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

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MANITOBA'S

Children's Advocate

ANNUAL REPORT

April 1, 2006 - March 31, 2007

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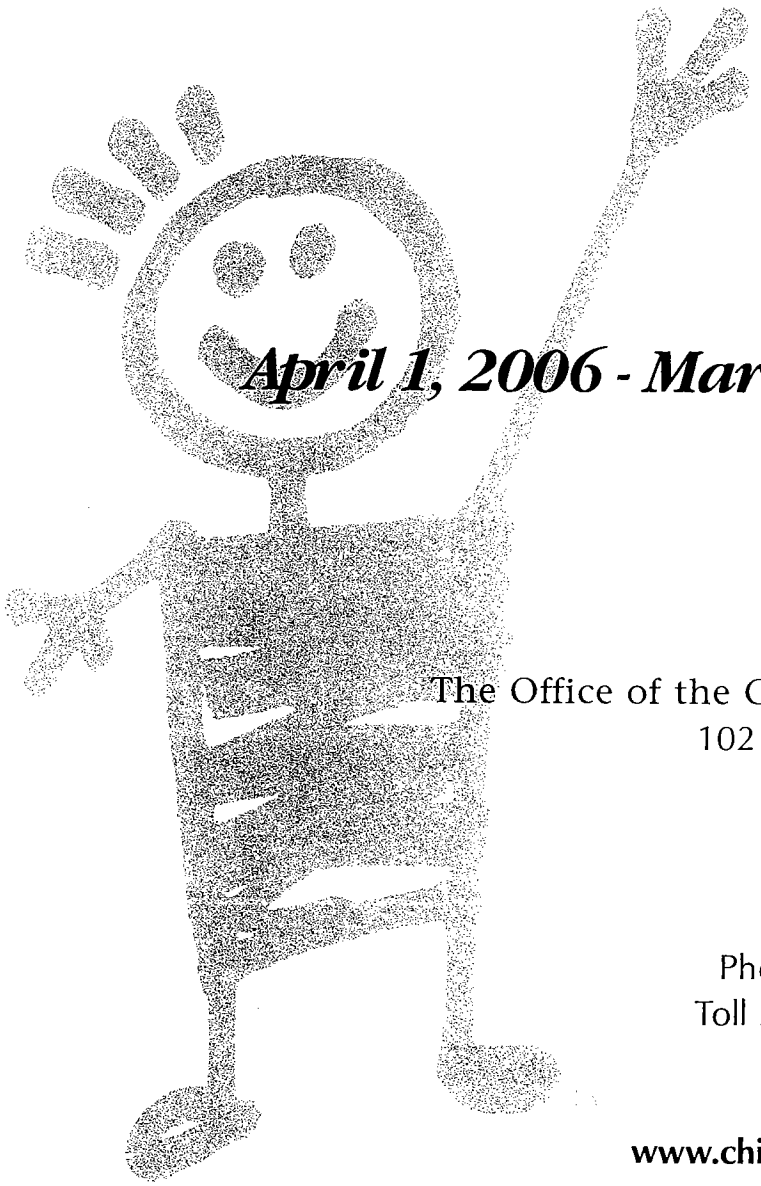
Annual Report of the Office of the Children's Advocate of Manitoba



April 1, 2006 - March 31, 2007

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Acknowledgements

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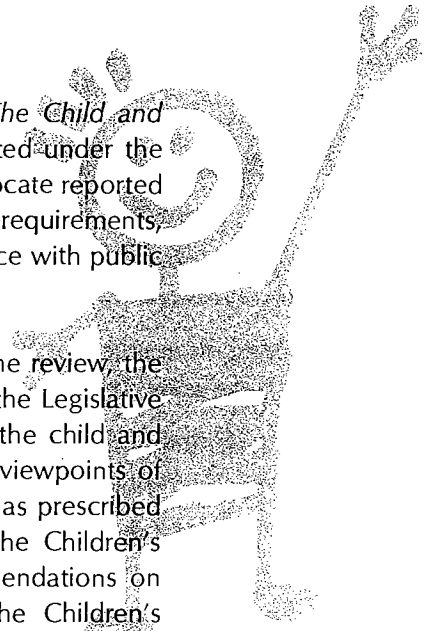
- The Child Death Review Team consisting of Mr. Dave Macdonald, Ms. Jocelyn Greenwood, Ms. Cybil Williams, and extra thanks to Dr. Kathleen Jones who was the team lead and was responsible for the majority of the research conducted in this report,
- Elders Margaret and Jules Lavallee and Ms. Faye Sasson who helped guide us and keep us grounded during the intense work surrounding the child deaths,
- My co-chair Dr. Jim Newton for his wisdom, kindness, and patience while working with me on the *"Honouring Their Spirits"* report,
- Mr. Andrew Koster of Ontario who assisted us by conducting the review into the death of a five-year-old child,
- Mr. Dave Macdonald who worked with Andrew Koster on the review into the death of a three year old child,
- Ms. Karen Kawaler for her hard work in providing administrative assistance toward the report writing,
- My co-chairs Ms. Irene Hamilton, Manitoba's Ombudsman and Mr. Michael Hardy of Ontario for their shared expertise,
- The External Review Team, which included our OCA Children's Advocacy Officer, Mr. Nelson Mayer Jr.,
- Ms. Alex Wright for her research and report on *"Best Practices'* in child welfare,
- Ms. Alice McEwan-Morris for her research and preparation of the report *"Strengthening our Youth ...",*
- Ms. Marie Christian, Program Coordinator of Voices: Manitoba Youth in Care Network for her coordination and assistance in bringing us together with child and youth focus groups,
- The Manitoba children and youth who used their voices to provide valuable input into the national report titled "Canadian Youth Speak Out About Violence Against Children",
- Deputy Children's Advocate, Bonnie Kocsis and OCA Office Manager, Patsy Addis Brown for keeping the OCA running smoothly during the intense and draining months of the reviews,
- The OCA team for their hard work and to the Advocacy officers who contributed to the content of this report, and,
- Mr. Errol Boulanger (social work student), Ms. Cybil Williams (term staff), and Mr. Brent Anderson (secondee) for assisting in addressing the heavy demands on Intake.

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

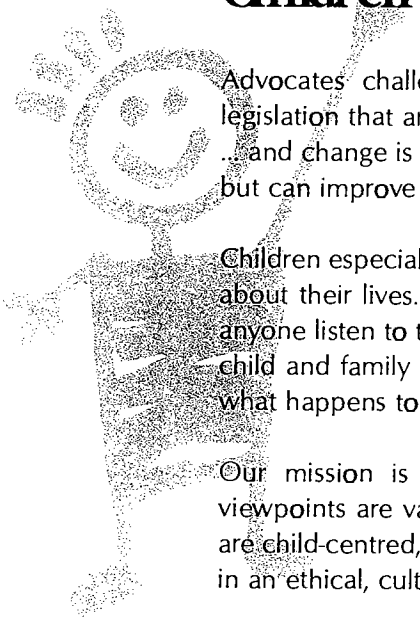


The Office of the Children's Advocate (OCA) was created under *The Child and Family Services Act* and proclaimed April 1, 1993. The office operated under the umbrella of the Department of Family Services and the Children's Advocate reported to the Minister of Family Services. In 1996, consistent with 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 an annual report to the Speaker of the Legislative Assembly.

On April 8, 2005, the Lieutenant Governor in Council, on the recommendation of the Standing Committee of the Assembly on Privileges and Elections, appointed Ms. Billie Schibler as the Children's Advocate for a three-year term.

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 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.

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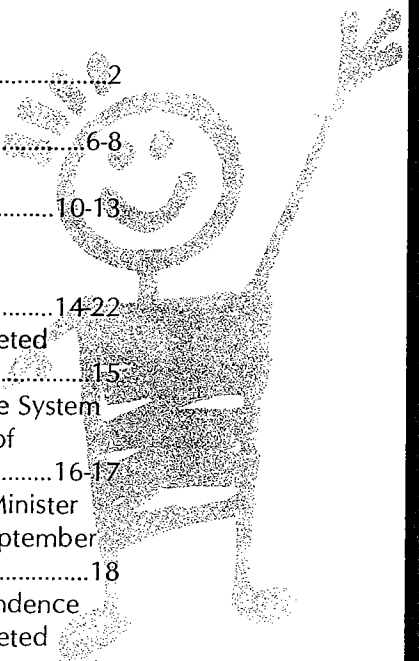


A Message from the Children's Advocate

In accordance with Section 8.2 (1)(d) of The Child and Family Services Act, I respectfully submit this document as my annual report for the time period beginning April 1, 2006 to March 31, 2007.

The fiscal year of 2006-07 was an extremely busy and challenging year for the Office of the Children's Advocate (OCA).

Let me begin by saying that I believe it is important to draw to the attention of the general public, issues that relate to the safety and well-being of children. The majority of Manitobans have very little knowledge of the terrible plight that many of our province's children face which results in the need for the Child Welfare System's involvement. It is imperative that the public be educated on matters relating to the welfare of children. This results in the people of Manitoba being given a window into the sometimes distressing world that children live in, while also being the impetus for improving service systems.

In addition to our ongoing casework, I was called upon to conduct four major reviews with respect to the child welfare system's service delivery. We also initiated a fifth report relating to systemic concerns frequently brought forward to the OCA around youth exiting from the child welfare system.

The five major reviews undertaken by the Office of the Children's Advocate during the 2006-07 fiscal year are as follows:

- A Special Case Review into the Death of a five year old child, completed September 2006,
- "Strengthen The Commitment" - An External Review of the Child Welfare System - A Report to the Minister of Family Services and Housing, Province of Manitoba, completed September 2006,
- "Honouring Their Spirits" - The Child Death Review - A Report to the Minister of Family Services and Housing, Province of Manitoba, completed September 2006,
- "Strengthening Our Youth" Their Journey to Competence and Independence - A Report on Youth Leaving Manitoba's Child Welfare System, completed January 2007, and
- A Section 4 Special External Report on the Death of a three-year-old child, completed January 2007.

These Reviews gave the Office of the Children's Advocate an opportunity to objectively examine many aspects of the child welfare system.

While the External Service Review was the largest and most complex of the reviews, its focus was about the child welfare system and how it's services work, with recommendations for improvement. The "Honouring Their Spirits" Report, examining children's deaths, was a more profoundly emotional and draining experience. This report was not about numbers. It was not about statistics. It was about children's lives. Each child had an individual story, some very sad and tragic, and their stories needed to be told.

In the 289 recommendations made in the five reports, we found ourselves re-voicing historic concerns regarding service delivery within the child welfare system. We found ourselves looking at issues cited by the previous Children's Advocates and others that had been ignored for far too long – things like the overwhelming numbers of caseloads carried by individual workers, insufficient training in assessing risk, barriers to the effectiveness of the child and family services information system (CFSIS), and youth in care being inadequately prepared for independence.

While the Children's Advocate has the power to make recommendations relating to services provided under The Child and Family Services Act, sadly, there is no mechanism in place that gives the Children's Advocate the power to ensure these recommendations are carried out. Not giving these recommendations full attention over the years has been at the peril of this province's most vulnerable children.

The reviews have provided an opportunity for the child welfare system to once again examine the way it relates to children and families, setting a new tone and direction to enhance and support the path being paved by the Devolution. Yet, it is a travesty that children have had to die to bring about an environment where change can "hopefully" happen.

Those departmental sectors, agencies and authorities who acknowledge their need for improvement and are supportive of external reviews should be commended. It demonstrates their willingness to rectify problems and their desire to give children and families confidence that they are being provided with the best services.

What we have achieved through the physical change of devolution is an ideological shift that needs to be accompanied by a process of "resolution" before we can move into a healthy "evolution" of ideal service delivery.

The outcomes that can result from implementing the recommendations in our five reports have the potential to further change the course of history regarding child welfare in Manitoba.

I have had the benefit of providing 15 years of mandated child protection services. What I have come to understand is that policies and standards govern the day-to-day practice. However, that practice is also influenced by the culture and environment in which you work. An environment that emphasizes best practice, the best interest of children, preparatory training, continued professional development, support to staff and creative thinking in a world that is not black and white, will result in better services. However, it is important to remember that the world of child welfare is full of

variables which can change in a split second. What worked in one situation may not work in another. And sadly, in some situations all the knowledge, skills and best practice may not be enough to prevent a tragedy.

While the reports provided a valuable opportunity to heighten public awareness to the deficits that exist in an essential but sometimes flawed system, it must be noted and it is important to recognize that there is a population of social workers who give the greater part of their career as devoted, conscientious professionals who care greatly for the children and families they serve.

And while our recommendations reflect many areas for required improvements, in a service that receives very little positive recognition, painting the entire profession with the same brush stroke dangerously affects morale which in turn affects services.

The ultimate result of these reports should serve as a reminder not only to the Child Welfare System, but to all readers that we, as a community, as a Province, are responsible for protecting children and promoting their well-being.

However, those in every facet of the child welfare system must fully acknowledge the content of the reviews we conducted. Accept it. Resolve it. Then move on to something better. Make a commitment that you don't want to go back there again. Change. Cooperate more. Communicate. Work together. Put children first.

Respectfully Submitted by

Billie Schibler
Children's Advocate

The following is taken from the poem

MISS, WE ARE GOING TO DISNEY LAND

She didn't smile or talk or didn't have much to say...

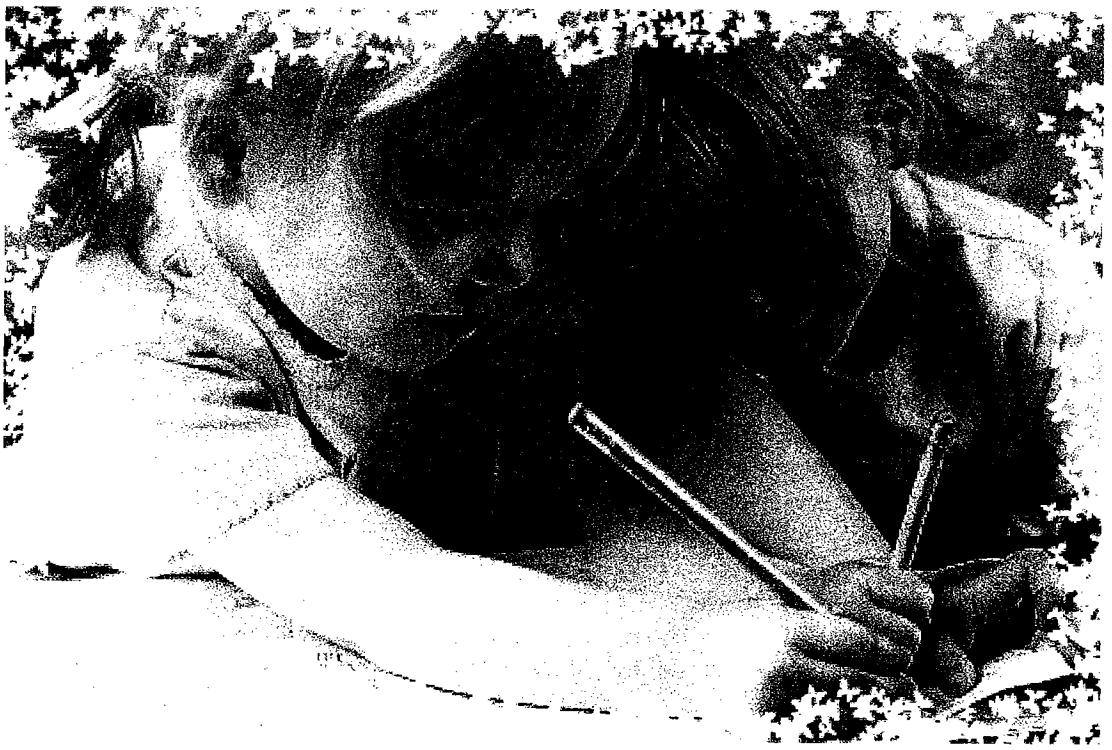
I told her about our plans about going to Disney Land
She just cried and held my hand
Dad's friend came over with a beer
I'll only have this one, I saw my mom's fear

I went to bed with Disney Land on my mind
Wondering if Mickey Mouse would be hard to find
I awoke with screaming, the stench, and the yelling
No more drugs, no more drinking, no more selling...

Miss, don't tell anyone what I said, I'm okay
We are going to Disney Land with his next pay
In Disney Land, there is laughter and fun
Families holding hands, skipping in the sun

Vera C. Tourangeau
A book of poems titled "Miss it Hurts"

DEVOLUTION:
STILL A WORK IN PROGRESS!



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Devolution: Still a Work in Progress!

As there has historically been an over-representation of First Nation status, non-status, and Métis children in the Manitoba child welfare system, one of the intents of devolving the system was to create a philosophical shift in service and practice, aimed at providing more sensitivity to cultural needs through supporting Aboriginal agencies to serve Aboriginal families and children. More than two years after the formal devolution, the questions that emerge are whether this "philosophical shift" has indeed taken place, and if it has resulted in improved services to children and families.

The assumption accompanying devolution was that the changes would strengthen and create a better service system. But has it?

In last year's Annual Report, we noted instances where people (service providers) "refused to work with other agencies, refused requests for information sharing, or failed to attend or excuse themselves from important scheduled meetings. Some did not return phone calls and some became rude and adversarial."

We also noted that "some agencies did not want to report to the new authorities as they saw the authorities as a new level of bureaucracy, one that might possibly curtail their autonomy. In turn, the authorities struggled to establish relationships with their new agencies, while at the same time trying to balance their responsibility and accountability back to the Department of Family Services and Housing."

These challenges continue. They have no place in Manitoba's child welfare system. The bottom line is that all of these service providers must be accountable for ensuring the protection and safety of vulnerable children.

During this fiscal year, the Office of the Children's Advocate completed five major reports. One report was a systemic review of the deaths of Manitoba children serviced by the CFS system. Two reports involved the deaths of specific children known to the child welfare system. Some common themes emerged while preparing the reports. We found that some workers have very little understanding or awareness of *The Child & Family Services Act, The Child and Family Services Authorities Act,* or the Provincial Standards. While this seemed more prevalent in remote areas, it was a finding that was reflected across the province. As a result, there is a varied interpretation by workers and agencies in understanding what their responsibilities are in carrying out their duties under the Acts, along with their accountability under the new authorities.

Child welfare practices should always revolve around two fundamental concepts: determining what is in "the best interest of the child" and what constitutes "a child in need of protection". Some factors such as child abuse and neglect are obvious. Others are much more subjective and may be based more upon the personal experiences of workers and supervisors. Their own education, values, beliefs, and personal/professional experiences within the child welfare system are examples of the types of subjective criteria upon which such decisions are made.

While these experiential and emotional factors provide social workers with greater insight into the strengths, needs, or struggles of children and families, they can also cloud professional judgment. Workers, supervisors, senior managers, and board members at agencies and authorities form or

influence decisions based upon their own personal experiences. However, those experiences could at times either represent a focus on removing children by erring on the side of caution or an over-vigilance in keeping children within their family.

One senior manager indicated to the OCA that he/she did not believe in formal risk assessments. Obviously this statement indicates that there is a wide variation in assessing risk, interpreting a child's best interest, and the types of interventions that will result.

This is further complicated by the significant staff turnover that exists at some agencies. As a result, it is not uncommon for a family to experience several different interventions and conflicting case plans. We have seen examples where one worker will not allow a family access to their children, while the next worker's case plan calls for a complete reunification of this family.

These inconsistent practices may further contribute to a family's existing problems. The inconsistency can create an adversarial relationship with the agency; also affecting the community's perception of the agency's effectiveness.

It should therefore come as no surprise that families and community members contact the OCA for assistance with requests to change service agencies. It demonstrates the gap between what the people believe to be appropriate services and what the agency perceives to be appropriate. With damaged credibility, the agency encounters further barriers in its attempt to work collaboratively with other service providers or for the agency to broaden its "circle of care" through the recruitment of foster families. Of the greatest concern is the lack of faith that the child or family receiving services may have in their agency.

The current post-devolution environment strongly suggests that ongoing education and training is essential; so is the importance of standardized practice. It is recognized however that there may be instances where the standard cannot be met.

It is therefore the Recommendation of the Children's Advocate that:

The Province and Child Welfare Authorities conduct a forum to debate the merits of creating Provincial Standards in a manner that still allows for some flexibility through planned, pre-authorized variances under certain unpreventable circumstances. However, any variance from the provincial standards should have to be approved at the highest level of authority.

The Children's Advocate further recommends that:

There are annual provincial file audits conducted of the child welfare agencies to ensure compliance to the Standards and to ensure any non-compliance is supported by a variance approval.

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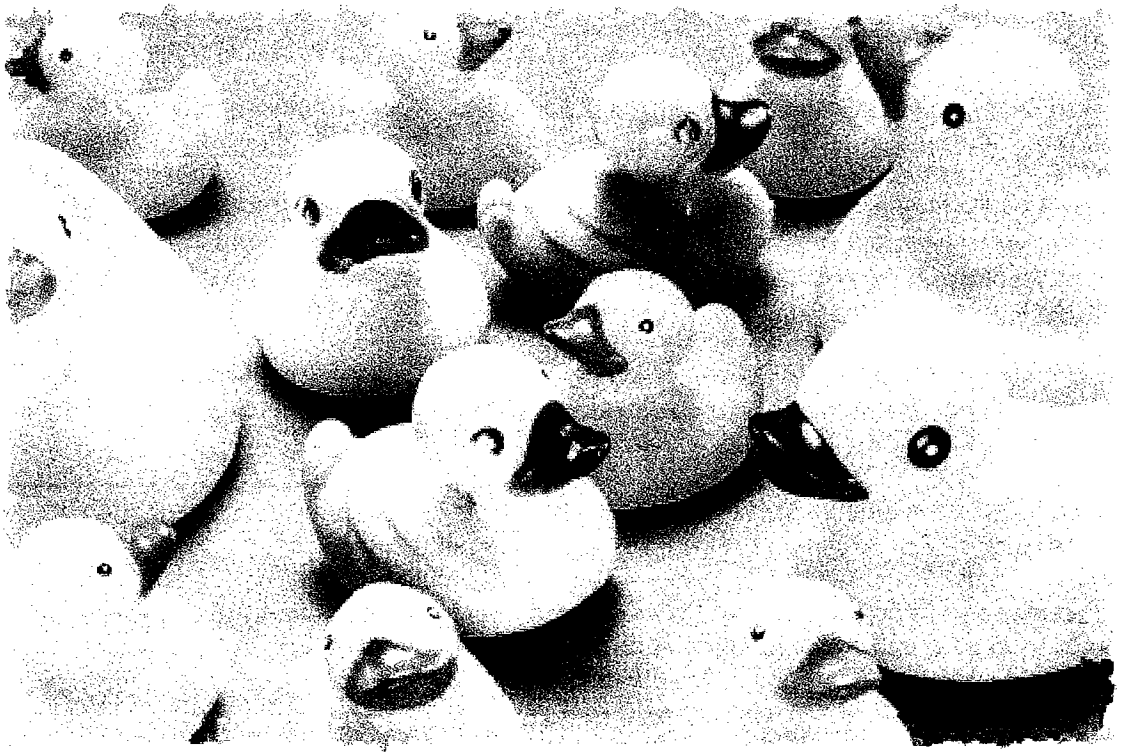
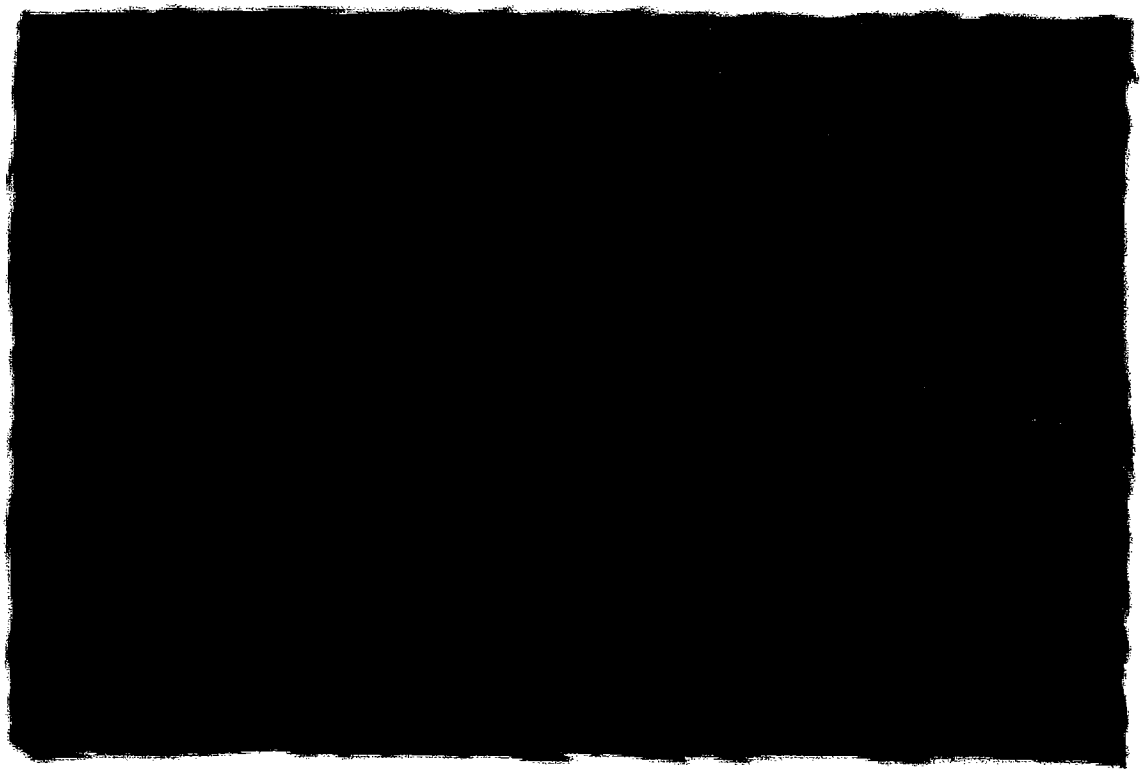
We believe this type of measure would accomplish multiple objectives by helping ensure that:

- There is greater accountability across the child welfare system
- Agencies know the standards and are aware of non-compliance
- Authorities are more aware of service delivery issues/concerns within the agencies they oversee
- Non-compliance is tracked and used to identify themes so we can better understand the challenges and needs of children, families and workers within all the systems, individually and collectively, and
- The entire child welfare system is consistently working towards best practice.



AN OVERVIEW OF THE MAJOR INITIATIVES UNDERTAKEN BY THE OCA

2006 - 2007



The Five Provincial Child Welfare Reports and Reviews Conducted Chronologically

Legislative Basis for the Special Case Review (Section 4)

Under subsection 4(2)(c) of *The Child and Family Services Act*, and under section 25 of Child and Family Services Authorities Regulations, the Director or an Authority has power to:

> "conduct enquiries and carry out investigations with respect to the welfare of a child dealt with under this *Act*."

Further, under *The Child and Family Services Act*, the Director has the following powers to acquire information as part of an investigation launched pursuant to 4(2)(c).

> "require any person who in the opinion of the director is able to give information relating to any matter being investigated by the director
>
> (i) to furnish information to the director. And
>
> (ii) to produce and permit the director to make a copy of any record paper, or thing that, in the opinion of the director, relates to the matter being investigated and that may be in the possession or under the control of the person."

These powers may be delegated in writing to another person or agency at the discretion of the Director.

1. A Special Case Review into the Death of a Five Year Old Child

A Section 4 Review was requested on March 20, 2006 by the Department of Family Services and Housing. It was to determine whether there had been a failure in the child welfare service system with respect to the services provided to a five year old child and her family according to *The Child and Family Services Act* and the provincial service standards.

This report sought to examine 'the circumstances that may have contributed to the death of this child as her family had received protection services within a year prior to her death. As criminal charges have been laid in this death, we worked closely with the RCMP while conducting this review to ensure that we did not interfere with their investigation. We immediately reported to them all information we came across that was relevant to their investigation.

The report was completed at the end of September, 2006 and delivered to the Department of Family Services and Housing the following week. Due to confidentiality as set out in *The Child and Family Services Act* and the ongoing criminal investigation into this child's death, the findings contained in this report were not made public. However, to help prevent similar incidents from occurring in the future, the report's 32 recommendations were made public and include some of the following:

- Agency training on intervention at the case management level with children and families where significant risk factors are evident,

- Strength-based assessments and risk assessments on all families where a child is found to be in need of protective services,

- That case reviews are completed as per the Standards on all children in care and recorded in both the family and the child's files,

- That funds be made available to ensure that the computerized information system (CFSIS) provides timely and coordinated information on children at risk and their families,

- That the Child Protection Branch work in partnership with the Authorities to develop a set of Provincial Standards to apply to all mandated child welfare agencies,

- That the Child Protection Branch, in partnership with the various Authorities ensure that all child welfare agencies follow these provincially approved Standards unless specific written permission to modify or be exempt is granted to them through the designated Authority by the Child Protection Branch,

- That all workers acting in all front line positions in Manitoba's child welfare agencies be provided with essential core training in abuse, CFSA, assessments, risk assessment, counseling, breaking through resistance, and relationship building with difficult clients, and

- That this training be delivered in a manner that is appropriate to the learning needs of new and experienced workers and supervisors.

2. *"Strengthen The Commitment"* - An External Review of the Child Welfare System - September 2006

Due to the tragic circumstances surrounding the death of the five-year-old child referred to in the Section 4 Review, an external review of the child welfare system was conducted. The Minister of Family Services and Housing called this review on March 20, 2006 to examine standards, processes, and protocols surrounding the opening, transfer, and closing of cases in child and family services. It would review the caseloads managed by front line workers. It would provide recommendations for improvements in these areas as well as any other areas of concern identified during the review.

A review team was assigned the task of meeting with and hearing from service providers at all levels of authority as well as service recipients and collaterals. This team was overseen by three independent co-chairs: The Ombudsman, Irene Hamilton; the Children's Advocate, Billie Schibler; and Mr. Michael Hardy, Executive Director of Tikinagan CFS in Ontario. The co-chairs determined to examine the Provincial Standards and service delivery as compared to best practice. The team made more than 100 recommendations.

Through our review team, we consulted with people in government, the Authorities and agencies in 32 communities across the province. More than 700 people who work within the system or were affected by it provided input. We heard from children and youth in the system whose perspectives were critical in order to understand how child welfare has affected them. We also heard from care providers, and collateral service providers. The views of the people interviewed throughout the review were reflected in the report.

This review was conducted at a point nearing the end of a process known as the AJI-CWI, a significant restructuring designed to transfer responsibility for Aboriginal child welfare to Aboriginal Authorities. Early in the review it became apparent that numerous concerns in the child welfare system predated this transfer. While the transfer was not the source of these concerns, the review concluded that it did represent a unique opportunity to address some of them.

Government, the Authorities, and the agencies need to strengthen and build on their commitment to the relationships, partnerships, and collaboration started in the AJI-CWI process. Government must demonstrate its commitment to the child welfare system in Manitoba by providing new resources and making the necessary structural changes to build on the existing framework of the AJI-CWI initiative.

Critical Findings

We found that the Authority structure needs to be enhanced in order to achieve the full goals of the AJI-CWI. There must be an appropriately resourced mechanism to develop and implement these goals.

We found that additional funding is required to provide Manitoba families with prevention and support services consistent with the principles set out in legislation, and that the child welfare system is currently based on child protection being its first and often only response.

We found that there are legitimate concerns with the Child and Family Services Information System (CFSIS), a province wide electronic tracking system that is not always effective. Many agencies are not using the system either because their community does not have the technological capacity to allow its use, the agency does not have the necessary equipment to run the system, or the agency has developed its own system. Regardless of the reason, CFSIS is lacking significant amounts of information. Similar problems exist with a new intake program, the Intake Module.

We found that the current intake structure, in which a "designated intake agency" provides intake services for all agencies in the same geographic area and serves as the public's front door to the system, requires further fine-tuning to ensure that transfers from intake to service delivery agencies are timely and appropriate.

We recommended the use of new methods of service delivery that will not only protect children but also build on the strengths of families and communities and promote the use of best practices in the delivery of child welfare services in Manitoba.

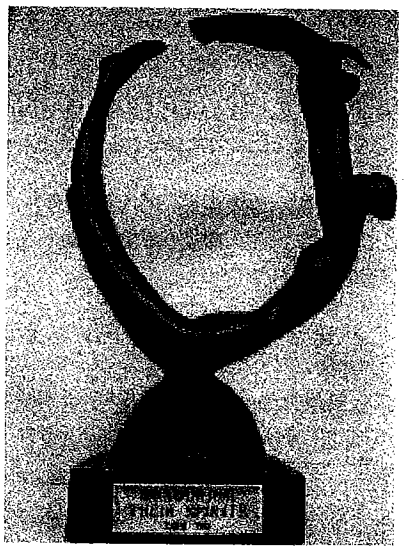
We recommended that significant resources be allocated to the child welfare system to allow for preventive and supportive services to families, to provide additional time for social workers to work with them and to create better and consistent places for children to live if action is required for their protection.

We recommended a structure that will promote province-wide seamless service delivery so that children and families can expect to receive the support that they need no matter where they live. This structure includes a Child Welfare Secretariat designed to provide operational capacity to the people responsible for the governance of child welfare - the Director of the Child Protection Branch, and the four Chief Executive Officers of the Child and Family Services Authorities. We believe that its creation will be a focal point for standardizing provincial child welfare services where necessary.

We believe that, if implemented, the recommendations in this report will allow Manitoba to move forward and position itself as a leader in child welfare. With their implementation, the government and authorities will strengthen their commitment to improve the lives of children and families.

These recommendations can be viewed in their entirety on the OCA website at www.childrensadvocate.mb.ca.

3. *"Honouring Their Spirits"* - The Child Death Review: A Report to the Minister of Family Services and Housing,- September 2006



The third request by government was for a Child Death Review of children who had died within one year of receiving child welfare services. We reviewed 99 deaths of natural and unnatural causes based on the Section 10 Reports provided by the Chief Medical Examiner's Office. These child deaths occurred between 2003 and May 2006. A team of four investigators was overseen by the Children's Advocate and co-chair, Dr. Jim Newton, Director of Psychology, Manitoba Adolescent Treatment Centre.

There were 78 recommendations stemming from this Review, relating to;

- suicide prevention,
- mental health services,
- age-of-majority planning,
- provincial standards,
- case management,
- Fetal Alcohol Spectrum Disorder,
- rural/northern/remote issues,
- the Child and Family Services Information System (CFSIS),
- the need to develop a library of digital photographs of children in care to be used in cases of emergency,
- crisis support,
- children with disabilities,
- child welfare prevention services,
- safety/risk assessments,
- the provision of uninterrupted services to children while awaiting resolution of inter-jurisdictional funding disputes (Jordan's Principle), and
- Resources and training.

These recommendations can be viewed in their entirety on the OCA website at www.childrensadvocate.mb.ca.

Government's Response to the Reviews: *"Changes For Children"*

On October 11, 2006, in response to the more than 200 recommendations stemming from the three reviews generated by the death of a five year old child, the Minister of Family Services and Housing made a public announcement of the government's plan to implement all the recommendations through a strategy titled *"Changes For Children"*.

The provincial government committed $42 million toward this strategy, which includes front-line staff training, suicide prevention, early intervention in family services, upgraded computer system for child tracking and information sharing, family preservation services, enhanced crisis response, up to 150 new positions to support front-line staff through work load relief, and to accelerate foster care recruitment.

A team was created to implement the recommendations and to develop a website that would allow the general public to track the progress of the *"Changes For Children"* commitment.

While the OCA is pleased to hear of the provincial government's commitment to change, these changes must start with more cooperation, compliance, and accountability at every level of the child welfare system.

4. *"Strengthening Our Youth"* - Their Journey to Competence and Independence

On January 10, 2007, Manitoba's Children's Advocate released a report on the struggles facing youth leaving the child welfare system, including 45 recommendations to improve outcomes for their lives after being in care.

The report was initiated and funded by the Manitoba Office of the Children's Advocate in response to concerns voiced about the lack of support and resources for youth who reached the age of majority (18) and have to leave the care of the child and family services system; and by youth in care, or formerly in care, who are feeling inadequately prepared for the transition to adulthood.

The report noted almost 1,600 Manitoba youth would be "aging out of care" in the next three years. Most of the youth (70 per cent) are Aboriginal and a significant number (28 per cent) have a diagnosed disability. Many others may have disabilities that have never been formally diagnosed such as Fetal Alcohol Spectrum Disorder (FASD), Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).

Research by the National Youth in Care network showed that less than 30 per cent of youth in care complete high school in Canada, compared to 85 per cent of the general population, so they become unemployed, underemployed or receive social assistance to survive.

Research has shown this population of youth is disconnected from the family and community supports that other young adults enjoy well beyond the age of 18. Only in the child welfare system do we systemically force children to leave their homes and support system at 18. Leaving care, they are already vulnerable, poorly prepared for the challenges of living on their own and at high risk of becoming victims again and again.

A large number of former youth in care become homeless. Because educational, financial and emotional challenges put them in unsafe environments, it is not uncommon to see a high number of youth who have left care drifting toward gangs, engaging in substance abuse, becoming victims of sexual exploitation and being involved in criminal activities. They are more likely to be at risk of self-harm, have suicidal ideations and suffer depression due to their life circumstances.

It simply does not make sense to expect that these young people can make it on their own the instant they turn 18, without adequate financial, emotional and moral support, but that is largely what has happened to youth leaving the child welfare system in Manitoba. The resulting situation has not been a benefit to them or society.

The provincial legislation governing care is complex, with more focus on entry into care and little attention to exiting care. Manitoba has taken steps to ensure the availability of adult service programs that support youth with special needs, mental health issues and disabilities after the age of majority. However, what about those youth who function marginally, but do not meet the stringent criteria to qualify for specialized Adult Support Services? Without the supports of a family or the child welfare system that was responsible for their care, it is critical that government extend their commitment to providing this population of vulnerable young adults with the necessary support services.

Young people need help while in care to prepare them to live independently. They need to be better educated so they can have more options. They need a safe place to live once they leave. They need time to transition. They need at least one person in their lives, ideally a network of caring people, to take a significant interest in their lives while in care and after care.

The provincial government needs to address these issues.

The Children's Advocate made 45 recommendations to improve the outcomes for youth leaving Manitoba's child welfare system.

Some of these recommendations are as follows:

- Include youth in independent living preparation as much as possible, well in advance of them reaching age of majority,
- Develop policy and regulatory standards for youth leaving care (including independent living preparation and post-care services),
- Ensure that policies and standards are developed in consultation with youth in care or formerly in care, and then applied consistently across the Province,
- Provide services up to the age of 21 years rather than 18 for those requiring or requesting additional assistance, and up to the age of 25 if necessary for youth to continue their education or develop work skills,

The Children's Advocate made 45 recommendations to improve the outcomes for youth leaving Manitoba's child welfare system.

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- Caregivers should be provided with Core competency training so they can effectively mentor and prepare the youth in their care to be more independent and possess greater life skills when exiting care. The training should be geared to meet the needs of youth at various age intervals beginning at age 15.

- Services to prepare youth for leaving care should outline a flexible and functional process and include mandatory needs assessments, individualized transition plans and post care services, particularly focusing on the diverse special needs of youth who may not meet the criteria for adult supported-living programs,

- Establish a fund for community organizations to develop and deliver aftercare services to former youth in care,

- A team of individuals significant to the youth be part of their independent living planning and continue as a strong support network for the youth upon leaving care,

- A mentoring program to be developed linking "aging out" youth with former youth in care through *Voices, Manitoba Youth in Care Network*;

- That Authorities and Agencies develop a practice standard that promotes reconnections with biological and extended family, former foster parents or other significant persons in the life of the youth,

- That the system be open to aiding older teens requiring protection services. They are often turned away by agencies as they are seen by the child welfare system to be too close to the age of majority to commence involvement. Little or no attention is given to the emotional damage and future challenges these young people face. They are referred to the adult welfare system for financial and shelter support. We recommend that the authorities review the admission to care standards to allow for the admission of youth nearing the age of 18 in need of shelter and emotional/financial support,

Further recommendations were made for youth in the areas of housing, education, and health.

All 45 recommendations contained in the report can be viewed on the OCA website at www.childrensadvocate.mb.ca.

Government's Response to The Age of Majority Report

Immediately upon release of the OCA's report on youth aging out of the child welfare system as they legally become adults, (*"Strengthening Our Youth" - Their Journey To Competence and Independence*), the Minister of Family Services and Housing accepted all of the recommendations and committed to providing $240,000 towards their implementation. These new recommendations have been included in the government's *"Changes For Children"* strategy to be addressed along with the recommendations stemming from the other reports.

5. A Special Case Review into the Death of a Three Year Old Child

In August 2006, at the request of the Director of the Child Protection Branch, the OCA agreed to conduct an independent external review under Section 4 of *The Child and Family Service Act* into the suspicious and untimely death of a three year old child.

Though such reviews are typically conducted through the Child Protection Branch, this request came to the OCA, as we were in the midst of the Child Death Reviews generated from the death of a five year old child.

The family of the three year old child had received services from the child welfare system within the year prior to the child's death. Criminal charges have been laid in this matter. In conducting this review we, once again, worked closely with the RCMP to ensure that we did not interfere with their investigation, while also ensuring that any information relevant to their investigation was reported to them.

The completed report of our findings and recommendations was delivered to the Department in January 2007. Due to limitations of confidentiality as set out in *The Child and Family Services Act* and the ongoing criminal investigation into this death, the findings and recommendations contained in this report were not made public.

Conclusions Arising from the Special Case Reviews - Section 4 Reports

In concluding the two reviews, we discovered that both shared striking similarities.

Some of the common findings are as follows:

- a lack of updated and accurate case file recording to reflect the contact and level of involvement with the family,
- inadequate safety/risk assessments,
- no support services for intervention despite early signs of stressors,
- failure to follow provincial standards,
- inability for workers to effectively manage cases due to high workload volume,
- a lack of adequate resources and staffing for the volume and complexity of cases,
- the provincial computerized child welfare information system (CFSIS), was inaccessible in some regions or was not adequately updated with relevant, timely information,
- a lack of inter-provincial coordination of services and information sharing, and,
- A lack of critical information-sharing between the child welfare system and related collateral services.

We further concluded that services for these children and their families should have been delivered more effectively. We made recommendations to address the concerns stemming from our findings and to hopefully decrease the risk of a death in a similar situation.

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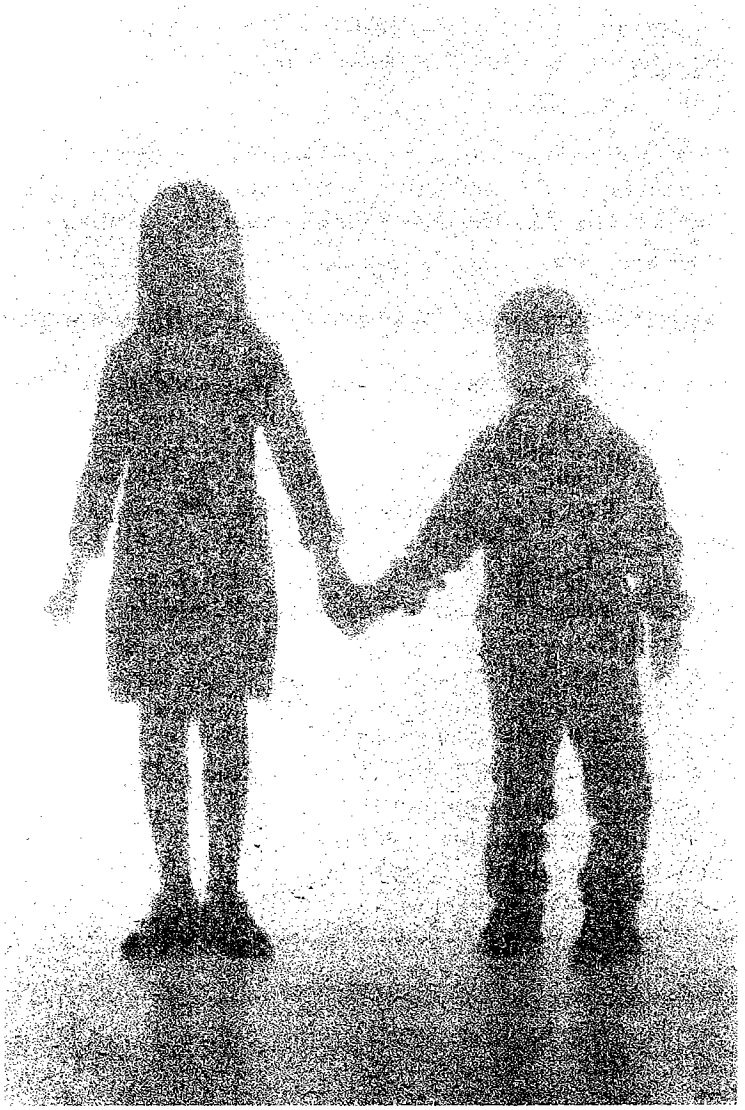
PROPOSED EXPANSION TO DUTIES AND LEGISLATIVE MANDATE

BILL 16: *THE CHILDREN'S ADVOCATE'S ENHANCED MANDATE ACT*



Section 10 Reviews into Child Deaths

During the months of our work on the *"Honouring Their Spirits"* report, we spent countless hours reviewing the files of the children who had died. Despite their tragic and untimely deaths these children belonged to families. They were part of a community. They had a name and an identity. They had a spirit.

We realized that the responsibility of society and the child welfare system toward a child does not end when the child dies. That child still required the advocacy services of the OCA and we had the responsibility to animate their voice and to "honour their spirit." We realized that it was incumbent upon us to tell their story, as they could not do it for themselves. And, in doing so, we continued to ask ourselves "could there have been something done differently in the services provided? Could communication between service systems, even outside of the child welfare system, have resulted in a different outcome for that child? For many of those children who left this world far too early, the answer is "YES".

As a result of recommendations from the reviews, in mid-October, 2006, the Minister of Family Services & Housing announced that the Section 10 Child Death Reports would be moving from the Office of the Chief Medical Examiner to the Office of the Children's Advocate. A proposed budget increase to hire two additional investigators and administrative support will be provided. Included are additional funds for travel, operational expenses, and additional office space. The two investigator positions presently assigned to these reports at the Office of the Chief Medical Examiner will also transfer to the OCA.

Under the new Act the reports will be provided to the Minister of Family Services & Housing, the Ombudsman, and the Chief Medical Examiner. The OCA will provide an annual report on the child death findings. The Ombudsman will now report annually on the follow-up of the OCA recommendations.

This will require amendments to *The Child and Family Services Act, The Fatality Inquiries Act,* and the *Ombudsman Act* to reflect the changes in the duties and responsibilities surrounding the Section 10 Reviews. They were introduced for legislative change in late Fall 2006 through Bill 16, *The Children's Advocate's Enhanced Mandate Act.*

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Systemic Issues

Maltreatment of Children in Care

While the Office of the Children's Advocate was involved in reviewing the deaths of children who had died while receiving child welfare services within the year before their deaths, we received an additional request for service from the community. We were asked to look into the circumstances of children who have suffered injuries as a result of neglect, assault, and acts of omission while receiving services or while in the care of a child protection agency.

This fiscal year, the OCA investigated 49 cases where there were concerns that children in care were being neglected or injured in their foster homes, group homes, or emergency shelters.

Some examples of the **allegations** included:

- general neglect such as leaving a young child unattended or using a young child to baby-sit younger children,
- a child being struck by a staff person in an emergency shelter,
- staff neglecting to take an injured child for medical attention,
- sexual assault on a child by a caregiver,
- injuries incurred as a result of untrained staff who were restraining a child in their care,
- caregiver shaking an infant, risking serious injury to the child,
- assaults of children by other children or youths in their placement,
- emotional abuse by caregivers through swearing, putting children down or threatening to return them to a previously abusive home,
- exposure of children to inappropriate sexual material such as pornography belonging to the caregiver, and
- Exposure of children to inappropriate television programs and movies with sexual content or excessive violence.

While the majority of the allegations were found to be unsubstantiated through investigations conducted by the agencies, six were substantiated. In two cases criminal charges were filed against the caregivers. In three instances, service providers at emergency placements or collateral placement agencies did not report these incidents when they occurred. At the time this report was written, six cases were still being investigated.

During our investigation into these allegations a number of themes emerged. It became apparent that some of the agency workers lacked understanding of their responsibility to report any serious injury of a child in their care to their Executive Director and/or the Child Protection Branch. In addition, all allegations of abuse and suspicious injuries of children in care must be investigated and the investigating worker must write an Abuse Incident Report. Some of the workers we spoke to in these cases indicated that they had not been informed that they were required to report all injuries of children in care for follow-up. The result was a scattered approach to investigating these allegations.

Additionally, although all residential homes licensed by the province are required to report all injuries involving children in their care to the Child Protection Branch, our investigations indicated that there is, at times, non-compliance in submitting these reports. In some instances, the Branch only became aware of an incident when the OCA requested an investigation by their office.

The OCA also found that there were foster homes where concerns had been raised and substantiated but there appeared no system in place to track these homes to ensure that, if warranted, they would no longer be considered by another agency as a place of safety for children in care.

Another area of concern was the lack of reporting to a parent or guardian when their child had been injured while in care. Some of these parents were not informed until well after the incident. In some cases the parents were not informed at all. In other cases the parents became aware of the injury or assault only when a third party brought it to their attention. When the parents did become aware of an injury or alleged abuse by a caregiver, many of those parents reported that the agency did not respond to their requests for information regarding the investigation of these injuries.

Our office found that in some of these cases, there had not been an investigation into the allegations or reports of suspected abuse. This was particularly apparent in cases where parents or families raised the concerns or allegations. It became apparent that some workers discounted the family's concerns, seeing it as an attempt by the parents to shift the blame to the agency or other caregivers rather than taking responsibility for the behaviour that put their children into care. They felt the parents were simply attempting to sabotage the child's placement.

Some reports to our office were related to injuries of children resulting from restraints being used in an effort to control their behaviour. Reports of children as young as five or six years of age being restrained came to our attention. Our office recognizes that there may be incidents in which a child requires restraints to protect the child from self-harm or from harming others. However, we found incidents in which these children were improperly restrained, resulting in injuries, including broken bones. In these particular situations, it was found that the foster parents and most shelter workers who had to restrain an "acting out" child did not have formal training in the use of restraints or alternatives such as non-violent crisis intervention. In our view, none of the mitigating behaviours of these particular children met the criteria of "imminent risk to the child/youth or caregiver" to justify the use of restraints or the level of force used on the child being restrained.

The OCA will continue to investigate in this area and will report our findings.

Helping Children and Families to Heal

As indicated in last year's annual report, children become "afraid of the repercussions of being seen as the one who upset the delicate and often precarious balance of life that exists around them." But what does Child and Family Services do to help repair families after intrusive intervention?

For many children who are reunified with their families you can see evidence of the emotional scars of disappointment, anger, and distrust. The children are often fearful that there may be recurrences of the behaviours that separated the family. The parents and siblings may have anger and resentment toward the child who had disclosed and "blown the whistle." Agencies often do not have a complete reunification service to help the family reintegrate and work through the emotions they carry.

We have seen evidence of families being thrown back together, being read the "Riot Act" of what they should and should not do in the future, and being given the message by the Child and Family Services system, "we will be watching". These families are left trying to put themselves back together again - trying to re-establish their rapport with one another. It is hoped that over time these families will solidly recover from their wounds. But how vulnerable has the system left the child who was responsible for disclosing? This child is at risk of being re-victimized, even by his or her own siblings. Quite often this victimization manifests in the form of emotional persecution.

Whether the family reunifies or not, the agency must still respond to the individual "healing" needs of each family member.

And what of the adults - the caregivers? How well are they able to deliver on the expectations set out for them? How well can a family function, following re-unification, if the parents are continually fearful of failure or of being reported to child welfare? Is it realistic to think that families can fully recover from a trauma without intensive support services to help them reconcile?

And while these children are out of their family homes and in care, what supports and education are provided to the alternate caregivers/foster parents? How well has the agency prepared them to ensure that they are highly sensitive and able to respond to the complexity of emotions that children experience when their families have been dismantled or are being reunified? The child's feelings of anger, guilt, disappointment, loss, and fear may often transform into challenging behaviours. These children need to be encouraged and given opportunity to grieve, purge, and heal before and after being reunified with their family of origin.

The OCA believes every child protection agency has the responsibility and moral obligation to ensure that services are offered to rebuild all the fragmented pieces into a whole and functioning family unit wherever possible. Whether the family reunifies or not, the agency must still respond to the individual "healing" needs of each family member.

Child Sexual Exploitation

> *Child sexual exploitation is the act of coercing, luring or engaging a child under the age of 18 into a sexual act and involvement in the sex trade or pornography, with or without the child's consent, in exchange for money, drugs, shelter, food, protection or other necessities.*
>
> - Definition developed by the Manitoba Sexually Exploited Youth Strategy Team

In Manitoba, the sexual exploitation of children is a very tragic reality affecting many of our most vulnerable children. Historically, society had viewed these children as willing participants in the sex trade. The child welfare system often did not respond well to these children, seeing their exploitation as one of choice and outside of their mandate.

However, *The Child and Family Services Act* includes sexual exploitation under the definitions of abuse. There is a growing understanding that these children are the victims of sexual abuse rather than willing participants in a criminal act. These children are entitled to the same protection from abuse as all other children covered under this *Act*.

The Manitoba Government acknowledges that these children require a specific and targeted intervention and has initiated the Manitoba Sexually Exploited Youth Strategy to address this very serious issue. While there is recognition that children are being sexually exploited across this province, the nature of the exploitation and the interventions and resources needed to address these concerns vary from region to region. In February 2007, the provincial government held community consultations to hear feedback from stakeholders regarding this topic.

The Manitoba Association of Friendship Centres were contracted to evaluate each region and to identify the stakeholders who would be interested in forming regional teams that could address this issue in their respective communities. There are now two active regional teams (Northern and Winnipeg) that are formulating strategies and providing education to their communities. Although other regions have expressed an interest, at the time of this writing, there has been no funding provided to assist these areas in team development and implementation.

The Northern team has provided much needed information to their communities and has identified the need for an outreach worker and a Crisis Unit to address these concerns.

In Winnipeg there have been a number of community organizations responding to this issue with a variety of supports and resources to assist these children:

- The Training and Employment Resources for Females (TERF) program run out of New Directions provides comprehensive education, treatment and mentoring programs for sexually exploited youth.
- N'dinawe offers shelter and outreach. In partnership with Red River Community College and Manitoba Education, N'dinawe also offers a comprehensive educational program that trains experiential women who want to work with youth and mentor them toward a safe and healthy lifestyle.

- Marymound's Rose Hall and Ma Mawi Wi Chi Itata Centre's Honouring the Spirit of Our Little Sisters, cares for children in their residential treatment home/safe transition home.

- The Drug Stabilization Unit and the Crisis Stabilization Unit provide short-term stabilization for children in crisis.

- Mount Carmel Clinic's Sage House, in partnership with the North End Schools Safer Corridors Project provides the Biindigen Outreach Project. This is an outreach program that seeks out youth who are being victimized on the streets and provides prevention services.

The Stop Sex With Kids Campaign has also raised awareness of exploitation of these youth. (Funded through National Crime Prevention and the Manitoba Family Services and Housing and developed in partnership with Child Find Manitoba).

The Safer Communities Investigation Unit (a Manitoba Justice initiative) specializes in tracking down sexual predators of children. Winnipeg Police Services have been more proactive in identifying these children at risk, and then referring them to service agencies, rather than simply arresting them, as once had been the practice.

Until this year, the Joint Intake Response Unit (JIRU), now the All Nations Coordinated Response Network (ANCR) had designated a community worker to liaise with community organizations and

agencies providing programs and services for sexually exploited youth. Community outreach workers and the police were able to report to this liaison worker any children identified as being exploited. That worker would then connect the children with the appropriate interventions offered through the Child and Family Service agencies. The worker was also a valuable resource to the agencies in connecting children in care with the various community resources.

Although sexual exploitation is now recognized as a serious child protection concern, when the central intake community program was reorganized, this position was eliminated. As a result, the community organizations and police now are required to go through the regular CFS intake process, and the workers who are responsible for caring for these children no longer have that worker's expertise at their disposal. Once again many of these children are slipping through the cracks and are too often a low priority when responding to the many requests for child protection service.

Given the changes that have taken place in the Intake Services after devolution, there is now an opportunity to have this service based out of the abuse units rather than the community program. Provision of those specialized services out of the abuse units would be a more accurate response to sexually exploitive abuse. It would directly link the abuse units of the agencies who are struggling to provide interventions to these children and youth to community organizations and their valuable resources and expertise.

The OCA supports the following initiatives to be undertaken by government:

- Provision of a liaison worker who works between the youth, the agencies and community through the abuse units based out of ANCR.
- Provision of resources necessary to continue in the development of regional teams, and to implement the strategies that are identified by those teams.
- Provide an updated definition of Child Sexual Exploitation in *The Child and Family Services Act* to ensure that agencies understand their responsibilities toward these children.

Informing Children and Youth

Let us see our Files!!!" According to Marie Christian of *Voices: Manitoba's Youth in Care Network*, this is a common phrase voiced by children and youth.

"Let us see our Files!!!"

As a child welfare agency's principal focus is the safety and protection of children, the work of ensuring that children have a chronological, pictorial history of their family of origin and their time in agency care, is often not given priority. Not having this detailed information and concrete understanding of who they are will leave a child confused and uncertain.

Particularly concerning to the OCA is that in many instances agencies seem to have a lack of protocol or policy about compiling and sharing children's histories with them.

This lack of information has resulted in children waiting for too long to begin to understand what is happening to them, to understand where they belong in this world and what the future holds for them. This lack of identify can create emotional pain and poor self-esteem, often resulting in high-risk behaviours.

Children who come into the care of an agency have the right to know why this has happened. They have a right to be informed and to participate, at an age appropriate level, in the decisions that are being made on their behalf. All children have a right to know their family history and wherever possible continue or develop relationships with extended family. Consistent with Article 12 of the Convention on the Rights of the Child and as indicated in our *Strengthening Our Youth* report, it is critical for young people to be involved or included in their case plan wherever possible.

While it is always best to start this process from the moment a child enters agency care, it is never too late to begin this work. This information-sharing needs to occur on a continual basis as children's perceptions and their level of understanding change over time. Adolescents have a special need to reaffirm their place in the world and need to understand their past in order to move forward into their adult life.

At this time, the right to information is not well addressed in child welfare. *The Rights of Youth: Youth in Care* publication, dated April 2007 was jointly produced by the Manitoba Human Rights Commission, the Ombudsman's Office and the Office of the Children's Advocate. It says to youth: **"you also have the right to be involved with your case plan".**

It is therefore the Recommendation of the Children's Advocate that:

- **Agencies recognize the importance of sharing information with children and youth in their care, and furthermore, provide the time, training and resources necessary to consistently provide this service to these young people,**
- **Provincial Case Management Standards be developed to include guidelines for providing children/youth with ongoing information about their history and life circumstances,**
- **Agencies develop processes where they can gather thorough information at the point when the child enters the child welfare system,**
- **Agencies review their child-in-care files to determine if the child's information is thorough and develop a plan to locate missing information, as per the provincial standards noted in point two of the Children's Advocate's recommendations.**

Unless you stop arguing, you can't hear me!

Unless you stop arguing, you can't hear me!

The Need for Advocacy in Custody/Access Disputes

The need for advocacy in custody/access cases was raised in last year's annual report.

It can be argued that it is our children who feel the greatest impact from separation and divorce. Despite this, it is also our children who have the least amount of control on decisions being made around them. Decisions may be made about their future with no

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regard to their needs or wishes. There is a need to create a process for meaningful participation of children affected by custody disputes. Giving children a voice and including them in processes that impact upon them helps create an environment where they can feel more valued and empowered.

The United Nations Convention on the Rights of Child states;

Article 3
In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be a primary consideration.

Article 9
... where the parents are living separately and a decision must be made as to the child's place of residence ... all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

Article 12
Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Of the 933 cases closed in our call management system this fiscal year, 130 (14 per cent) were calls about custody/access disputes. In the year prior we received 167 custody/access calls. Custody/access issues are outside of our mandate. We cannot advocate in these matters so the majority of these callers were referred back to their respective legal counsel or to Family Conciliation for help.

Recently, Family Conciliation's *"For the Sake of the Children"* Program has been made mandatory for parents involved in contested custody/access cases. This is certainly a step in the right direction as this program serves to provide parents with the necessary information and skills to adjust to separation so they may in turn assist their children in adjusting.

Family Conciliation provides a wide range of other conflict resolution services to families experiencing separation and divorce. While these services are an invaluable tool to the families who access them, there is no one who can legally advocate on behalf of the children's best interests.

Our experience over the years has shown that as the court process moves forward, the emotions of parents often can cloud their ability to plan in their children's best interests. Advocacy allows an opportunity through alternative dispute resolution to assist parents in resolving issues for their children as they arise rather than allowing them to grow into larger issues.

The Office of the Children's Advocate is an obvious choice to take on this role and work to ensure that these children have a voice. This would require an expansion of the legislative mandate governing the Children's Advocate. Doing so would enable our office to provide these children with an opportunity for meaningful involvement in the decisions being made about their futures.

Regardless of whether this advocacy service becomes a part of the OCA's mandate, there is clearly a need for this type of formal advocacy service in Manitoba.

Dual Mandate/Youth Justice

In last year's Annual Report, the Office of the Children's Advocate noted serious concerns that were referred to our office from within youth correctional facilities.

As many of the youth were in the care of the child welfare system, the Children's Advocate asked the Department of Family Services to conduct an investigation into these matters.

Many incarcerated youth have lived in poverty. They have no support systems. They are marginalized due to frequent moves within the child welfare system that have further strained their already fragile emotional, social, and educational needs. The OCA continues to express the need for advocacy on behalf of these youth to ensure that essential services are provided to meet their unique needs.

A review of services provided at the Agassiz Youth Centre and the Lakewood Unit had been completed in 2001. We were notified in June 2006 that Youth Corrections Services, in discussion with the Child Protection and Support Branch of Family Services, had recommended that a broader review be conducted as some of the matters were deemed to be unresolved, ongoing systemic issues. The review entitled *Manitoba Youth Centre: Moving Forward* looked specifically at MYC, the point of entry into youth justice.

At the time this report was written, we had been informed by the Department of Justice that the review would examine areas around their intervention approaches as well as services provided to youth with special needs and their female youth population. One of the OCA's advocacy officers had been requested to participate on a sub-committee specifically examining services to the female Aboriginal youth population. As the female population is primarily of Aboriginal ancestry, the committee will consider whether the services at the centre could and should be more culturally sensitive and reflective of the population. It is our understanding that a draft implementation plan is scheduled for September 2007 with a full implementation plan slated to be in effect by December 2007.

We have also been advised that as of January 2007 the Department of Justice has made strong efforts not to place any females at their Lakewood facility. We further understand that following the *Moving Forward* review, service reviews of the other youth correctional facilities will follow.

Hotels and Emergency Placements

In the 2000-2001 Annual Report, the Office of the Children's Advocate reported on the use of hotels as emergency placements for children and youth. A Review of the Operations of the Winnipeg Child & Family Services Emergency Assessment Placement Shelter System was prepared in March 2004, resulting in 78 recommendations to the department. Yet, there were as many as 170 plus children and youth placed in hotels during the peak of the 2006-2007 fiscal year. As noted in our annual report last year the OCA has made a commitment to report upon the progress that government has made in implementing the recommendations made in the previous OCA reports on the child welfare system's use of hotels and emergency shelters. This progress review is currently underway and should be completed in early 2008.

ACTIVITIES AND COMMUNITY DEVELOPMENT

Community Involvement:

National/International

- Canadian Council of Provincial Child and Youth Advocates, Executive Meeting and Pump Up the Volume Conference, Toronto, ON.
- CWLC Annual Meeting and Board of Directors Meeting, Ottawa, ON.
- Joining Together: Conducting Forensic Investigations on behalf of the Young Abused Child, Calgary, AB.
- Family Group Decision Making 2006 Conference, San Antonio, Texas, USA.
- World Forum 2006, Vancouver, BC.
- CIS Steering Committee Meeting, Ottawa, ON.

Provincial

- CFS of Western Manitoba Annual General Meeting, Brandon,
- CFS of Central Manitoba Annual General Meeting, Portage la Prairie
- New Directions, Project VIP (Violence Intervention and Prevention) launch
- Boys & Girls Clubs of Winnipeg Annual General Meeting
- Knowles Centre Inc. Annual General Meeting
- Behavioural Health Foundation Annual General Meeting
- Senate Standing Committee on Human Rights presentation, Winnipeg
- Southern CFS Authority Annual General Meeting, Portage la Prairie
- General CFS Authority Annual General Meeting, Winnipeg
- West Region CFS Annual General Meeting, Dauphin
- Crossways Honouring Ceremony - hosted by New Directions
- Awasis Agency Annual General Meeting, Prince Albert, SK.
- Manitoba Foster Family Network 5th Anniversary,
- Child Welfare Reform; Progress on the Path to a Child and Family Friendly System Workshop,
- Rossbrook House Annual Open House, Winnipeg
- B & L Resources for Children Open House, Winnipeg.
- Kani Kanichihk System Advocacy discussion forum.
- Mother of Red Nations Women's Council workshop

Presentations and Submissions

This fiscal year the Children's Advocate and the staff of the OCA made presentations to the following organizations:

- Child and Adolescent Mental Health Program team (MATC).
- WCFS Area Councils
- MSW Social Work Program of the University of Manitoba.
- Villa Rosa
- Senate Standing Committee on Human Rights
- Red River College Child & Youth Care students
- Case Documentation in Child Welfare, Aboriginal CFS Diploma Program, U of M downtown campus
- Circle of Courage Keynote Address

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- Manitoba Association of Secondary Teachers of At-Risk Students
- Red River College Youth Recreation Activity Worker Program
- Inner City social work program
- WCFS foster parents
- Students, Aboriginal Child Welfare Certificate Program, U of M
- Frontier School Division school counsellors and panel discussion
- Mother of Red Nations Women's Council Aboriginal women workshop
- Aboriginal Counselling Skills Program, U of M downtown campus
- Frontier School Division students

In June 2006, the Office of the Children's Advocate held focus groups with youth to hear their thoughts and personal experiences in the area of violence, for the purpose of a submission to the United Nations Secretary-General's Study on Violence Against Children. The youth discussed with us the many types of violence they are exposed to and how this violence has affected their lives. The information provided through these focus groups was shared through the Canadian Council of Provincial Child and Youth Advocates and became a part of the 122 page report: ***Canadian Youth Speak Out*** About Violence Against Children. The report was generated through the partnership of the Canadian Council of Provincial Child and Youth Advocates, Ontario's Office of the Child and Family Service Advocacy, the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario, Save the Children Canada, and UNICEF Canada.

In September, the Children's Advocate presented to the Senate Standing Committee on Human Rights at a forum held in Winnipeg. The Senate Standing Committee was meeting with individuals across Canada to discuss Canada's commitment and effectiveness with respect to the UN Convention on the Rights of the Child. The concerns brought forward by Manitoba's Children's Advocate related to the high number of youth suicides in Manitoba. Through this presentation, information was brought forward about how the youth in our focus groups had relayed their sadness at the high level of violence that exists in their world. They experienced this violence in music videos, movies, television, media, their communities, families, through their peers (i.e. bullying) and through their awareness of what was happening on a global level. This exposure to violence resonates with them in their day-to-day lives, leaving them with very few healthy role models / influences and very little hope for their future. In their opinion, this is one of the contributing factors in the rise of youth suicide. The submission in its entirety can be read on our website at www.childrensadvocate.mb.ca

In the OCA's 2005-06 Annual Report, we reported that our office convened a gathering of service providers and stakeholders to discuss concerns about youth suicide in the province. We committed to gather information on the members' programs and disseminate this information to the rest of the committee. Since the writing of the last annual report, the OCA created a **Youth Suicide Prevention Resource Information Newsletter**. The first issue was released in November 2006 and will be updated every spring and autumn. These Newsletters can also be viewed on our website at www.childrensadvocate.mb.ca.

OCA Involvement on Committees

The Children's Advocate and the staff of the OCA participate on the following community committees:

- Child Inquest Review Committee (CIRC)
- Provincial Advisory Committee on Child Abuse (PACCA)
- Voices, Manitoba Youth in Care
- Canadian Council of Provincial Child and Youth Advocates
- Advisory Committee for Sexually Exploited Youth
- Child Health Committee, Children's Hospital
- Media Awareness Initiative about Sexually Exploited Youth (MAISEY)
- Social Planning Council of Winnipeg
- Circle of Courage
- Child Welfare League of Canada
- CIS Steering Committee (Canadian Incidence Study of Reported Child Abuse and Neglect).

Youth Rights Pamphlets

In 2006-07, continued collaboration and work between the Manitoba Human Rights Commission, the Office of the Manitoba Ombudsman and the Office of the Children's Advocate resulted in the creation of five more *The Rights of Youth* pamphlets on ***Criminal Justice, Family Matters, Neglect and Abuse, Youth In Care,*** and ***Adoption***. They were developed in consultation with youth and launched in April 2007. They are available through each of our websites.

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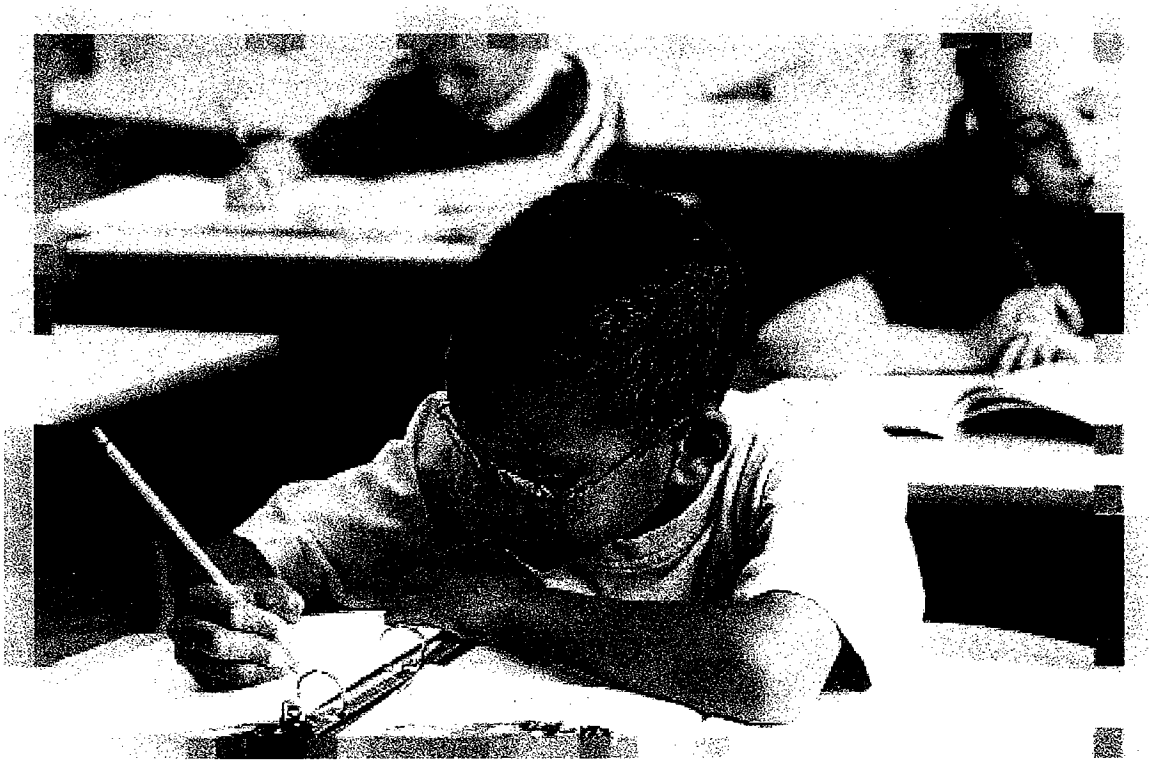
Year-end Statistical Analysis

April 1, 2006 to March 31, 2007



CALL MANAGEMENT	2006-2007
First Level Requests for Service	502
Second Level Requests for Service	1015
Total Call Management Services	**1517**
First Level Requests for Service Resolved	502
Second Level Requests for Services Resolved	431
Total Calls Resolved in Call Management	**933**
Calls Referred to Third Level	575
Calls Awaiting Resolution at fiscal year end	9

CASE MANAGEMENT	2006-2007
Case Files open from previous year	315
Case Files Opened - Information & Self-Advocacy Assistance	442
Case Files Opened - Brief Services	96
Case Files Opened - Advocacy Intervention	64
Total Case Files Opened	**602***
Case Files Closed - ISAA	436
Case Files Closed - BS/AI	235
Total Case Files Closed	**671**
Case Files Remaining Open at end of fiscal year	246

*Does not include 2 Systemic Issue files.

Files are only reflective of the files open and not necessarily the number of children served or the complexity of the case. Files are open on (multiple) sibling groups but only one file is opened on the oldest sibling.

Most Advocacy issues are common across the sibling group. For example, access by parent to the child. However, if another sibling in the group requires additional advocacy services and their issue is a separate issue a second file is opened.

Definition of Advocacy Intervention:

Complexity of services refers to matters where the issues identified are multi-dimensional and/or there is a lack of community and/or family resources to meet the identified needs. Such cases can include but are not restricted to:

- Family or support systems can no longer cope, given current resources available.
- Resources or service provision may end (i.e. transition planning, reunification, withdrawal of or refusal of critical CFS services).

- The community lacks the resources to meet the complex or unique needs of the child/youth.
- Complex multi-service cases (funding, case responsibility not clear).
- Cases where there are jurisdictional barriers to services (Federal vs. Provincial; services unavailable in the child/youth community).

Cases are seen as immediate, when there exists, significant personal or environmental breakdowns that require immediate intervention by one or more service providers. Such cases can include but are not restricted to:

- Death of caregiver
- Unavailable caregiver
- Suicide/suicide gesture
- Deterioration of Mental Health
- Deterioration of Physical Health
- Homelessness

Lack of Placement Resources:

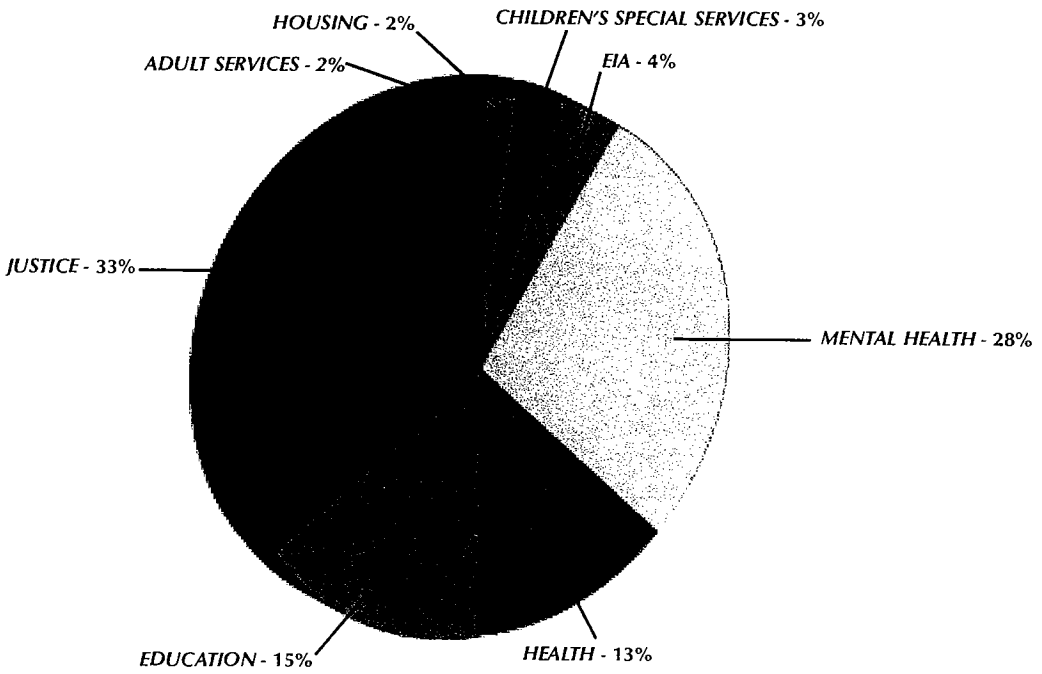
During the first months of 2006/07, a lack of placement resources for higher needs children was recognized. A tracking form was implemented in July 2007 and new user-defined fields in the case management database were created to aid in tracking this data. The following are the results:

UNAVAILABLE RESOURCES	Number
Mental Health Transitional Placement	8
Emergency Placement Resources	8
Other	3
Appropriate Education Resource	2
Total	**21**

Some of the comments documented were:

- High-risk child requires secure setting - shelters do not provide this.
- This child is a level 5 child in care/permanent wards who had to leave foster placement due to abuse allegations in the home.
- Lack of appropriate level of support from Psych Ward to regular placement option.
- High needs youth released to hotel placement. Youth refused to stay must be released if not acute.
- ADHD, running from placement.
- High risk, FAS, Bipolar - staff not skilled enough to meet his needs.
- Lack of Sexual exploitation and addiction treatment resources.
- Sexual offender who requires staff who are trained to meet his needs.

Dual Mandate Cases: (n=135)(103 Case Files)



- The majority of these cases fall into the youth criminal justice and mental health systems.

Dual Mandate:

- Dual mandate category refers to those cases open to the OCA and involved not only with the CFS agency/regional office but also involved another child serving system.
- Child and youth involved in the CFS system often have multiple service providers. The advocacy issue maybe central to the CFS system or to other child serving systems.
- Though CFS workers may be the individual who holds final, often definitive responsibility to and over the child, their ability to influence, control and/or direct resources of another system to address the needs of the child may be in many cases limited.
- To be considered a dual mandate case, the case characteristics need to include:

  (i) Child/youth had to have current involvement with the CFS system.
  (ii) Child/youth is not involved with the CFS system but is entitled to, yet refused services by a CFS agency prior to referral to the OCA.
  (iii) The case issue resulting in a referral to the OCA was identified as cross-jurisdictional involving another child caring system other than CFS.

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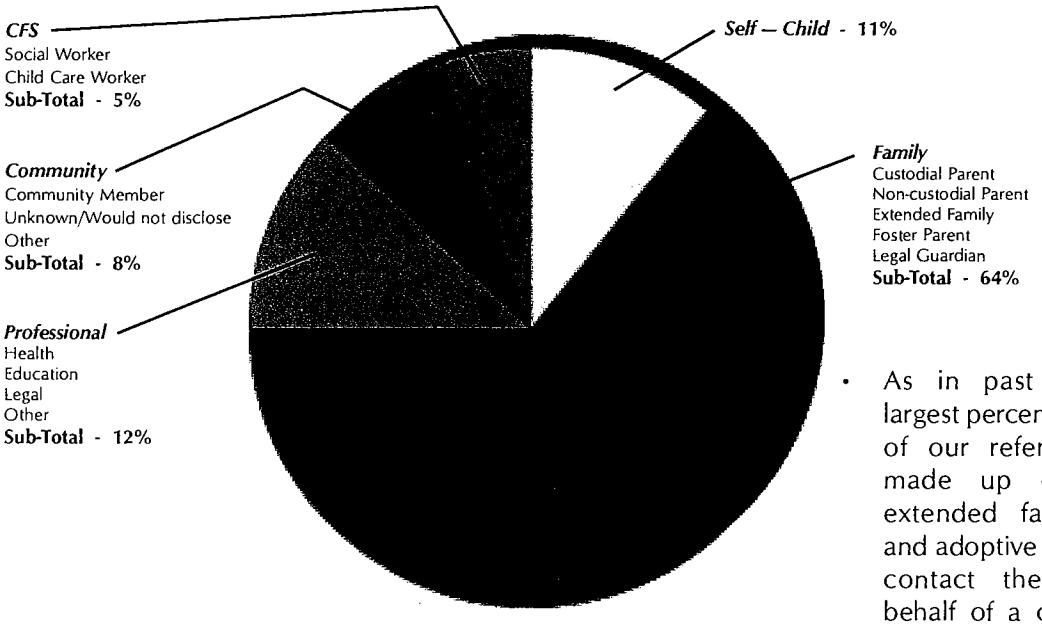
Who Contacted the OCA: (n=602)



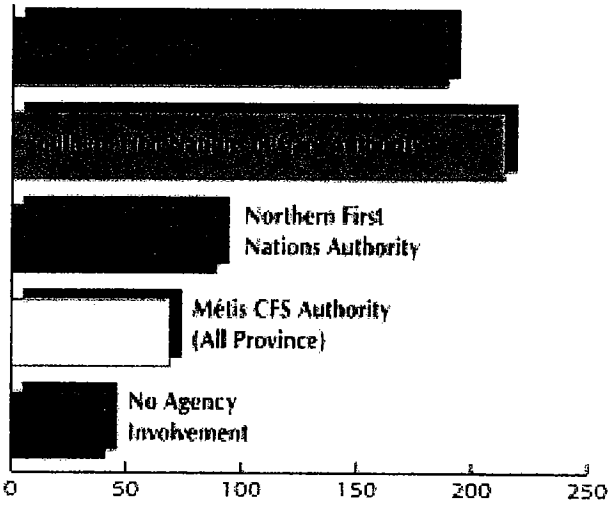
- As in past years, the largest percentage or 64% of our referral base is made up of parents, extended family, foster and adoptive parents who contact the OCA on behalf of a child and or youth.

Case Category/Involvement: (n=602)

CFS Case Category	Number	Percentage
Adoption	2	-
Child in Care	375	62
Protection	142	24
Emergency Placement Services	2	-
Voluntary Family Services	40	7
No current CFS involvement	41	7
Total	**602**	**100%**

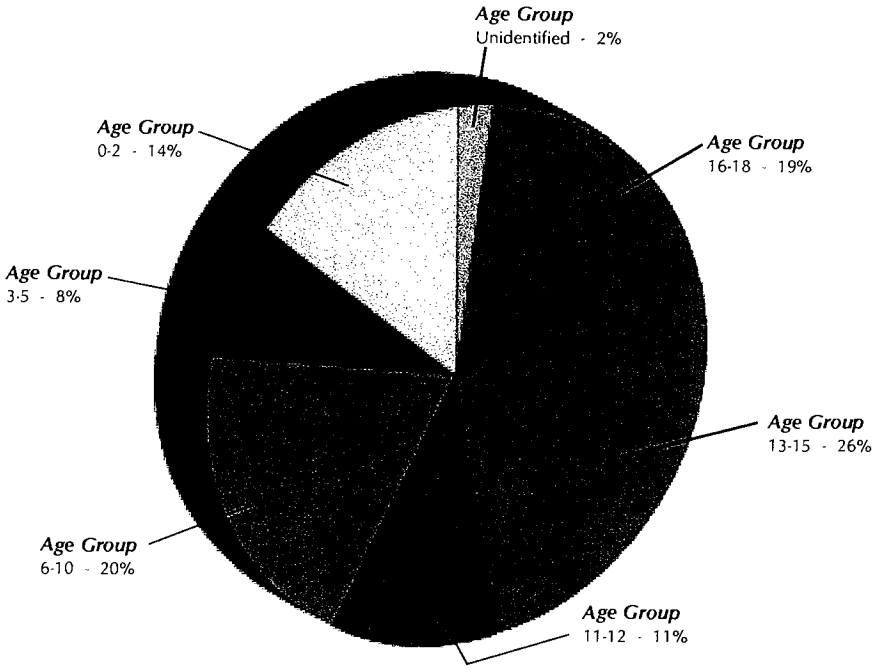
- 561 or 93% of the cases opened to the OCA had open and active CFS involvement with a CFS agency or regional office.
- 519 or 86% of the cases open to the OCA were open to a CFS agency or regional office as an active protection file prior to requesting advocacy services.
- As we saw in previous years, we again see an increase in requests for our services concerning children already in care. In 2002-03, we reported that in 25% of the files requesting advocacy services were children in care. In 2003-2004 that percentage increased to 42%; 2004-2005 that percentage increased to 58% and in 2005-2006 that percentage held relatively steady at 52%. This year, 2006-2007 the percentage increased to 62% of requests for our services concerned children in care.

Case Breakdown of CFS Agencies: (n=602)



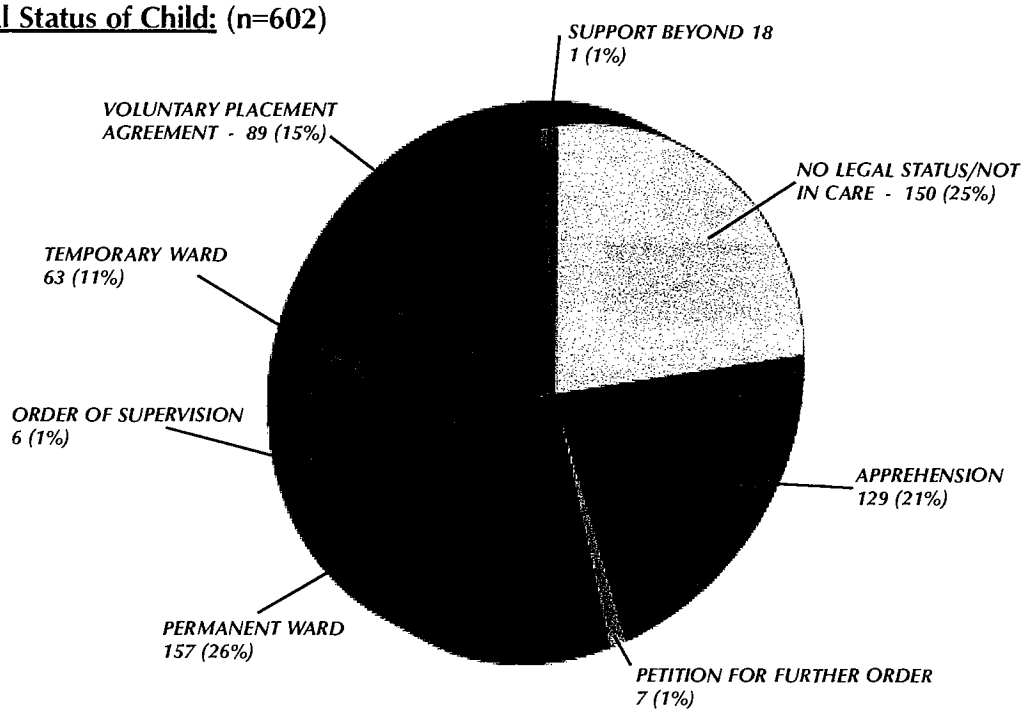
- In this fiscal year, 357 or 64% of the cases opened to the OCA with CFS involvement were children and youth being provided services by an Aboriginal Agency.

Child's Age and Gender: (n=602)



- As in past year, we served slightly more females than males.
- This year we served primarily young adolescents aged 13-15 (26%), children 6-10 (20%) and older adolescents ages 16-18 (19%).

Legal Status of Child: (n=602)



- 452 or 75% of the children and youth involved with the OCA were children in care with the CFS system where the system had a legal responsibility over the child.

Over the last eight years the OCA has opened 5118 cases to advocate for children and youth.

The Whereabouts of Children/Youth When Advocacy Files Were Opened

Often when people call the OCA their situation has reached a crisis point. Many youth have run from placement or left home. Parents at times will and have removed children from care situations approved by a private agreement or other formalized custodial arrangements.

We determined where a child is supposed to be living as approved by parent, caregiver or agency. This is called the Intended Placement.

Intended Placement: (n=602)

Placement Type	Number	Percentage
Parent/Guardian	168	28%
Non-Relative Foster Home	235	39%
Relative Foster Home	28	5%
Receiving Resources/Shelter	27	4%
Group Home	22	4%
Residential Facility	20	3%
Relative/Friends	28	5%
Hotel/Motel	26	4%
Place of Safety	20	3%
Youth Correctional	14	2%
Adoptive Home	2	-
Mental Health Facility	3	1%
On Own	5	1%
Unknown	3	1%
Other	1	-
TOTAL	**602**	**100%**

- We then determined if the child or youth is living elsewhere then their intended placement. We call this their Current Whereabouts.
- We found 48 or 8% of the children and youth served by the OCA were not residing in their intended placement

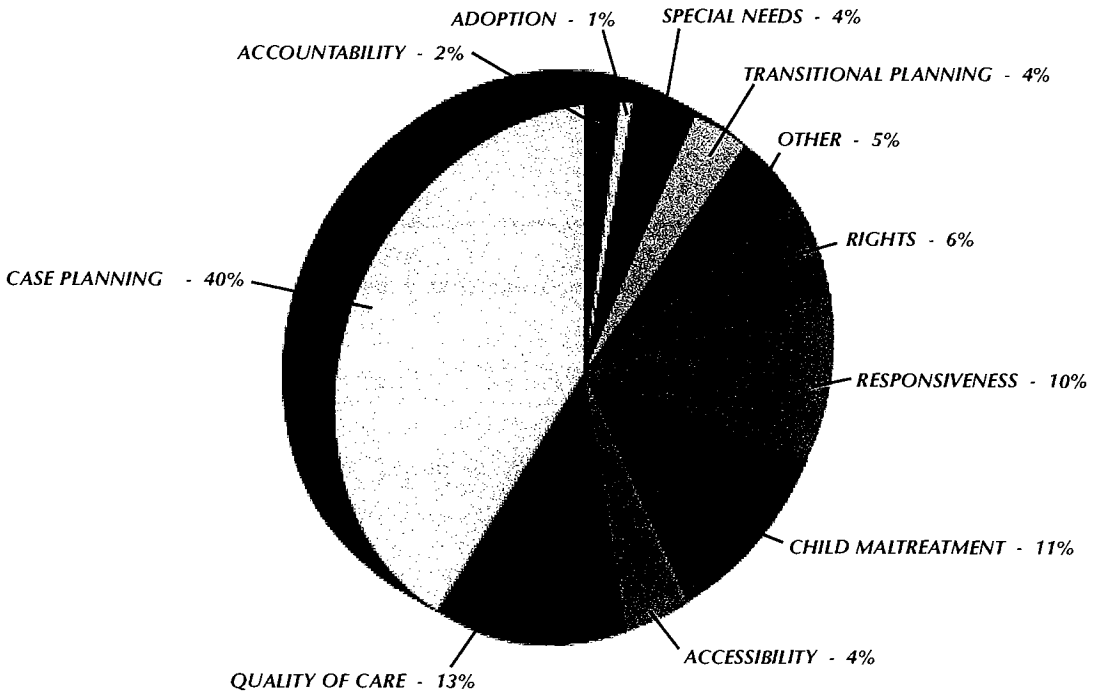
Current Whereabouts:

Placement Type	Number
Parent/Relative	19
Friend/Community	7
AWOL	9
Street Shelter	5
Other	3
Unknown/Would not disclose	3
Homeless	2
TOTAL	**48**

- In 2002-03, 17% of the children and youth served by the OCA were not residing in their intended placement. In 2003-04 this number dropped to 12% and remained the same at 12% in 2004-2005. In 2005-2006 and 2006-2007, only 8% of the children and youth served by the OCA were not residing in their intended placement.

- The majority of these young people are youth aged 13-18. In this age category, it is typically the older youth (ages 16-18) that are not residing in their intended placement. However, in 2006-2007 we once again see an increase in younger youth (ages 13-15) that are not residing in their intended placement.

Top CFS Related Concerns by Category:



Total CFS Related Concerns by Age by Category: (n=1591*)

ISSUE	0-2	3-5	6-10	11-12	13-15	16-18	18+	UK	ST	%
Accessibility	7	5	17	9	7	18	-	-	63	4%
Accountability	5	5	7	2	3	5	-	-	27	2%
Adoption	3	1	2	3	-	4	-	-	13	1%
Case Planning	114	71	150	54	148	93	-	-	630	40%
Child Maltreatment	19	21	66	22	28	20	-	-	176	11%
Quality of Care	16	20	35	42	65	32	-	2	212	13%
Responsiveness	18	16	36	12	39	33	-	1	155	10%
Rights	11	11	26	9	28	17	-	-	102	6%
Special Needs	2	2	10	6	21	15	-	3	59	4%
Transitional Planning	2	1	1	-	2	52	-	-	58	4%
Other	11	7	15	10	24	19	-	-	86	5%
Devolution	3	-	2	1	2	2	-	-	10	-
Total	**211**	**160**	**367**	**170**	**367**	**310**	**0**	**6**	**1591**	**100%**

*This does not represent the number of cases but the multiple numbers of concerns identified.

- Case Planning, Quality of Care, and Child Maltreatment were the top concerns of 2006-07.
- Over the last eight years these issues have remained constant. The top issues remain Case Planning, Quality of Care, and Child Maltreatment. New for 2006-07 are concerns regarding Responsiveness by service providers.
- During the 06-07 fiscal year, the OCA made a total of 39 recommendations to the Agencies resulting from concerns identified during the course of investigations into specific case matters. The Children's Advocate intends to follow up with the Authorities overseeing the Agencies to determine the progress being made on implementing those recommendations

Total Issues (CFS Related): 2006-2007

Category	Number
Case Planning	
Disagree/Refusal of/with CFS	214
Poor reunification planning	61
Lack of case planning	55
Lack of planning for family	56
Lack of parental/family participation	50
Other	50
Lack of worker contact	37
Lack of appropriate protection plan	36
Lack of child participation	24
Lack of permanency planning	21
Change of worker	14
Lack of Service standards	12
	630
Quality of Care: Child in Care	
Access/visitation to CIC	52
Lack of appropriate care resources	44
Mental health intervention/treatment	20
Other	18
Child AWOL	15
Lack of education program	12
Lack of Clothing	10
Inappropriate discipline acts	9
Too many placement moves	9
Inappropriate use of intrusive measures	8
Lack of health care	7
Lack of food	3
Lack of recreation	2
No contact with peers	2
Lack of privacy	1
	212
Child Maltreatment	
Suspected child abuse in community	60
Suspected child abuse CIC	47
Suspected child neglect in community	39
Suspected child neglect CIC	30
	176
Response/Timeliness	
Unresponsive	83
Service delays	41
Administrative delays	19
Over response	12
	155

WHAT DO THE NUMBERS REALLY SAY

Although the OCA was never intended as a crisis response service, this year we have continued to see an increase in urgent requests, indicating imminent risk to children*. Once again, matters have become more complex and time consuming.

* Any calls made to the OCA identifying safety concerns or risks to children are immediately referred to the child protection agency for their follow-up.

Web Site Statistics:

Our web site continues to be very popular. This year the site received over 82,000 visits from Manitoba, Canada and around the world.

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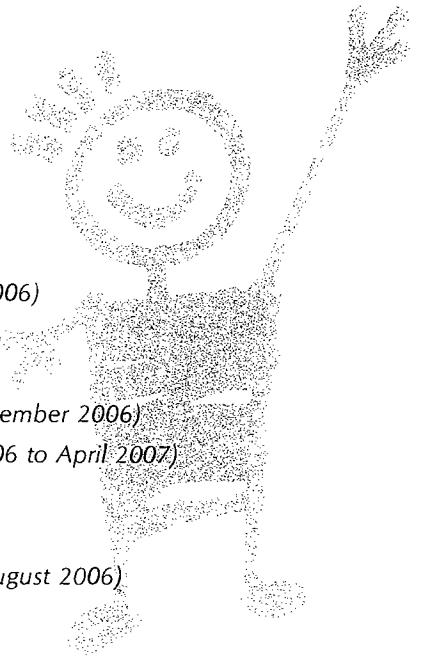
The Fiscal Year Budgets for The Office of the Children's Advocate

Expenditures	$(000)	FTE
2006-2007		
Total Salaries and Employee Benefits	549.9	10.5
Total Operating Expenses	193.9	

The Office of the Children's Advocate Staff List

Billie Schibler, Children's Advocate
Bonnie Kocsis, Deputy Children's Advocate
Patsy Addis Brown, Office Manager
Thelma Morrisseau, Children's Advocacy Officer
Jacek Beimcik, Children's Advocacy Officer
Rosie O'Connor, Children's Advocacy Officer
Nelson Mayer, Children's Advocacy Officer
Carolyn Parsons, Children's Advocacy Officer *(beginning December 2006)*
Melvin Armstrong, Children's Advocacy Officer *(until October 2006)*
Debra Babey, Advocacy Assessment Officer - Intake
Cybil Williams, Advocacy Assessment Officer - Intake *(October to December 2006)*
Brent Anderson, Advocacy Assessment Officer - Intake *(December 2006 to April 2007)*
Debra Swampy, Administrative Secretary
Karen Kawaler, Administrative Secretary *(Casual)*
Gazheek Morrisseau-Sinclair, Administrative Secretary *(May 2006 to August 2006)*
Errol Boulanger, Social Work student



Staffing Changes at the Office of the Children's Advocate

In August 2006, we were approved for the hiring of one additional Intake Assessment Officer and 1.5 Children's Advocacy Officer positions. As a result of increased staffing, the OCA has been able to establish a stronger presence in remote communities by assigning specific geographic areas to our advocacy officers.

We all have a hand in it!

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