures, and to use natural advocates within the community. As a result we are finding there is now a wider awareness of available options when seeking resolution to disputes with child caring agencies. Before contacting the OCA, many individuals were unaware of their rights and once they have the information to self-advocate they feel empowered to address their concerns with agencies and or government departments.

Another area of concern that we have noted over the last few years is that agencies and departments can ignore any recommendation made by the Children's Advocate because the OCA has no ability to enforce recommendations or even require a response from those cited. For example, while the Minister of Family Services and Housing announced an action plan within days of receiving our Shelter Review and its 70-plus recommendations, we have had no response to recommendations we made in the Pauingassi Review.

There is no mechanism for the Children's Advocate to publicly report these problems other than by highlighting them in an Annual Report. Given the challenges and workloads within

the OCA, releasing an annual report in a timely manner is virtually impossible. It would be far more beneficial to children and youth if the Children's Advocate was provided with the opportunity to publicly report on important issues that, in the Advocate's view, can not wait to be publicly released in the annual report.

Having cited the challenges of follow-up with agencies and CFS regional offices, it is also important to note that we have noticed an improving relationship with many of those involved in providing child and family services in resolving complaints and issues. We have noted that in many cases there is a freer flow of information with agencies and with the Department of Family Services and Housing. This enhanced level of co-operation can only serve to benefit the children and youth in the child and family services system that we all serve.

With the formal creation of the four new child and family services authorities on November 24, 2003, planning continues on the overall restructuring of the child and family services system throughout the province. We would hope the environment of co-operation continues to grow, and that all parties involved put the best interests of children and youth at the forefront of our dealings. The role of the OCA in the new system has remained unchanged and we look forward to working with the new authorities.

Janet Mirwaldt
Children's Advocate

An Overview of the Initiatives and Activities Undertaken by the Office of the Children's Advocate

Fiscal Year 2002 - 2003

OCA Advocacy Officer Wins A National Award for Children's Services

Terri Hammerback, an Advocacy Officer in the Office of Manitoba's Children's Advocate, received the Children Welfare League of Canada's Outstanding Achievement Award for Children's Services. The national award recognizes individuals who have demonstrated exceptional commitment, creativity and dedication in their direct work with children, youth and families in the child welfare system. Mrs. Hammerback has been with the OCA since 1993.

The Children's Advocate, Janet Mirwaldt was invited to be a part of the Steering Committee for Turnabout.

Turnabout standardizes the way police, workers in the child welfare system and the community deal with children too young to be charged for acts that could otherwise be dealt with in the justice system. Incidents were previously dealt with on a case-by-case basis. This project tracks contacts with police and collect data that provincial agencies and community groups can use to better plan and deliver services to children. Referrals are made to help children in trouble.

Turnabout's goals:

- To prevent a child from having further police involvement, either as a child, youth or adult.
- To identify as early as possible children who are demonstrating serious and persistent behaviour, and arrange for them to receive the appropriate services.
- To reduce the number of children under 12 coming into conflict with police.

Manitoba's Children's Advocate, Janet Mirwaldt Was Appointed President of the Canadian Council of Provincial Child and Youth Advocates in October 2002

Though having varying mandates, the provincial advocates who make up the council are united in striving to ensure that children are treated equally and with tolerance, dignity and respect within our communities and in government, practice and legislation. The council provides an opportunity to focus attention on issues that transcend individual provincial jurisdictions.

The Call Management Database System Became Operational in December 2002

In December 2002, the OCA instituted a Call Management system, which allowed us to create and manage a waiting list. Though we would like to respond to all cases immediately, this is not always possible, given our resources and the demand for advocacy services.

Our waiting list averages about 20 cases a day. These individuals are waiting for the OCA to determine if they can or will receive advocacy services from our office. Calls and contacts coming directly from children and youth receive immediate responses.

Should an individual or family require advocacy services they are moved to Intake who screen their case again. Only those who have a direct involvement with the CFS system or who have been recently refused CFS services, or present issues likely to require CFS services are moved to this level.

Pauingassi Report

The OCA was contacted on December 18, 2002 regarding incidents involving Southeast Child and Family Services staff detaining several children in the local RCMP cells that they believed were under the influence of solvent. The results of our review and recommendations were submitted to the Executive Director of Southeast Child and Family Services and the Director, Service Delivery Compliance, Department of Family Services and Housing on October 15, 2003. A condensed version of the review follows:

Pauingassi Report

The OCA was contacted on December 18, 2002 regarding alleged incidents involving Southeast Child and Family Services (SECFS) staff detaining several children in the local RCMP cells that they believed were under the influence of solvents and at risk for self-harm, in July and August 2002.

The SECFS supervisor explained to investigators that her actions and directions to staff were in the hope of protecting the children from self-harm and possibly suicide.

The RCMP and Department of Family Services and Housing (DFSH) had both conducted reviews of this incident before the review by the OCA. No criminal charges followed from either review. The use of RCMP cells for detaining children under the influence of solvents was immediately discontinued.

The OCA investigation into this matter identified a number of issues, including a reportedly high degree of solvent abuse in the community; a lack of community resources available to assist SECFS staff; the questionable manner in which the agency made case decisions and file recordings; and an apparent inability for the community, agency and other organizations to tackle these issues.

Community Profile and the Response to the Solvent Abuse Issue

This office received statistics from the local child and family services supervisor in Pauingassi. The current population (at the time of writing the report) of Pauingassi is estimated to be 500 people. Three hundred are youth under the age of 18. SECFS agency staff reported to the OCA that they believe a high number of the youth abuse solvents (sniff). The unemployment rate is consistently between 85 and 90 per cent. There is an average of 10 reported suicides each year, but no estimate is available on the number of suicide attempts that are not reported. It has been reported that children as young as 10 years old have attempted suicide.

There are no outside service providers in the community. When the OCA staff visited this community nurses no longer resided in the community, having cited safety concerns. There is only one Community Health Representative (CHR) to take care of first aid concerns. It was reported that the CHR has no ability to assess or respond to suicide attempts. The RCMP has a limited presence in the community, with no permanent detachment in the community.

Poverty and widespread substance abuse affect the community of Pauingassi. The current trend of suicide and attempted suicide largely depicts a generation of lost children with no other means of escaping the harsh realities of their environment. It would appear that many people in the community see solvent abusers as part of a generation of youth whose parents themselves have been ravaged by the effects of alcohol, poverty and unemployment. The harsh conditions to which children and families have been exposed leave people with a heavy feeling of hopelessness and despair.

In an attempt to deal with these demons, many children have turned to sniffing gas and/or solvents as a means of escape.

The community of Pauingassi is now faced with a situation where it is dealing with multi-generational addictions. Mainstream society has seen the effects of alcohol on newborn children, commonly known as FAS (Fetal Alcohol Syndrome) babies. In Pauingassi the community is now faced with dealing with a syndrome unknown to mainstream society - FSS (Fetal Solvent Syndrome) babies.

The community of Pauingassi employs three local residents as Band Constables. SECFS staff informed the OCA that children using or under the influence of solvents are turned over to the SECFS staff by the local Band Constables. We have been informed that the local SECFS office and staff do not have the resources or training to deal with the solvent abuse which they described as epidemic in the community.

The approach commonly used by the SECFS staff was to bring the children into the office and attempt to keep them safe. In cases where they assessed the youth to be at risk of self-harm or harm to others, SECFS used local RCMP cells to detain them. The children were held there until they were no longer at risk.

The current SECFS supervisor in the community was asked what they do with children brought to their attention who are under the influence of solvents now that they cannot use the RCMP cells. She stated that there isn't anything they can do or anywhere children can be detained in the community, leaving SECFS with few, if any, options to help. She asked bluntly:

> *"What do you want me to do with the sniffers? There are no resources in the community capable of dealing with or containing the sniffers in the community."*

History of CFS Involvement with the Children

Three of the children from the two reported incidents had previous CFS involvement. We found that records pertaining to these children were generally inadequate and lacked detail regarding areas like case reviews and planning objectives. Supporting documentation such as medical and police reports were not consistently on file. The poor quality of the files raised a number of questions around the value the agency and staff placed on detailing case matters and having documentation monitored, supervised and used as a basis for measuring case progress and/or accountability. This issue was particularly troubling, since all three children had chronic solvent abuse problems and one had a history of suicide attempts.

What was also apparent to the OCA was that the agency lacked an understanding of the standards of care outlined by the DFSH-Child Protection and Support Branch and they did not comply with those standards. As reported by DFSH, the SECFS agency director had not reported the actions of her staff to the Support Branch until September 23, 2002 weeks after the incidents in question took place. The DFSH believed the agency director's response was delayed and not in compliance with provincial standards.

In response to the DFSH report SECFS acknowledged that the incident occurred and committed to a series of corrective measures including the suspension of the three staff members involved. The supervisor was reassigned to a front line position and the other two staff were placed on probation. Additional staff training was also provided. The agency stated that the three staff involved "must attend to the community and make whatever reparations are considered appropriate by the community and the Agency. In this respect, we understand that unconditional apologies to the youth, their families and the community were expected."[1] SECFS further committed to a file audit with "particular attention paid to Pauingassi to ensure proper file management and that provincial standards were being met".[2]

Five months after SECFS undertook these commitments family members informed the OCA that no one from the agency has spoken to them. No one has apologized and apparently the continued assignment of one of the staff to the community was questioned.

Our review of the files in question has shown little adherence to provincial standards. Beyond the failure to document the individual CFS issues when dealing with the involved children, the agency appears to have no ability to track the incidence and prevalence of solvent abuse in the population they serve.

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[1]SECFS correspondence dated December 16, 2002 to DFSH
[2]Ibid

Viewpoints

Some of the parents and guardians spoke to the OCA about their perceptions, feelings and concerns regarding the incidents in question. For the most part they were glad that the incidents were being addressed, but not satisfied with the way the agency had handled the matter. The continued assignment of one of the staff to the community was questioned. There was no explanation or apology from the agency for the manner in which the children had been treated, nor did the agency's response to the incidents seem to go far enough in assisting in the healing process that should have followed. It was hoped "something good would come out of what happened that night" that would benefit the children of Pauingassi.

Resource Issues

If the parents, extended family and community are unable to care for the children, it falls to SECFS and to collateral resources to work with the community to develop services that can assist families. The primary difficulty in this case is that the collaterals have left and SECFS alone now holds primary responsibility. The small team assigned to work in Pauingassi has no resources to assist in the onerous tasks relating to child protection and the substance abuse issue.

"I am not prepared to chase a bunch of sniffers through the bush" appears to be the attitude adopted by those responsible to respond to the crisis in Pauingassi. If a concerted effort to change this attitude is not made, nothing much will change for the community, the children and their families. It cannot be left to any one individual, agency or level of government. It will require a determined and co-operative plan to begin to find the solutions required. It begins, however, by providing the resources and support to deal with the immediate crisis.

SECFS provides child and family services on reserve as delegated under provincial legislation (*The Child and Family Services Act*) but is funded to do so by the Federal Government through the Department of Indian and Northern Affairs. The matter of federal funding is a complicated process that the OCA will not review in detail in this report. However, the expectation of the national funding criteria known as Directive 20-1 requires that First Nations agencies such as SECFS provide a comparable but not necessarily equivalent range of services on reserve as provided by the mainstream provincial child and family services system in "similar circumstances".[3]

The Directive has two basic components that determine funding for a First Nations agency CFS service activity. The first is the administration and operational budget line, the calculation of which is primarily influenced by the number of children aged birth to 18 years living on-reserve. The second component provides for the reimbursement of actual maintenance cost of children in care.

However, the funding of First Nations agencies through Directive 20-1 provides the "same level of funding to agencies regardless of how broad, intense or costly, the range of service is."[4] The funding formula does not take into consideration the "very challenging socioeconomic circumstances" that impact on the ability of First Nations Child and Family Services Agencies (FNCFS) to provide a "comparable range of services" as provided by their provincial counterparts. This is particularly true of isolated First Nations communities such as Pauingassi.

FNCFS Agencies have continued to struggle in the face of funding inequalities between FNCFS and provincially funded CFS agencies. A report on First Nations Provincial Funding Issues, which was presented to Joint Management Committee, AJI-CWI stated that:

[3]First Nations Child and Family Services Joint National Policy Review Draft Final Report June 2000, p. 111
[4]First Nations Child and Family Services Joint National Policy Review Draft Final Report June 2000

"The inequities of funding FNCFS agencies have continued for too long. ...There needs to be a commitment to fair funding practices with open communication and co-operation. The government needs to involve the FNCFS agencies in making decisions that will affect them through the AJI-CWI."

Historically there have been reported funding inequities in past provincial funding formulas that have impacted on services provided to First Nations children and families. As pointed out by the AJI-CWI Financial Working Group Financial Report, funding to mainstream agencies provides for Central Support, Services to Communities and Families and Protective Family Services as well as for Children in Care, whereas First Nations Agencies have been funded for Children in Care only.

As the AJI-CWI initiative progresses many of the historical funding issues are to be negotiated by the partners. Timelines are clearly spelled out in the Detailed Implementation Plan, which is ongoing. It is therefore premature to comment upon the outcome of that process.

Children's Rights

During the OCA review of this matter, everyone involved has acknowledged that the events of August 2002 were unacceptable and a violation of the children's' rights and dignity. The Provincial Investigator has already completed a DFSH report and the OCA concurs with her recommendations. SECFS has responded to the DFSH report and has acknowledged that the incidents were unacceptable.

The general response to these incidents has been focussed on the individual wrong done to the involved children and the agency's actions as outlined in the provincial investigator's report. The OCA acknowledges this individual wrong and in no way minimizes the impact of the events.

But what of these children's collective rights to services? The agency contends that a significantly high percentage of the children and youth in Pauingassi are abusing solvents and that there are no resources in the community to help them. The agency contends that they alone are now dealing with the ramifications of this situation, yet they cannot communicate or demonstrate any planned intervention at the community level to deal with these children and their families any differently. While children are not being detained any longer, according to agency staff they are being ignored. This is an unacceptable response. It is as much a violation of their rights to services, as were the events that occurred in the summer of 2002.

Historical and systemic issues paved the way for the events of summer 2002 to occur. These issues require a systemic response. At the same time, the individual actions of agency staff involved in the specific incidents should not be minimized because of the systemic issues. There are internal problems in this agency that cannot and should not be ignored.

Recommendations Made

The following eleven recommendations were made:

1. SECFS should provide detailed and ongoing training to their community workers to enable the staff to successfully interpret the current Child and Family Service legislation, regulations and accompanying standards.

2. SECFS should implement ongoing training with respect to solvent abuse for the staff assigned to Pauingassi and for the Local Childcare Committee (LCC) to better deal with solvent abuse.

3. SECFS should redefine the roles of the LCC by limiting their responsibility for the direction of case planning and shifting it to an advisory role. In addition, SECFS should develop and provide training to the LCC that would enable them to better understand this role.

4. As SECFS is the only visible resource in the community it should take the lead role in developing an integrated service response to children and youth who are abusing solvents with existing community collaterals, NADAP, health, educational and policing authorities. The purpose of such an integrated response would be to share the limited resources of the community, develop responses to children and youth based on assessed needs, to collectively share the responsibility of such services, and foster working relationships between service providers.

5. Though SECFS committed in December 2002 to meet in the community with the children, youth and families affected, the OCA was advised by some of the family members that no one from the agency has met with them. This needs to occur. SECFS must provide therapeutic support and counselling to the youths and their families that were involved in the incidents.

6. SECFS provide therapeutic support and counseling to the youth and their families that were involved in the incident on August 14, 2002 in Pauingassi.

7. SECFS, in co-operation with the Department of Family Services and Housing, must develop procedures for local workers who deal with children under the influence of solvents.

8. The RCMP cells in the community should not be used as a detention unit for youth under the influence of solvents.

9. The Department of Family Services and Housing should conduct a program audit of Southeast Child and Family Services Pauingassi unit, focussing on record keeping, assessments, case planning and more specifically the use of Voluntary Placement Agreements.

10. As stated in the OCA review, the Joint National Policy Review has pointed out the deficits of the Directive 20-1 program. This national review made 17 recommendations. There has been limited progress in implementing these recommendations. Movement in this area would be of assistance to the children and youth of Pauingassi and the agency created to support them.

11. Additional resources are clearly needed in this community to address the problem of solvent abuse. It requires a co-operative effort of all levels of government (Federal, Provincial and Local) to determine the prevalence of the problem and the development of a community solution required to address it.

An Overview of the Initiatives and Activities Undertaken by the Office of the Children's Advocate

Fiscal Year 2003 - 2004

The OCA Gets an Additional Staff Member in 2003.

The Children's Advocate was pleased to receive funding for an additional staff position effective on November 24, 2003.

The Children's Advocate Janet Mirwaldt accepted an invitation to become a member of the Board of Directors of the Child Welfare League of Canada in February 2004.

The Child Welfare League of Canada (CWLC) is a membership-based national organization dedicated to promoting the well being and protection of all children, especially vulnerable children and youth. Member organizations include provincial and territorial ministries of child and family services, child and family service agencies, health and social services and university research units and faculties. CWLC members serve over half a million families each year.

Deputy Children's Advocate Michael Bear became a Member of the Board of the Adoptions Council of Canada in June 2003.

The Adoptions Council of Canada raises public awareness about all aspects of adoption in Canada, promotes placement of waiting children and stresses the importance of post-adoption services.

The Children's Advocate Janet Mirwaldt worked on *Within Our Reach: Preventing Abuse Across the Lifespan.*

Completed in 2004, *Within Our Reach* examines the issues associated with violence and abuse across the lifespan and reviews programs, practices and policies that have been developed to address these issues. Each chapter co-authored by an academic and a community practitioner, addresses specific topics and issues of violence commonly associated within age groups from early childhood to late adulthood. Christine A. Ateah, from the University of Manitoba Faculty of Nursing and the Children's Advocate, Janet Mirwaldt co-edited the 128-page publication.

Within Our Reach: Preventing Abuse Across the Lifespan is the fifth book in the Hurting and Healing series published by Resolve, a tri-provincial prairie research network that co-ordinates and supports research aimed at ending violence and creating partnerships among service agencies, government departments and universities across the prairie provinces.

The Office of the Children's Advocate Enters into Research about Issues affecting Children and Youth in Care.

The OCA has entered into partnership with the Awasis Agency of Northern Manitoba and the University of Manitoba Faculty of Social Work to look at the positive outcomes for children and youth living in care but placed with family, otherwise known as kinship care. The project entitled *Evaluating Factors that Contribute to Positive Outcomes in the Awasis Pimicikamak*

Cree Nations Kinship Care Program received a research grant from the Centre of Excellence for Child Welfare (Health Canada). The project, under way during the writing of this report, is being completed in the community of Pimicikamak Cree Nations in Northern Manitoba.

Over the past decade there has been increased recognition of the benefits of kinship placements by child and family service agencies. Within First Nation communities the use of kinship care is a long-held traditional child-rearing practice that recognizes the importance of culture and heritage and a child's right to them. It is believed that kinship care provides children and youth with better placement stability. This project aims to evaluate the kinship care program and identify factors that contribute to positive outcomes in kinship care placements.

It is our hope that this project will contribute to our knowledge about children in care and influence practice both in aboriginal and non-aboriginal child and family service agencies.

The Right Way

The OCA continued our partnership with **Save the Children Canada** to deliver **The Right Way** program. The Right Way is a youth-facilitated rights education and advocacy program serving youth. The program began as a joint initiative between **Save the Children's Canada**, the OCA and Human Resource Development Canada. A Youth Advocate was hired and the program began providing interactive workshops in March 2001. The workshops offered young people an opportunity to learn more about their rights and to practice advocacy skills in a responsible manner.

In April 2003 a second youth advocate was added. Gazheek Morrisseau-Sinclair joined Marie Christian, who became the provincial co-ordinator of the program. The addition of the second youth facilitator made it possible to reach more participants and widen the scope of the workshops to include younger children.

Between 2002 and 2004 the program staff completed:

- 55 workshops (2002-2003) and 72 workshops (2003-2004) in Manitoba schools, group homes, after-school clubs, recreational programs, and treatment facilities and youth correctional facilities.
- Reached well over 1,000 children and youth.
- Completed workshops on youth rights for professionals such as social workers, group home staff, and recreational workers and youth community workers.
- Held workshops for parents and interested community members.
- Created a child's colouring book explaining the concept of rights and advocacy for our younger participants.

The Right Way program was originally envisioned as a three-year project. It concluded successfully on March 31, 2004. We thank the youth co-ordinators for their dedication to the program. The greatest tribute to the program was always rooted in the spirited debates and discussions that the workshops generated. Some of the feedback about the Right Way program follows:

"The Right Way program brings a new and fresh perspective for talking about rights that pure charter discussions and case law does not. The Right Way program, especially the way it is presented is a worthwhile and excellent way to reach youth and teach them about rights and advocacy".

Corey Hahn,
Mini-University Law Instructor
Summer, 2002 and 2003

"Thank you very much for telling me all my rights. I really appreciate it. I hope that it will help me in my new foster home"

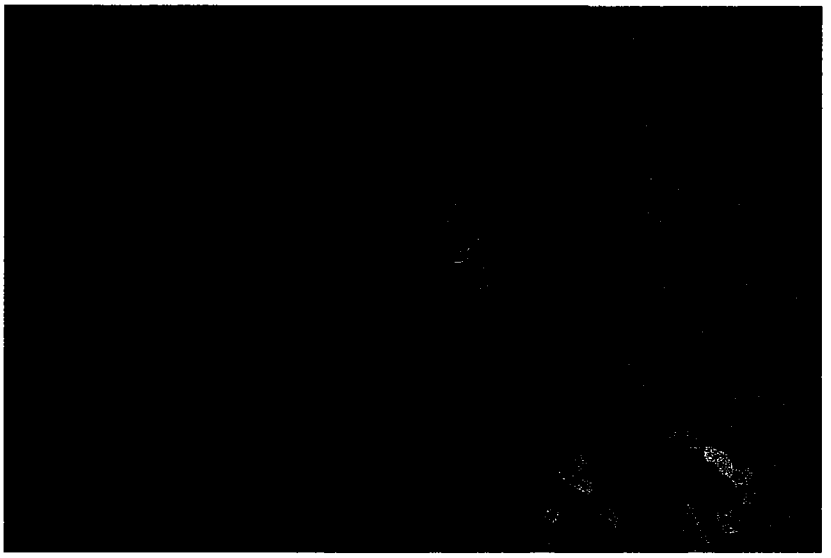
Youth participant, age 12

The Office of the Children's Advocate Reviews the Winnipeg Child and Family Services (WCFS), Emergency Assessment Placement Department (EAPD) shelter system.

In December 2003, the Honourable Drew Caldwell, the Minister of Family Services and Housing at the time, requested that the Children's Advocate complete a review into the operation of Winnipeg Child and Family Services (WCFS), Emergency Assessment Placement Department (EAPD) Shelter System. The review was completed and submitted to the Honourable Christine Melnick, Minister of Family Services and Housing in March 2004. The OCA's review and the department's response were publicly released by the Minister of Family Services and Housing on April 7, 2004.

The complete 183-page review is available at the Children's Advocate's website at: http://www.childrensadvocate.mb.ca/.

A condensed version of the review follows.



A Condensed Version of the Office of the Children's Advocate's Review of the Winnipeg Child and Family Services (WCFS) Emergency Assessment Placement Department (EAPD) Shelter System

Submitted in March 2004 to The Minister of Family Services and Housing

Shelter Review Background:

In December 2003, the Honourable Minister of Family Services and Housing Drew Caldwell, requested that the Office of the Children's Advocate complete a review into the operation of Winnipeg Child and Family Services (WCFS), Emergency Assessment Placement Department (EAPD) Shelter System.

The review was precipitated by concerns that had been publicly raised to the Minister's office and to the OCA about the quality of care in the WCFS shelter system. Concerns were also raised about the safety of children and the staff, the cost of the program and the impact that shelter care may have upon children and youth.

The review's purpose was to document and assess the shelter system and to make recommendations on the use of shelters to care for children and youth. In addition the review was to provide a forum for the voices of children and youth residing in the shelters system.

In completing the review, the OCA interviewed 124 children, youth, staff, managers and collaterals that had direct knowledge and experience in the WCFS-EAPD program. The OCA reviewed 5 years of WCFS-supplied statistical data for the period ending 2003. The OCA conducted on-site inspections of 47 shelters. The OCA reviewed all EAPD related material made available and completed a file audit on all EAPD administrative files. The review was completed and submitted to the Minister of Family Services and Housing in March 2004. The Minister of Family Services and Housing released the OCA review and the department's response on April 7, 2004.

The complete review is available at the Children's Advocate's website: http://www.childrensadvocate.mb.ca/.

Findings:

Historical Development of the EAPD-Shelter System

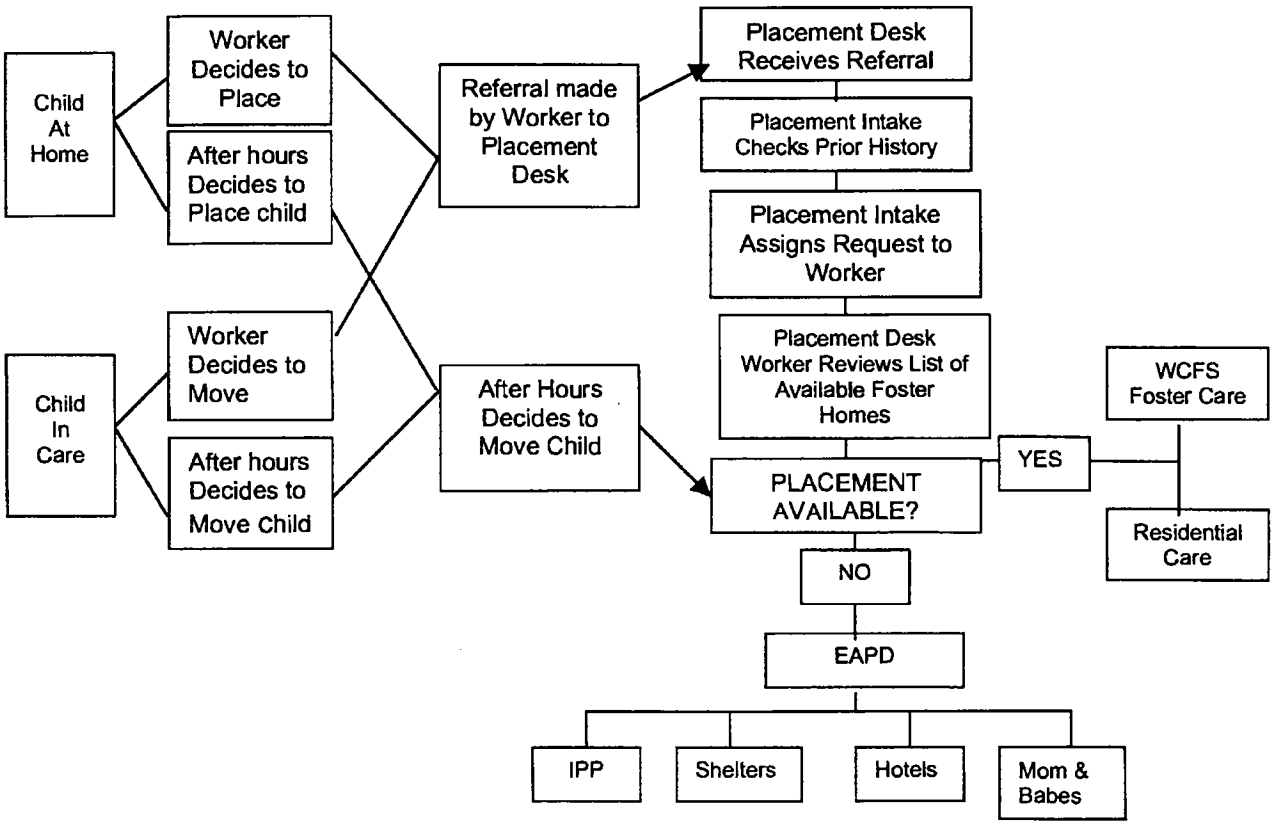
"We called it a short-term system and hoped it would go away. It never went away." *(Past WCFS staff person)*

The EAPD shelter system developed over a period of 10 years was a response to a resource crisis. When first designed, the shelter system was based on a foster care model but as resources were needed and fewer individuals were prepared to 'foster,' the system drifted towards shift-staff care in agency-run shelters. Over the five years reviewed (1998-2003) the EAPD shelter system housed 2,318 children and youth and cost $46,009,176 to operate.

Children and Youth Living in the Shelters System

The OCA found that WCFS had difficulty identifying the population served by the shelter system. What the OCA found was 3,085 children were placed in the EAPD emergency care system between 1998 and 2003. Of these, 2,318 children and youth were placed in EAPD shelters. Those children who resided in the shelters stayed an average of 44 days. Sixty per cent of the children and youth exit the shelters within 60 days, but 40 per cent remain longer. Sixty per cent were 11 or younger, and 25 per cent three or younger. Forty-three per cent were female, 57 per cent male. More than half of all children entered EAPD system (shelters and other emergency care) from the foster care system.

How a Child is Placed Inside EAPD System



"We design resources around specific populations because we are in crisis to find suitable placements."
(DFSH staff)

Realities and Pressures:

Throughout the review a number of general themes emerged which contributed to the development of the program we find today.

Aboriginal Children and Youth:

Historically aboriginal children and youth are over represented in the CFS system. It has been demonstrated through numerous studies that the CFS system has not served aboriginal children, youth and their families well. This is the fundamental reason for the AJI-CWI. The shelter system affects the aboriginal community more than any other. In developing any new emergency care system we must be aware of the population it will primarily serve. Currently, this system serves primarily aboriginal children and youth and their families living in the City of Winnipeg.

In the WCFS EAPD system 62 per cent of the children and youth placed were aboriginal; approximately 43 per cent held treaty status. However, 83 per cent of children and youth placed in the shelters were aboriginal. Of the aboriginal children and youth placed in emergency care, most were under 11. Alarmingly, compared with non-aboriginal placements, a large percentage of these children were 4 or younger. As well when the OCA looked at the youth population we found that non-aboriginal youth (ages 12 to 17) were more often placed in emergency care other than the shelters, than were aboriginal youth.

Though the majority of all children and youth enter emergency placements from foster care a higher percentage of non-aboriginal children and youth come from foster care (61.5 per cent) than aboriginal children and youth (45.5 per cent). A higher frequency of aboriginal children and youth (35 per cent) enter shelters from hotels as compared to their non-aboriginal peers (17 per cent). Aboriginal children and youth are more likely to enter emergency care under apprehension than their non-aboriginal peers.

The data received from WCFS was limited in that it did not, among other information, completely capture aboriginal status. The OCA reviewed case files through CFSIS to gather information with respect to aboriginal status and other areas where information was missing. Despite our efforts information with respect to aboriginal status still could not be determined in 223 of the files reviewed. Providing care extends beyond simply basic care. It requires an understanding and full knowledge and appreciation of that child's identified family, community, culture and history. It is extremely important that there be appropriate recording of the status of children, and this will be underscored further as the child and family service system moves forward.

The Resource Crisis:

A majority of children and youth entering the shelter system are coming from foster care; only 8.5 per cent are coming from residential care. The EAPD system appears to be primarily supporting the CFS care system. This situation implies that our child welfare system is not able to support the care plans of children and youth already under its care.

It should be noted, however, that the shelter system accepts a large percentage of children from hotels, thereby reducing the agency's reliance on this unregulated and unlicensed care resource.

We simply do not have the foster care resources to match the needs, particularly culturally-appropriate resources. It is clear that the shelter system grew in response to the resource crisis.

Through the AJI-CWI process, our foster care system will be reviewed. It is our sincere hope that this process will begin to address a number of issues.

"Staff person (name) and I can talk. I trust her, and we do things together. We talk about future plans. I find the staff easy to talk to."
(Youth resident)

The issue of whether children and youth enter the shelter system from foster or residential care is significant but what is more important and requires greater emphasis is the impact of such breakdowns on children and youth. That impact can often affect a child's future placements. The more placements a child must endure, the greater the negative impact on the child's development. The question of why these breakdowns are occurring has not been fully addressed by the DFSH or the agency.

The Development of Care: What came first, the crisis or the resource?

Agency staff reported there is a shortage of residential care beds and that residential care facilities are restrictive in their selection process. Access to residential care beds is through the DFSH and the process was described to the OCA as cumbersome at times and non-responsive in other times. Line social work staff are often left scrambling to find the next best alternative.

DFSH staff interviewed maintain there is no evidence that residential care facilities are not taking high-needs children and that the centralized access to residential care ensures that every child or youth has an equal opportunity to receive services. DFSH staff, however, conceded that resource development is often designed to accommodate crisis.

Generally there appears to be no overall vision and co-ordination of resource development. Our CFS system needs to develop the capacity for community resource development for out-of-home care for children and youth in a systematic and planned fashion. Doing so will allow our system to:

- Identify current and projected resources needed by children, youth and families.
- Communicate and demonstrate to the community, policy makers and funders that the resources are needed.
- Obtain the appropriate level of financial support for those services.
- Develop a province-wide service capacity to meet the identified and projected needs within our communities.
- Monitor the services to assure that they effectively meet the needs of children and youth.

Admission to residential care beds from a centralized source can ensure equitable opportunity for access. However if the Provincial Placement Desk is only to vet placement requests and not assist in planning or quality assurance, it is little more than a reservations desk. The Provincial Placement Desk should become a multi-disciplinary committee that will actively assist in planning for high needs children and youth. Social workers need to be brought back into this process and be afforded access to information about residential care bed openings. Such information can then be shared in a timely fashion with parents, children and youth who are involved in case planning.

Licensing and Monitoring of Care:

The DFSH is responsible for licensing the EAPD shelter system. The shelter system operated for four years before changes in legislation (1999) required compliance with *Residential Care Licensing*. To expedite the licensing process of pre-existing shelters, the DFSH provided a level of latitude to the agency in the licensing process. Had the facilities been required to qualify for licensing at the onset and before any new facility opening, the level of scrutiny would have been higher.

"The stove is so old it makes funky smells. This is a nice place, but they need to fix it up. Paint the walls because the paint is falling off. They need to do house maintenance, fix the leaky toilets, update some of the cabinets, and decorate the yard."

(Youth resident)

The DFSH was clearly not ready to absorb the shelter system into the licensing process. The DFSH reported that in 1999, 27 shelters required licensing. By February 2001 the number of shelters requiring licensing grew to 67. During this time, the agency was attempting to create short-term resources while complying with licensing legislation, leaving the DFSH in the position of "catching up" in the process of issuing a license. The DFSH focus then became on getting the shelters licensed. The requirements of the licensing process became less stringent for the shelters.

Before the legislation changed, the concept of emergency residential care was not a concept well understood by the DFSH. While the issuing of a license does ensure that children and youth are not placed in unregulated care, the current standards do not adequately address the uniqueness of emergency shelter care. The EAPD care facilities are not always able to ensure consistency in adhering to a program description or program statements reflected in standards due to the continual changes in the population within each shelter.

Interviews with DFSH also reveal that the licensing process fails to speak to the issue of quality of care. Licensing standards and regulations are intended to operate as minimal guidelines. Quality of the home environment, log documentation, staff skill levels, programming and recreational opportunities are all left to the interpretation of the individual facility operator. There is no ability for the DFSH to ensure that facilities exceed minimal standards.

Currently the DFSH employs only one staff person to license all residential care facilities in the province. This same staff person also issues all the variances to the licences and provides support to residential care in striving to create and maximize service goals. One staff person cannot adequately complete all annual reviews, variances, and monitor and provide support to all residential care.

In 1999 the DFSH created a Provincial Child Abuse Investigator (PAI). This individual is required to investigate allegations of abuse by staff, in all forms of residential child care facilities licensed by the Province of Manitoba, including youth correctional facilities. The PAI does investigate allegations of abuse inside the WCFS shelter system. The role, however, is limited to investigating only staff employed by WCFS and not purchased-service staff. When allegations arise concerning purchased-service staff, WCFS social work staff investigates.

The recommendations made in the PAI report are not consistently implemented and there is no process in place in WCFS to acknowledge the receipt of the report or respond formally to the investigator's recommendations.

The role of the PAI is important and much needed. As a licensing authority it is the responsibility of the DFSH to monitor the care children and youth receive and immediately investigate when allegations are raised. One staff position is insufficient to ensure adequate monitoring of care.

The System: The Purpose of Care

Child and Family Service agencies are required to provide a broad range of services to ensure the wellbeing of children and to assist families in caring adequately for their children. Services should be immediately available, matched to the specific needs of the child and family and in compliance with relevant legislation, regulations and best-practice standards.
CFS agencies must have the capacity to provide care in a setting appropriate to the needs of child and family and provide a range of services to meet the child's health, mental health, education, social and cultural needs. Intensive services and vigorous efforts to reunify the family and child must also accompany out-of-home placement.

The EAPD shelter system was to provide emergency temporary care whose outcomes ensured that:

- Children and youth were adequately and immediately protected from harm.
- Superior care was provided in safe, nurturing home-like environments.
- Care was temporary and transitional.
- Children and youth were stabilized through the provision of superior care, which promoted healthy development.
- Children and youth were supported to maintain their connection to family and community.
- Children and youth were reunified with family as soon as reasonably possible.
- Children and youth if unable to be reunified moved logically to the next most appropriate substitute care resource.

"It was crisis management without management realising there was a crisis" -
(Past WCFS staff)

The EAPD shelter system was to carry out a number of activities to ensure their outcomes were met. These activities included:

- Provision of superior care.
- Completion of functional assessments based on the individual child's needs.
- Provision of innovative programming to meet the child's identified needs.
- Completion of transitional planning to support the reunification of the child to the family or the child's transition to the next appropriate care resource.
- Provision of supports and opportunities for the child and youth to maintain or reconnect to family, neighbourhood and community.

The EAPD shelter system, though well intentioned, did not carry out a number of the stated core activities required to support its intended outcome.

Internal Pressures to the Agency:

Program Development:

WCFS's provision of emergency residential care was a response to a resource crisis. When first designed, the shelter system was based on a foster care model but as resources were needed and fewer individuals were prepared to 'foster,' the system drifted towards shift staff care. This drift was not intentional. The agency through the creation of guaranteed 12- and 24-hour shifts moved to stabilize the work force while attempting to support its service philosophy of consistent single caregiver.

The agency was attempting to provide services while reacting to an ever-changing environment. These larger environmental pressures resulted in ongoing structural and staffing changes. The agency reorganization to a Program Model moved Human Resource support to head office. Shelter co-ordinators were left without adequate human resources supports to assist in the shift to a residential care model. The Program Model also attempted to connect Quality Assurance and Community Development programs to EAPD but given the ongoing changes to the agency structure this connection was never fully realized or supported.

In conjunction with and following the agency's reorganization, senior managers' time and attention were diverted from program development to larger systemic initiatives, leaving EAPD staff to develop the program in isolation. The program continued to grow in care capacity without adequate program evaluation and development to support that capacity. In the end the program did not develop a program model that defined its goals and objectives, resources, program activities and/or outcomes. EAPD, now required to respond to the needs of any and all children and youth requiring emergency care, operated within increasingly impermanent programmatic boundaries.

"It (EAPD shelters) is a program that cannot say no. You have to accept any and all children needing placement."
(WCFS staff)

Without a program model, policies and procedures to support the program activities did not systematically develop. Originally EAPD policies and procedures "piggy-backed" onto the foster care licensing, regulations and standards. As the program's operational environment changed, moving from single caregiver to shift staff, these policies and procedures no longer fit the EAPD model.

Problems quickly arose concerning administrative procedures, child management practices and roles and responsibilities and conduct of staff. EAPD managers began to address problems by developing a series of reactionary policies. These policies dictated not only child care practices but attempted to address human resource issues if the procedure employed by staff varied from the initial policy. Reactionary policies quickly evoke staff reaction and lead to erosion of staff autonomy in carrying out their employment function. In the background, but directly impacting on the development of the program was the breakdown in staff/management relations creating at times a hostile and untrusting work environment.

Licensing:

WCFS also appeared to struggle in coming to understand the significance of appropriate licensing and monitoring either through the Residential Care Licensing Branch (prior to 1999) or the DFSH (after 1999). Changes to the City of Winnipeg fire code in 1998 required child care facilities (those with four or more beds) housing children up to 10 year old to install inter-connected fire alarms and a second means of egress. WCFS had been provided a three-year period to have their buildings brought to code in order to comply with fire code regulations. Instead WCFS made a decision to move from a four-bed model to a three-bed model to avoid the fire code regulations.

When *The Child and Family Services Act* was amended in 1999, it required residential care licenses for child care facilities for fewer than five children that were operated by agencies where care and supervision was provided by persons employed by the agency. Before this amendment the shelters operated without a license. The DFSH began discussions with WCFS in February 1999 to bring its facilities into compliance. This meant that the agency's previous attempts to circumvent zoning bylaws, health and fire code would now have to be addressed. When the OCA questioned past and current managers as to why the shelters were unlicensed, no one could adequately respond. Though managers stated they were aware that the changes in the Act were coming into force they assumed that the program staff were addressing this issue with the DFSH. Potential liability and cost ramifications were never fully appreciated by agency leadership.

Staffing:

Overall the OCA found that WCFS staff interviewed were well qualified and committed to their chosen field. There were, however, a number of concerns that have been raised throughout this report about staffing of the shelters. Of most concern was the strained labour/management relationship that had created hostility, suspicion and fear among staff, co-ordinators, managers, past boards and now may possibly extend to government.

Shelter staff are isolated given their job function and location. They do not feel a part of the agency service structure. The majority of shelter staff could not identify the overall service vision of WCFS and how EAPD fit into the agency's larger service vision and model. The majority of shelter staff did not possess a basic understanding of the larger role of WCFS, the mandate of the agency or the agency's organizational structure.

Supervision of shelter staff is inconsistent and does not occur across all shifts. Regular staff meetings are not routinely held and even when they are, not all staff can attend because of shift work. Communication among management, co-ordinators and shelter staff is fragmented. Shelter staff must rely on co-ordinators for all communication and information whether that information is case-specific or deals with overall agency activities. Staff conduct issues are not seen to be effectively dealt with by all parties (staff, co-ordinators, managers and union).

"The older kid smacked me. Staff said 'just leave it alone'. He (older resident) ran away after that and never came back." *(Youth resident)*

The guaranteed 12- and 24-hour shifts also impact on care. Shelter staff reported that long shifts could cause fatigue, given the high needs of children and youth. When staff members are tired, mistakes in judgement can be made. Union officials say that 12 and 24 hour shifts are required for children and youth that require consistency of care. There is, however, little doubt that the combination of long shifts, behaviourally challenging children and youth and the lack of effective supervisory support will impact on care.

Youth report that single staff shifts also impact on care. Single staff shifts can curtail activities. Youth also report the inappropriate matching of children residing in the shelters will also impact on care.

"I can't go out swimming or something else I like unless the little kids are sleeping, or are in daycare." *(Child resident)*

The guaranteed shifts and accompanying hours also impact on the agency's ability to move skilled staff to needed areas. Though staff are not guaranteed a specific work site, the agency reports that the guaranteed shift configurations prevent the movement of staff to needed areas. Staff are moved to sites where their shift configuration and hours can be met, as opposed to moving staff to meet the needs of a child or youth. As a result it has been reported that some staff may now be working with children or youth not because they have the requisite skills, personality or patience, but because the agency is required to guarantee a particular shift configuration and number of hours.

A high number of casual and contract staff are used to fill shifts. Many of them are unfamiliar with the procedures in individual shelters and this can lead to inconsistencies in the running of the shelter and the ultimate care of children and youth. Shelter staff report problems occur when contract staff are used. The majority of permanent WCFS shelter staff reported that WCFS staff and contract staff do not work well as a team. Shelter co-ordinators do not directly supervise contract staff. Children and youth report that they are not able to identify which staff are WCFS staff and which are contract staff

Training:

It appears the WCFS shelter system lacks a comprehensive staff development strategy that can integrate training, supervision and regular performance appraisals.

The lack of effective training has direct impact on the care of children and youth. When dealing with behaviourally challenging children and youth it has been reported that staff will often enter into power struggles that can escalate situations. It has been reported that staff in such situations will "get too hands on too quickly." Staff will seek the assistance of police when having difficulty with behaviourally challenging youth. However 14 per cent of requests for police assistance are in response to a "suicidal youth." The YECSS system, a community based crisis response program designed to deal with such issues appears to be under utilized. However shelter staff reported difficulties in relating to the YECSS system.

"Kids don't place kids at risk, untrained staff do."

(Shelter staff)

The agency has never completed a review of its present staff and their level of skill and expertise. Nor have they systematically offered additional training for dealing with challenging children and youth. Certainly there are skills common to all levels of the child care profession. But additional and specialized skills are often required to work with sub populations of children, such as the younger child, the physically challenged child, the child with pervasive developmental delays, the victimized child or the child who is diagnosed as suffering from FAS. The agency does not expect that each child placed will have similar needs but the structure of EAPD assumes that all shelter staff as child care workers possess an equivalent set of skills to deal with all children and youth. This simply is not possible.

Shelter co-ordinators have limited opportunity for training in supervisory skills. Co-ordinators have an important role in supporting staff in providing care to children and acting as a liaison with other agency staff and community collaterals. They too require additional training and support to carry out this very important role.

More importantly the children and youth are entitled to the highest quality of care. Qualified, trained and well-supervised staff can ensure that quality of care. Any future system must develop and institutionalize a professional training capacity that uses professional and community resources to meet training and staff development needs. Correspondingly, our CFS system must be provided the financial resources to address training and staff development needs.

Quality Assurance:

Throughout the review the OCA requested program evaluation, needs assessments or costs analysis with respect to the EAPD system. Beyond the Prairie Research Report (1997) that spoke briefly to aspects of emergency care, no formal evaluations had been completed. When the agency re-organized into a Program Management Model, the Quality Assurance program was to take the lead role for "service reviews, program research and evaluation, policy analysis, co-ordination or response to external reviews, and agency risk management" (WCFS 1999:24).

This program was used in determining the number of emergency beds needed and the location of shelters. This was done in conjunction with the EAPD now under the umbrella of the Resources in Support of Services Program. It was hoped that these programs and the agency's community development program would assist the development of EAPD. The agency developed an overall Action Plan to address a number of issues including resource development. By 2000, as the agency moved to address other initiatives, the Action Plan ceased to be operational.

The connection between Quality Assurance and EAPD was never fully realized. Had it been, the agency could have better developed and evaluated the EAPD program. Consequently the EAPD program developed without an evaluation of cost, impact, effectiveness or outcome of the program. This is most evident in the program's inability to accurately describe its service population - the children and youth.

Management Information System:

The OCA found that the agency never clearly reviewed the population served by the shelter system. Shelter resources were developed to "fill the gap" when placement was needed. There was no analysis of the population and their corresponding needs (problem identification). The

agency and ultimately the DFSH relied too heavily on descriptive case-specific information, excluding longer-term issues and the development of appropriate alternatives. The agency quickly developed tunnel vision regarding the population the shelters were serving and in its attempts to create alternatives.

The agency operates multiple data base systems. The agency's case management information system (CFSIS) is not effectively utilized to gather information to adequately project needs. Without knowing the problem or the primary service population and their needs, the agency could never further prove its case to its funders or develop a program to address the needs.

Financial Development and Control:

As the EAPD program developed, the costs associated with shelter care continued to rise. Agency managers attributed the increased costs to the increased needs of children and youth requiring care and the costs associated with guaranteed shift hours and configurations.

During our review, the OCA heard allegations that the shelters were not adequately funded. Each shelter is provided funds on a semi-monthly basis to purchase food, household items and provide recreational opportunities for children and youth based on their assigned, but not necessarily filled, bed spaces.

Allegations were raised by a minority of staff that items (primarily food) would go missing from the shelters. Following consultation with senior officials from the DFSH, the OCA requested the assistance of Internal Audit and Consulting Services. Overall it was found that "adequate procedures" had "been established to ensure a satisfactory level of control over expenditures in the shelter system and to provide reasonable assurance that expenditures are being made as intended."

Though the fundamental controls were found to be adequate, there were a number of issues regarding the implementation of procedures, primarily that the shelter system lacks a formal procedure manual to guide co-ordinators and staff in the management of the allotments or disbursements. The ability to budget the allotments varied among staff. The use of contract staff in some of the shelters makes it difficult for some shelters to fully implement the procedures. The degree of monitoring procedure implementation, a responsibility of the shelter co-ordinators, varied among co-ordinators.

Further and fundamental to the daily operation of the shelters, and the care of children and youth, was the determination of the allotments provided to the shelters. The determination of the allotment to the shelter was not based on the ages of children or youth, but on bed space. Establishing rates for care premised on bed space is contrary to other funding models in foster care, residential care and even within the provincial income assistance. Disparity existed in the shelters when funding based on bed space was expected to provide for more than just the residents. The current funding allotment for food is expected to cover the cost of feeding both staff and residents. But the rates are not adjusted to cover additional staff when they are required. The current allotment method forces some shelters to manage more frugally than others. "Shelter staff occasionally cope with tight budgets by temporarily 'lending' their own funds to meet the needs until the next allotment cheque arrives or resorting to no-cost recreation or cheaper food."

When WCFS staff (line to middle management) were asked about the budgetary process, we were told that to their knowledge there was not a process in place. Executive managers described a process that took into account consideration of actual expenditures, days in care,

"It's good, there is food here, there is no money for food at home."
(Child resident)

the average cost of a day care and consideration of new program initiatives. However, the 2002 to 2003 budget for the shelters "was established at a level 41.7 per cent lower than the prior year's actual expenditures. The estimated number of days in care, which is the primary basis for the budget, was 35.5 per cent lower than the prior years' actuals. The rationale for these reductions was not readily evident." This process contributed to the agency going over budget.

The review found no valid process to determine the monthly allotments or realistic EAPD budget; at times budgeting was based on unrealistic assumptions (reduction of days in care) leaving the agency with little ability to effectively analyze or reasonably project costs.

The Quality of Care:

Basic Care:

Overall the OCA found that the basic care provided to children and youth was adequate. Children and youth reported that routines were established in the shelters, they received adequate nourishment and were involved in daily activities. Personal hygiene items were provided. Some issues pertaining to inadequate clothing were brought forward by youth that reported difficulties in contacting their social worker to authorize purchase of clothing.

"I can't get clothes until I have been in the shelter for a month. I only have a little bit of clothing from my foster mom." *(Youth resident)*

Home-Like Environment:

At the time of the review, EAPD had 51 facilities, all but one of them licensed. Eight of the homes were owned by the agency, 31 rented from private landlords or through real estate companies, and 12 were created through co-operative partnerships with Manitoba Housing Authority (MHA). The OCA undertook site inspections of 47 shelters.
The goal of the program was to provide a safe and nurturing home-like environment in the community but this goal was not consistently met. Physical location was a significant factor weighing upon quality of care for children and youth. Many shelters were in neighbourhoods that could present potential safety and risk factors to children. Many were in areas where social concerns were evident. Of particular concern are the shelters located within WPS District 1. This area contains 24 per cent of the shelters. Of these shelters 90 per cent were rated as least desirable due to their close proximity and exposure to observable criminal and anti-social activity (drug trade, adult sex trade) gang activity, abandoned homes, and high incidences of reported crime.

Three shelters inspected by the OCA were deplorable. These were pointed out to the agency and the shelters were reported to have been closed. Our inspections did confirm that the EAPD has rented homes with no way to monitor slow or negligent landlords. We observed mold, overflowing toilets, windows without screens, and water flowing in the basements of some shelters. Though there were complaints of over crowding in the shelters the OCA found no evidence that this occurred.

It was, however, the collective opinion of children, youth and staff that these areas are high risk. Children said they did not feel safe outside some of the shelters.

"I don't feel safe at night, I'm afraid of drive-bys. This sounds stupid but was real for me." Youth resident.

"I feel safe when I stay inside all day. It's not safe outside, someone tried to beat me up." Youth resident.

In addition to safety issues, many youth expressed concern that they were placed in homes far away from their families or the communities to which they were connected.

"I can't see my parents and no one said why." *(Child resident)*

"I was not allowed to see my sister." *(Child resident)*

"What would really help other kids coming to the shelter? Kids really need to know about the rules in the shelter, and how stuff happens."
(Youth resident)

Admissions, Discharges and Assessments:

The *Child Care Facilities Licensing Manual* and the EAPD Home Manual provide a guide for specific processes for case planning in the shelter system. This should include information regarding admission to and discharge from the facility. The Home Manual provided a checklist form for each child. These checklists are to assist staff in assuring appropriate documentation concerning a child is received, or forwarded, and all necessary appointments have been scheduled. The EAPD shelter system also is to complete basic functional assessments while the child resides in the shelters. These assessments are to assist in planning for the child.

The most pertinent information that would assist shelter staff in providing care is located within the admission forms. Shelter staff complained that information about the child is either not routinely provided or not provided to them in a timely manner by placing workers. At times placing social workers are uncertain as to what information they can share with shelter staff, citing confidentiality as a reason. Overall assessments are not completed, nor are staff provided any training to assist them in completing such assessments. Shelter staff reported discharge planning as being unco-ordinated with no formal written procedure.

Generally children and youth describe their admission to the shelters with feelings of uncertainty, fear and apathy.

"I have no idea where I am going to live. My mom may be moving, but I would like to live with her, my worker says he is looking for a more permanent placement which means foster care." *(Youth resident)*

School Attendance:

"I am waiting for my social worker to make the arrangements so I can attend school." *(Youth resident)*

School attendance for those in the shelters is inconsistent at best. Shelter staff reported that almost one third of the children do not attend school after admission to the shelters. Issues such as transportation, enrolment in the new school, proximity of the shelter to the new school and general lack of communication with school personnel had been identified as barriers to school attendance.

Of the children and youth interviewed 82 per cent reported attending school before admission to the shelters; only 66 per cent reported attending school after their admission.

"A day program would be better than just sitting around."

(Youth resident)

Programming:

"We go to the pool, play Nintendo 64, watch TV and sometimes go to Magic Land if our behaviour is good." *(Child resident)*

For children and youth who do not attend school or day programming very few activities are available inside the shelter system. The majority of the shelter staff could not accurately identify programs offered to assist children and more specifically youth when they are placed. Programming appears to mean the provision of recreational opportunities. However, there was inconsistency as to what would constitute a recreational program. Some shelter staff described programming as watching TV, playing video games, and going shopping. Other described recreational activities as including physical activities or going for walks and going to the 'Y'. Programming was, however, very much dependent on the availability of money. If the shelter experienced problems, money for recreation would be used on other items such as food.

The majority of children and youth cited watching movies or playing video games as the most common form of recreational programming inside the shelters.

Behaviour Management:

Shelter staff reports that they manage children and youth behaviours primarily through the restriction of privileges, verbal redirection and the use of time outs. Of concern is that staff are unable to consistently describe the EAPD policies with respect to behavioural management beyond the use of Non Violent Crisis Intervention or restraint as a last resort to manage aggressive behaviour. Yet 20 per cent of staff report using physical restraints on children ages 6 to 12. Sixty-eight per cent of staff advised that they have used physical restraint at some point in their career in EAPD. Twenty-two percent of youth report being physically restrained.

DFSH staff and collaterals reported that they believe shelter staff enter into power struggles and get too hands on too quickly. Concerns were raised about inappropriate restraint methods, which could lead to injury.

Incidents such as the use of physical restraint are to be documented and reported. Overall the OCA found inconsistent reporting of incidents to the agency and to the DFSH. Even if incident reports were properly documented and reported, neither the agency nor the DFSH routinely track these incidents. Any probative value to the incident reporting is lost to our system.

"She (staff person) is worse than my Mom." *(Youth resident)*

What the Children and Youth Say:

"I am very comfortable at the shelter. There is no pressure for me to be someone that I am not, and staff don't pretend to be my family." *(Youth resident)*

Generally children and youth reported positive relationships with their WCFS social workers. Overall, children and youth identified an adult (social worker, or shelter co-ordinator) that they could confide in if they had a problem in the shelter. But only 33 per cent were able to identify a shelter staff who they view as their primary worker, a shelter staff person who would help them when they had problems. Fifty percent of the children interviewed report that shelter staff "yell" at them, 22 per cent of youth report that staff "swear at them" and 33 per cent of

youth reported feeling "put down" or humiliated by shelter staff. Children and youth did report knowing when shelter staff have conflict with other staff inside the shelters.

> ***"I ran away because people are bossy here. I wanted to go back home."***
> ***(Child resident)***

The majority of children and youth reported that they are unable to maintain contact with their peers while in the shelters. Though the majority of children and youth report having family contact while they are in care, only seven per cent report being allowed to have family contact in the shelters. However, 48 per cent of youth report having unsanctioned contact with family while residing in the shelters.

Though children and youth generally felt safe inside the shelters, they reported not feeling safe in the neighbourhood. They also reported that at times other children and youth placed in the shelters could impact on their safety. Though a majority (58 per cent) stated they generally like the other children and youth they also reported that a wide age difference and a lack of commonalties were the two primary factors which impact on the shelter environment. Primary school aged children complained about being placed with infants. Youth complained that other residents stole their property or would engage in verbally, or at times physically, aggressive behaviours. Children and youth report appropriate matching and mixing of residents to be a key determinant in settling into a shelter placement.

The majority of children and youth reported wishing they were somewhere other than the shelters. Forty-one per cent of youth reported running away from the shelters, as did 33 per cent of the children interviewed. The majority of children and youth desired to return home following their discharge from the shelter system.

Our Emerging System:

It has become apparent that there is a need for an emergency care system specifically serving the City of Winnipeg. This system must be an integral component within the Provincial Care Continuum, regardless of the population served. It is anticipated that any system of emergency care will evolve as it responds to the needs and pressures placed upon it.

The system must operate within programmatic boundaries and guidelines that clearly outline goals, objectives, anticipated outcomes, and policies and procedures. It must be continually evaluated, not only to ensure that it is achieving its goals, but also to recognize progress that may not have been anticipated. The use of a Quality Assurance function is central to the measurement of this program's success, is integral to accurately projecting the programs funding needs, and is vital to determining whether the program meets the needs of the children it serves. Quality Assurance should always seek to obtain the input of these children.

Summary:

The OCA has noted that the DFSH has made efforts in various initiatives to create a number of alternate care resources for children, in addition to the efforts made to effect change inside the EAPD shelter system. However, this review has found little evidence that substantial change has taken place within the WCFS EAPD shelter system. There remain deep-seated suspicions within the organization and there still appears at times to be an adversarial relationship with DFSH.

A lack of leadership and direction had a direct and negative impact on the EAPD program development. There is a distinct lack of a feeling of ownership and accountability among those involved. It was unclear to those who worked in them what the purpose of the shelters was and when the model evolved from one using foster parents to one using paid staff.

Recommendations:

- Development of a true continuum of care model for children and youth, including preventive care, more in-home support and a wider range of out-of-home services including shelters and specialized accommodation for special needs.
- Creation of a Community Resource Development Office to assess the resources and needs of Manitoba communities. This body would co-ordinate among agencies to systematically plan needed resources. It would also create a standardized classification system for all out-of-home resources.
- The development of a multi-disciplinary Provincial Placement Desk to co-ordinate placements in facilities best suited to the needs of specific children and youth.
- DFSH should post, on a secure website, an inventory of all placement vacancies so that professionals in the field can better plan for placement of children and youth.
- The Provincial Abuse Investigator's office should be expanded and its mandate extended to include all concerns related to questionable child-care management with procedures to ensure that action is taken.
- DFSH, with the help of the Internal Audit service, develop a realistic budget for WCFS and the EAPD system and that DFSH take direct control of the EAPD system until budgets and a proper program model are in place.
- Appointment of an Educational Specialist to resolve problems relating to education for children and youth in the shelters and a Health Specialist to ensure that there is ready access to medical advice and service.
- Improvement of supervision in shelters and access for all shelter employees to supervisors, and creation of a position specifically for co-ordination and operation of the shelter system. Team-building through staff meetings held at least once a month.
- Training for staff and purchased-service employees should be provided to bring all up to standards, with a continuing training program.
- Improved HR support and performance reviews.
- Establishment of licensing standards for emergency shelters and increased inspection and enforcement from DFSH.
- No children under the age of 7 should be placed in group care emergency facilities unless there are specific defined reasons involving special needs or special competency in a group care facility.
- Shelters should operate on an eight to 10-hour shift configuration, with one staff member for every two children/youth placed.
- Shelters of up to six beds to accommodate sibling groups.
- More attention to placement and care for special needs children including multi-disciplinary teams working province-wide to provide planning and care.
- Children should be aware of their rights, including their right to contact the Office of the Children's Advocate and youth should be advised of the assistance available from Voices: Manitoba's Youth in Care.
- Greater efforts to recruit and retain foster parents.

The Manitoba Government Responds with an Action Plan:

On April 7, 2004, Family Services and Housing Minister Christine Melnick released the *Review of the Operation of the Winnipeg Child and Family Services Emergency Assessment Placement Department Shelter System* and announced an action plan that responded to

recommendations from the Office of the Children's Advocate for improvements. The province's action plan identified four key steps to be addressed immediately:

- creating 50 new spaces with foster care resources for children under age eight;
- establishing an implementation committee to further address major recommendations;
- implementing key recommendations to improve quality of care in the shelter system, such as increasing supports for shelter workers; and
- following through on recommendations to strengthen the system, such as hiring more staff for licensing and monitoring of shelters.

"I like to help people and teach people things like school work. Adults need help from kids too."
(Child resident)

The Department noted that before the review began and while it was under way, improvements were made to the shelter system, including:

- using shelters more effectively;
- redirecting resources from shelters to alternatives;
- strengthening on-site supervision and management of the shelter system; and
- improving training opportunities so staff could upgrade their knowledge and skills.

The implementation committee will be led by Joy Cramer, executive director, Child Protection Branch, Manitoba Family Services and Housing; and Dr. Denis Bracken, professor of social work, University of Manitoba. The committee will include representatives from the three Aboriginal child and family services authorities and the child and family services general authority.

The Minister stated that, "the Children's Advocate, Janet Mirwaldt, and the review team have provided a structure for important improvements and changes to the child shelter system. They are to be commended for their excellent work and I will act aggressively on their advice."

The Children's Advocate's Response to Manitoba Family Services and Housing's Action Plan:

The Children's Advocate was pleased that government had chosen to act so quickly. The DFSH Action Plan contains ambitious guidelines and resources that will be a challenge to implement within the timelines. The Advocate is mindful that the issues and challenges surrounding the placement of children and youth are a growing and complex problem. All stakeholders must continue to be vigilant in monitoring the progress being made on the recommendations contained in the report.

What happened after the review:

During the shelter review the OCA inspected 47 shelters. Of the 47 shelters visited three exhibited conditions that were viewed by the OCA as undesirable for any child. On May 27, 2003 the OCA recommended that these three shelters be shut down. WCFS and the DFSH responded and accordingly informed the OCA that the shelters identified were subsequently closed.

Based on this information the OCA reported that the three shelters as recommended were closed. This in fact did not occur. Despite assurances that all three shelters were closed, one remained open. The OCA discovered this on May 17, 2004.

In fact this shelter was now in more serious disrepair than when first inspected one year earlier. It had accepted and was continuing to accept and care for youth. The WCFS shelter staff stated to the Children's Advocate that they were aware that the shelter was to be closed following the OCA's 2003 inspection and were so informed by the shelter co-ordinator. They

too expressed confusion as to why this shelter remained open.
The Children's Advocate then informed senior officials in the DFSH and the Minister of Family Services and Housing of the continued operation of the shelter and requested that this shelter be immediately closed. The Minister and her senior staff were also under the impression that the shelter in question had been closed.

The Minister responded on May 20, 2004. She committed to securing alternative care placements for the affected youth. She directed that the shelter be immediately closed. The Minister assured the OCA that the department would address the internal issues that contributed to the OCA being lead to believe that the shelter in question was closed in May 2003.

Year-end Statistical Analysis of Children's Advocate Cases

April 1, 2002 - March 31, 2003
April 1, 2003 - March 31, 2004

	2002-2003	2003-2004
Cases open from previous year	100	11
Total Requests For Service	1343	2054
Request Resolved	1332	1880
Cases Remaining Open	11	174
Breakdown of total request for services		
Level one (request)	713	1373
Level 2 - ISAA Cases*	517	512
Level 3 - AI Cases**	113	169
Total:	**1343**	**2054**

* ISAA – Cases where the OCA provided detailed Information and Self Advocacy Assistance
** AI – Cases where the OCA provides Advocacy and Intervention on behalf of a child or youth

The OCA has experienced a substantial increase in request for our services, especially in the 2003-2004 fiscal year.

The new Call Management system provides a means to manage the increasing number of request for our services, to quickly respond to all calls and assess the need for advocacy services.

Cases opened by the OCA must fully fall within our mandate and require our services. Cases can involve multiple children, such as a sibling group, or individual children. Should a sibling group require our services, a single file is opened if the advocacy issue is similar for all the children. Requests for services that fall outside the mandate of the OCA are referred to the most appropriate agency, alternative oversight or regulatory body or government departments.

Summary of Case Activity over the Two Years:

- Between 2002 and 2004 the OCA saw a substantial increase in requests (53 per cent) for our services.

- A significantly higher number of children and youth are directly contacting the OCA asking for our help. In 2002-2003 13 per cent of our calls were initiated by youth. By 2003 -2004, that youth-initiated calls rose to 18 per cent.

- As in past years the largest percentages of individuals who call the OCA are parents, extended family, and foster and adoptive parents on behalf of a child/youth.

- Consistently over the two years the age groups most often served by the OCA were children ages 6-10, youth ages 13-15 and 16-18.

- The vast majority (82-89 per cent) of cases opened to the OCA concerned children and youth and their families already receiving services from a CFS agency or Regional Office.

- In 2002-03 we reported that in 25 per cent of the files requesting advocacy services were children in care. In 2003-04 that percentage increased to 42 per cent. This increase could also be connected to the higher number of youth initiated calls.

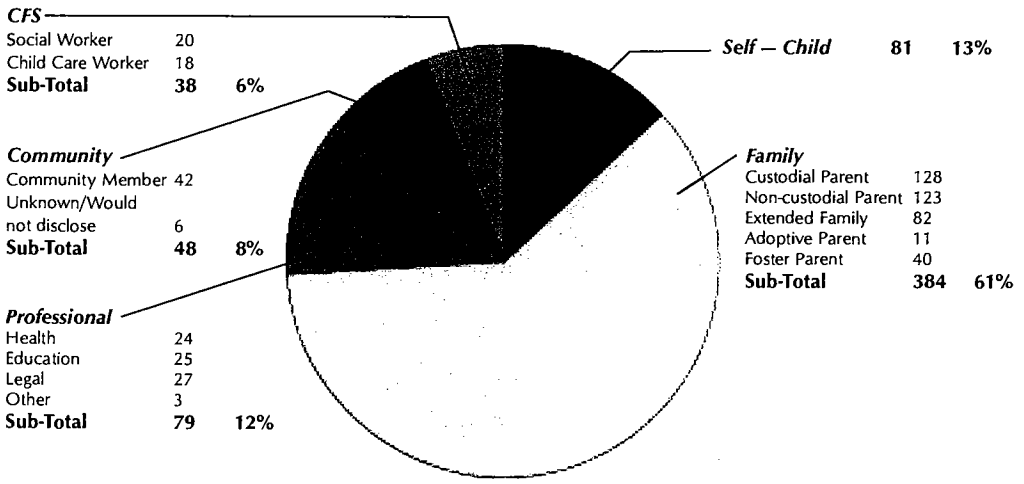
- The OCA primarily works with children and youth in care. In 2002-2003 56 per cent of cases opened to the OCA involved children and youth over whom a CFS agency or regional office held a legal authority over. That percentage rose to 63 per cent in 2003 to 2004.

- As in 2002-2003 the top concerns remain virtually unchanged. Case Planning far outweighs all other concerns reported to the OCA. This category speaks to planning for children in care, for families of children in care or with children living at home but who require supportive services of a CFS agency.

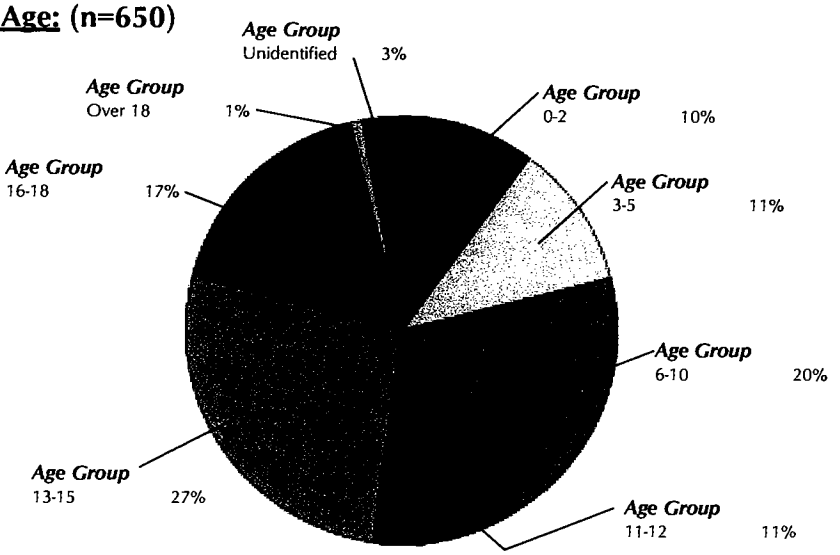
Statistical Breakdown for 2002-2003

The OCA opened 630 cases from April 1, 2002 to March 31, 2003.

Who Contacted the OCA: (n=630)



Child's Age: (n=650)



- We served an equal number of male and female children and youth.

Whereabouts of children/youth when advocacy files were opened:

Placement: (n=630)

Placement Type	Number	Percentage
Parent/Guardian	238	38
Non-Relative Foster Home	181	29
CFS Residential Care	40	6
Unknown/Would not disclose	32	5
Relative Foster Home	27	4
Relative/Friend	27	4
Youth Correctional Facility	21	3
CFS Receiving Resources	17	3
On Own	16	3
Place of Safety	11	2
Child Mental Health	7	1
Other	7	1
Hospital	6	1
TOTAL	**630**	**100%**

- 44 per cent of the children and youth we served lived in some form of agency provided care.

Case Category/Involvement: (n=630)

CFS Case Category	Number	Percentage
Adoption/Post Adoption	4	1
Child in Care	158	25
Protection	289	46
Expectant Parents Services	8	1
Voluntary Family Services	61	10
Had previous CFS involvement	80	12
No history of CFS involvement	30	5
Total	**630**	**100%**

- 83 per cent of the cases opened to the OCA had active CFS involvement, 12 per cent had had previous involvement and 5 per cent had no past CFS involvement.

- 72 per cent involved Protection cases, which are defined as cases receiving mandated services from a CFS agency or regional office.

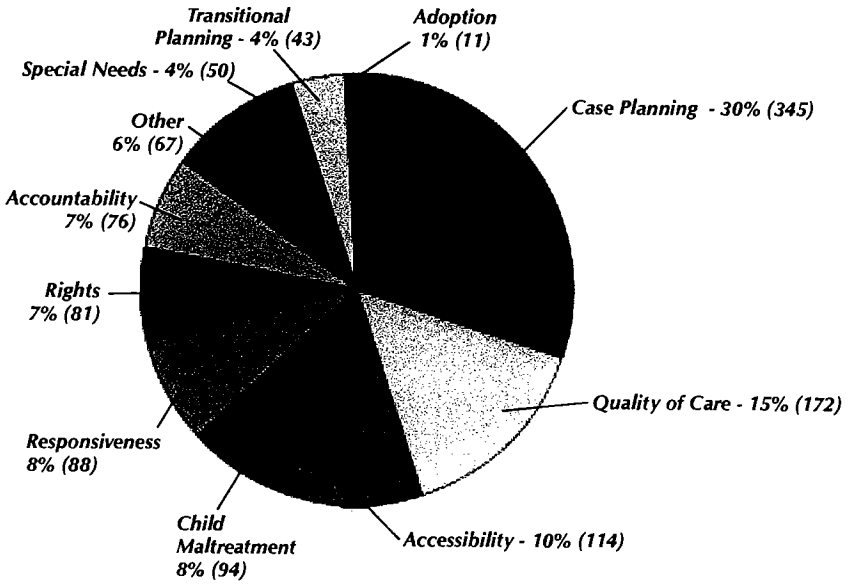
Legal Status of Child: (n=630)

Legal Status	Number	Percentage
Not In Care	276	43
Permanent Ward	118	19
Apprehension	94	15
VPA	68	11
Temporary Ward	54	9
Petition for Further Order	14	2
Order of Supervision	4	0.6
Over 18	2	0.4
Total	**630**	**100%**

- The OCA is primarily involved with children and youth in care of the CFS system. 352 or 56 per cent of cases opened to the OCA involved children and youth in care of the CFS system.

Why They Called the OCA for Help: Case Themes and Top Concerns: (n=1,141)

Cases may have more than one single issue and could present with multiple issues requiring advocacy services. In 630 cases there were 1,141 concerns noted.



Total Issue by Age Category: (n=1,141)

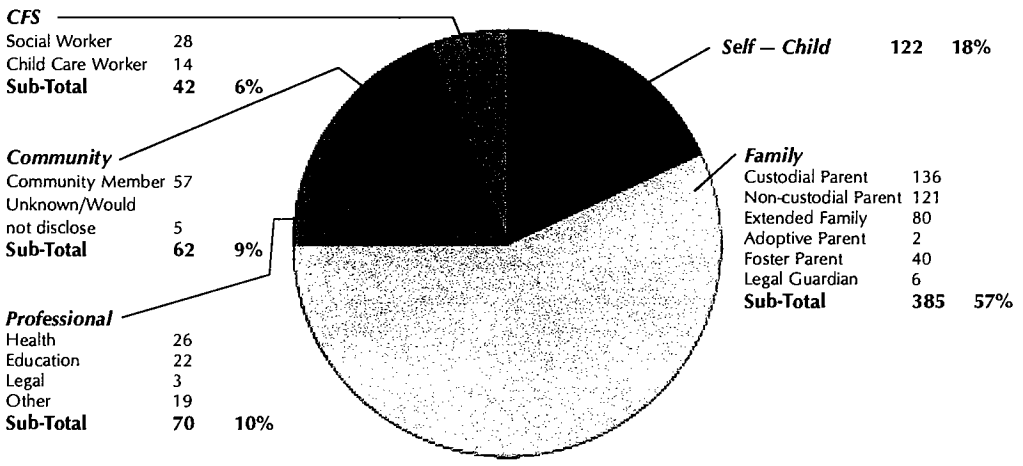
Concerns related to children and youth will often vary dependent upon the needs and age of a child or youth.

ISSUE	0-2	3-5	6-10	11-12	13-15	16-18	18+	UK	ST	%
Accessibility	12	4	20	9	34	29	0	6	114	10
Accountability	18	10	22	0	20	0	4	2	76	7
Adoption	1	2	3	1	2	1	0	1	11	1
Case Planning	30	48	77	27	91	58	2	12	345	30
Child Maltreatment	16	15	24	7	18	9	0	5	94	8
Quality of Care	8	11	45	14	66	25	0	3	172	15
Responsiveness	7	9	14	17	24	14	0	3	88	8
Rights	2	1	9	7	25	34	2	1	81	7
Special Needs	0	0	8	7	22	11	2	0	50	4
Transitional Planning	0	0	0	0	7	31	5	0	43	4
Other	5	5	14	6	19	15	0	3	67	6
Total	**99**	**105**	**236**	**95**	**328**	**227**	**15**	**36**	**1,141**	**100%**

Statistical Breakdown for 2003-2004

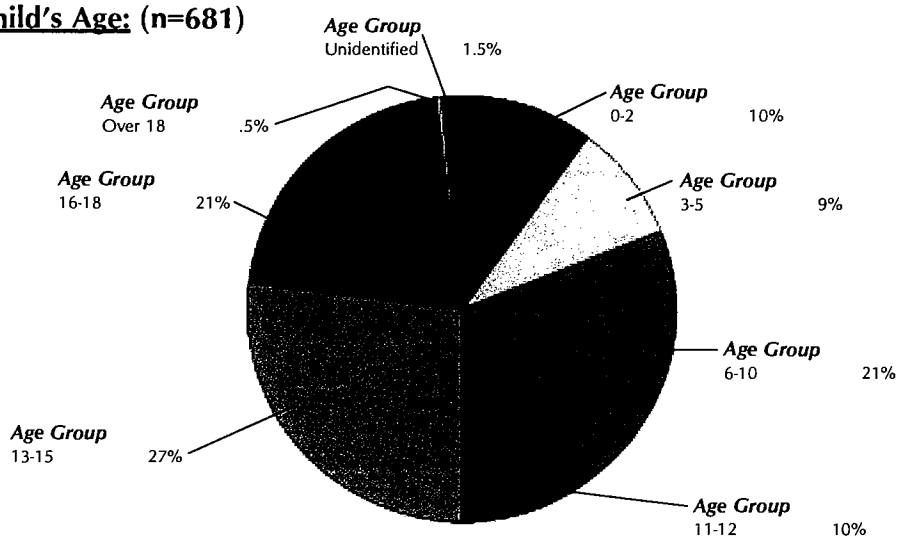
The OCA opened 681 cases in 2003- 2004.

Who Called the OCA: (n=681)



- 57 per cent of those who called the OCA self identified as family members or other adult care givers calling on behalf of the child or youth.

Child's Age: (n=681)



- Advocacy services were provided to virtually equal amounts of males and females.

Whereabouts of children/youth when advocacy files were opened: Placement: (n=681)

Placement Type	Number	Percentage
Parent/Guardian	215	32
Non-Relative Foster Home	192	28
CFS Residential Care	57	8
Unknown/Would not disclose	22	3
Relative Foster Home	46	7
Relative/Friend	29	4
Youth Correctional Facility	13	2
CFS Receiving Resources	56	8
On Own	15	2
Place of Safety	13	2
Hotel	7	1
Child Mental Health	5	1
Other	11	2
TOTAL	**681**	**100%**

- 48 per cent of children and youth we served lived in some form of agency provided care.

Case Category/Involvement: (n=681)

CFS Case Category	Number	Percentage
Adoption/Post Adoption	5	1
Child in Care	286	42
Protection	274	40
EPS	2	1
VFS	46	6
Previous CFS involvement	49	7
No or current CFS involvement	19	3
Total	**681**	**100%**

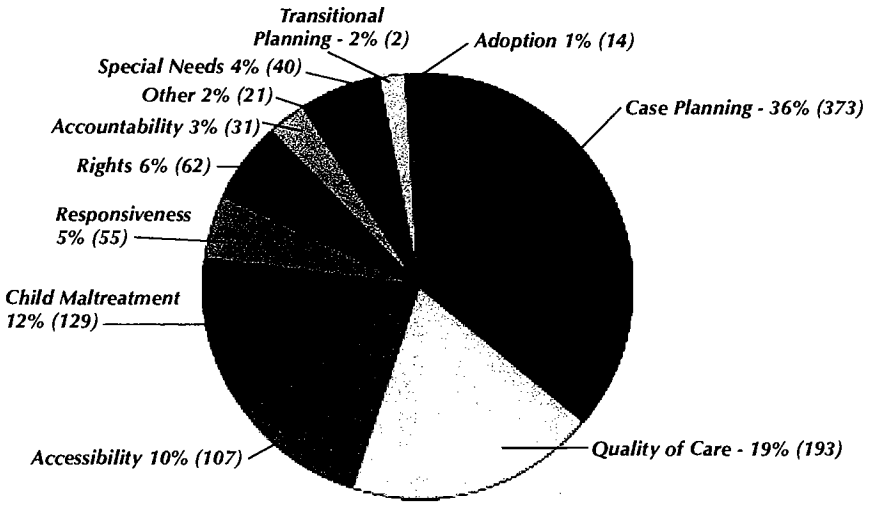
- 89 per cent of the cases opened to the OCA had active CFS involvement.
- 82 per cent of which were open to a CFS agency as an active protection file prior to requesting advocacy services.

Legal Status of Child: (n=681)

Legal Status	Number	Percentage
Non-Care	229	33
Permanent Ward	168	25
Apprehension	108	16
VPA	80	12
Temporary Ward	81	12
Petition for Further Order	9	1
Order of Supervision	5	1
Over 18	1	-
Total	**681**	**100%**

- The OCA deals primarily with children in care. Sixty-three percent (63 per cent) of cases open to the OCA involved children and youth where the CFS system had legal responsibility.

Why they called: Case Themes and Top Concerns: (n=1043)



Total Issue by Age Category: (n=1043)

ISSUE	0-2	3-5	6-10	11-12	13-15	16-18	18+	UK	ST	%
Accessibility	5	7	19	12	29	35	0	0	107	10
Accountability	4	8	8	6	4	1	0	0	31	3
Adoption	2	2	5	2	3	0	0	0	14	1
Case Planning	43	50	74	47	94	64	1	0	373	36
Child Maltreatment	14	18	35	23	32	7	0	0	129	12
Quality of Care	20	13	33	25	63	39	0	0	193	19
Responsiveness	4	6	18	6	12	7	0	2	55	5
Rights	1	3	6	8	20	23	0	1	62	6
Special Needs	4	1	13	0	11	7	0	4	40	4
Transitional Planning	-	-	-	-	-	17	1	0	18	2
Other	1	3	5	1	5	5	0	1	21	2
Total	**98**	**111**	**216**	**130**	**273**	**205**	**2**	**8**	**1043**	**100%**

The Fiscal Year Budgets for The Office of the Children's Advocate

Expenditures	$(000)	FTE
2002-2003		
Total Salaries and Employee Benefits	420.7	7
Total Operating Expenses	146.2	
2003-2004		
Total Salaries and Employee Benefits	471.0	8
Total Operating Expenses	165.4	

The Office of the Children's Advocate Staff List

Janet Mirwaldt, Children's Advocate
Michael Bear, Deputy Children's Advocate
Terri Hammerback, Children's Advocacy Officer
Thelma Morrisseau, Children's Advocacy Officer
Jill Perron, Children's Advocacy Officer
Cheryl Fontaine, Advocacy Assessment Officers (2003)
Patsy Addis Brown, Office Manager
Debra Swampy, Administrative Secretary

Marie Christian, Youth Coordinator, The Right Way Program (January 2002 – February 2004)
Gazheek Morrisseau-Sinclair, Youth Advocate, The Right Way Program (April 2003 - February 2004)

Nelson Mayer, Social Work Student (September 2003- to March 31, 2004)
Susan Thomas, Children's Advocacy Officer-Shelter Review (March 2003-October 2003)

We all have a hand in it!