Court File No. T-1621-19

FEDERAL COURT

B E T W E E N:

ATTORNEY GENERAL OF CANADA

APPLICANT/MOVING PARTY

- and -

FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA, ASSEMBLY OF FIRST NATIONS, CANADIAN HUMAN RIGHTS COMMISSION, CHIEFS OF ONTARIO, AMNESTY INTERNATIONAL and NISHNAWBE ASKI NATION

RESPONDENTS/RESPONDING PARTIES

MOTION RECORD OF THE RESPONDENT/RESPONDING PARTY

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Volume 1 of 3

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RESPONDENTS

AFFIDAVIT OF DR. MARY ELLEN TURPEL-LAFOND

(Affirmed November 7, 2019)

Volume 1

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Court File No. T-1621-19

FEDERAL COURT

BETWEEN:

ATTORNEY GENERAL OF CANADA

APPLICANT

- and -

FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA, ASSEMBLY OF FIRST NATIONS, CANADIAN HUMAN RIGHTS COMMISSION, CHIEFS OF ONTARIO, AMNESTY INTERNATIONAL and NISHNAWBE ASKI NATION

RESPONDENTS

AFFIDAVIT OF DR. MARY ELLEN TURPEL-LAFOND
(Affirmed November 7, 2019)

I, **Dr. Mary Ellen Turpel-Lafond**, of the City of Vancouver, in the Province of British Columbia, **SOLEMNLY AFFIRM THAT**:

1. I am currently a full Professor of Law at the University of British Columbia, Allard Law School, and the Director of the Indian Residential School History and Dialogue Centre, and a practising lawyer with Woodward & Company and have written and published extensive material on the issues surrounding First Nation children, women, inherent treaty and Aboriginal rights and the impact of colonial policies on First Nations and Indigenous governments, including human rights and child welfare and family issues. As such, I have personal knowledge of the matters hereinafter deposed to, save and except for those matters stated to be on information and belief and where so stated, I verily believe them to be true.

Introduction & Background

2. As noted, I am currently a full Professor of Law at the University of British Columbia, Allard Law School, and the Director of the Indian Residential School History and Dialogue Centre, and a practising lawyer. I received my law degree in 1985 at Osgoode Hall Law School and then went on to do a master's in Cambridge, England, and a Ph.D. in Harvard Law School. I have practiced law in Saskatchewan and also taught at Dalhousie University and the University of Saskatchewan.

3. Throughout my legal practice, I have done extensive work representing chiefs and children, family issues, including representation in court to get First Nation children back in their communities. Following a lengthy period of practice, I was appointed to the Provincial Court of Saskatchewan in 1998 and served on that court for a period of 10 years, including as the administrative judge for the largest judicial centre in Saskatoon.

4. In 2006, I was appointed British Columbia's first representative for children and youth, which is an independent officer of the B.C. Legislative Assembly. Over the following ten years, I was significantly involved in the area of child welfare, approximately some 17,000 cases over the period, including conducting investigations and reviews of child injuries and deaths reported in with the powers of the inquiry. As a result, I produced approximately 90 reports of different kinds in relation to these issues. Throughout this period I was either an active member of, or President of, the Canada Council of Child and Youth Advocates, which promoted issues for Aboriginal Children and Youth, focusing on the convention for rights of the child, the United Nations Declaration on the Rights of Indigenous People as applicable to children and families and pragmatically examining at the practice gaps.

5. Following the completion of this work in B.C., I briefly returned to the court and have since retired from my role as judge, returning to the world of private practice and teaching. I have published a significant amount of material on the issues surrounding First Nation children, women, inherent treaty and Aboriginal rights and the impact of colonial policies on First Nations and Indigenous governments, including human rights and child welfare and family issues.

6. As part of the National Inquiry into Missing and Murdered Indigenous Women and Girls, I was called as an expert witness to tender evidence specifically in the areas of law, legal and investigative practices, with specific expertise in child and family services, child welfare, custom adoptions, treaty rights, circle court process, domestic and sexual violence against women and girls, and investigatorial practice, including investigative reporting.

Child Welfare- Involvement & Relevant Reports

a. Hughes Reports- representative of children and youth

7. One of the places that I started in terms of the examination of child welfare in British Columbia was assisting on an arms-length review of the child welfare system in British Columbia which arose as a result of a number of deaths of children in British Columbia whose files had not been examined, appropriately reviewed or investigated, known as the "Hughes Report". In 2006 Ted Hughes, a Deputy Attorney General, prepared said report which called for an independent officer of the legislative assembly that could conduct investigations and review of the system, including compelling records as needed. The purpose was to establish transparency and commitment to look into the circumstances of these deaths to determine whether they were in any way preventable or connected to services they did or did not receive.

8. I was appointed to this role in 2006, being the Representative for Children and Youth. The first report prepared as a result of this role is entitled "Overview of Child Critical Injury and Death Investigation and Review Process in British Columbia February 2008." This was one of my early attempts after being appointed representative to get all the key players in the room as it pertains to child welfare, collaboration between these various entities being emphasized. As a result, by 2008, there was a memorandum of understanding in place between my office and the relevant parties, including the B.C. Ministry of Children and Family Development, to ensure information sharing protocols were in place. This included a forum where the parties could come together in the hopes of establishing an accountability process. Attached hereto as **Exhibit "A"** to this my Affidavit is a copy of the Report entitled "Overview of Child Critical Injury and Death Investigation and Review Process in British Columbia, February 2008".

9. As the review of the child welfare system in 2006 identified unmet needs around children and youth and established a variety of recommendations on the matter, a part of my role as the independent officer from 2006 when the report came out to 2010 was a review of the implementation of said recommendations. This included investigating and tracking whether or not the government in all of its components, from administrative to public bodies, were implementing these recommendations.

10. A Final Progress Report on the Implementation of the Recommendations of the BC Children and Youth was completed on November 29, 2010, which highlighted certain concerns with the implementation of the Hughes Report recommendations. It was clear at this time that there was a strong disconnect between the high level reporting and recommendation and the frontline implementation of the system. Overwhelmingly this reported identified that frontline social workers did not have the resources, coordination, or the focus to accomplish the recommendations made on the matter, specifically in relation to First Nations, Métis and Inuit children and youth. For example, page 43 of the report references that frontline staff were still trying to respond to request for service, were confused and did not understand what was happening. The lack of preventative services as a big barrier to respond to the needs of families was identified. A copy of the Final Progress Report on the Implementation of the Recommendations of the B.C. Children and Youth was completed in November 29, 2010, is attached hereto as **Exhibit "B"** to this my Affidavit.

b. Canadian Council of Provincial Child and Youth Advocates

11. Further to the issues identified within the child welfare system in B.C. and results from the Hughes Report, a national council was created, the Canadian Council of Provincial Child and Youth Advocates (the "CPCYA") of which I was either a member or President thereof during the period I was an independent officer of the legislature to address the provincial gaps in terms of the delivery of services and to address the interprovincial movement of children as part of child welfare services, effectively the national scope of certain cases. More particularly, this would address those falling under federal responsibility for which there is no point of leadership, including First Nations and other Indigenous children.

12. The CPCYA was mandated to address service gaps and advocate on these issues, including giving due effect to the conventional rights of the child, providing perspective on the issues observed to date and advocating issues for First Nation children and youth, taking a strong human rights focus which included looking at the United Nations Declaration on Rights of Indigenous People as applicable to children and families. A report was created on the matter to address this humanitarian crisis happening in Canada which became readily apparent when an international lens as coloured by these international materials was applied to Canada's existing child welfare system matter entitled "Aboriginal Children and Youth in Canada: Canada Must Do Better." A copy of said report is attached hereto to this my Affidavit as **Exhibit "C".**

13. Said report was submitted to the Prime Minister and Minister for the then Minister of Aboriginal Affairs to draw attention to the national issues surrounding the provision of services to First Nation youth. An acute conclusion from this 2010 report was the fact that Aboriginal children were disproportionally involved in the child protection system. At the time, one in five Aboriginal children in British Columbia would have some involvement of the child welfare system in their life at some point. It is fair to say that a number of conclusions reached and issues identified at said time these issues continue to persist within the system on a national level today.

14. National planning was viewed as essential to addressing these issues, as opposed to leaving it to the provinces and territories to continue to flounder with same resulting in First Nations and other indigenous families desperately seeking support which remained unavailable. This was the basis for significant promotion by the CCCYA with the federal government to direct attention to these issues on a federal level.

15. In my continued role as the independent Representative for Children and Youth, I observed that there continued to be an apparent disconnect between the announced changes to the child welfare system in B.C. arising as a result of the Hughes Report and the first-hand experiences with those involved in the system. In 2013 I prepared a special report entitled "When Talk Trumps Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in British Columbia," a copy of which is attached hereto to this my Affidavit as **Exhibit "D"**.

16. This report reflected that as a result of my investigations, it was clear that the B.C. government had not actually made a commitment to any fundamental changes to the child welfare system, despite having announced so. Of approximately 60 million earmarked for additional services, not a single file of a single child had received funds. There was no clear leadership in government or accountability and unsurprisingly, things were not changing. The report further highlighted the need for government to work with Indigenous peoples' governments to make the system more consistent with Indigenous practices, laws, customs, involvement and ensuring that Indigenous children have a right to belong to their families and the disconnect the existing system had with these ideals.

c. Aggregate Review- Sexualized Violence

17. As a result of my role as the representative of child and youth, I received a significant number of reports of injuries that children and youth experienced who were some way involved with the child welfare system. In 2016 I opted to put together an aggregate review looking at a cohort of reports of children and youth who were sexually assaulted or abused, in the hopes of determining whether an analysis of same could give rise to ideas for prevention of these abuses. A copy of the aggregate review entitled "Too Many Victims: Sexualized Violence in the Lives of Children and Youth in Care" dated October 2016 is attached hereto to this my Affidavit as **Exhibit "E"**.

18. This review identified that based on the then most recent B.C. adolescent health survey, 23 percent of female Aboriginal youth who responded to the survey reported they had unwanted sexual contact, versus 13 percent of the total female youth in B.C. As this is a matter that is significantly underreported, it is clearly a stark contrast and demonstrated that there is a pervasive issue demanding attention as the level of vulnerability was very apparent for Aboriginal girls. The exposure of Aboriginal girls and boys, in my experience as demonstrated in this report, to violence is very acute. The frequency and dose of violence, and of sexual violence in their lives is the most acute of all categories.

19. The review identified that years of government policies, including the forced removal of Indigenous children to residential schools, the experience of neglect and physical and sexual abuse

for many of the children in these institutional settings and their resulting intergenerational harm, have created the conditions where some Indigenous children and youth are at heightened risk for sexual abuse.

20. The review further made an egregious discovery, being that several of the Aboriginal children and youth included in the aggregate review were identified by their social workers as facing barriers consistent with discrimination from justice and health care professionals. This included treatment of various youths as a participant in violence rather than being a victim.

21. In terms of all the reports that I received for sexualized violence over my decade of work as representative, it was overwhelmingly more Aboriginal children and youth than anyone. This review continued to reflect these numbers and ultimately identified that one significant category of sexualized violence on Aboriginal children and youth occurred in care in a foster or a group home.

22. The report further identified that a major factor for removing children from their homes is the issue of perceived neglect, being some manner of suspicion that the family is no adequately able to meet the needs of the child. From a First Nations perspective, it is very generously used as a big ground for removal of First Nation children from their homes and often into situations wherein sexualized violence can proliferate, such as a foster or group home.

23. Nearly two-thirds of the victims in the review were Aboriginal, 79 of 121 children and youth. For these 79 Aboriginal children in the review who experienced sexual violence, there was no comprehensive cultural plan, connecting them with family and natural supports, including kinship, cultural or family supports. By failing to keep the cultural continuity and connection, the government likely elevated the risk for these kids.

24. Ultimately, the review concluded that the B.C. government's framework focused on existing initiatives and promised little in the way of new resources to prevent and respond to sexual violence, especially towards youth and children. Given the high level of sexual violence directed at children and youth in care, and how much of it goes unreported, it was clear that change was necessary to adequately prevent and respond to these abuses. Effectively these First Nation

children are being harmed, removed from their homes and then placed in situations where they are being re-harmed.

d. Aggregate Review- Suicide and Self Harm

25. In November of 2012 I prepared another aggregate review for the Legislative Assembly of British Columbia derived from the number of reports of suicide and self-harm to those children and youth who were some way involved with the child welfare system in the hope of determining whether an analysis of same could give rise to ideas for prevention of these tragedies. A copy of the aggregate review entitled "Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm" dated November of 2012 is attached hereto to this my Affidavit as **Exhibit "F"**.

26. This was an aggregate report involving 89 youths that were involved in the child welfare system in some way and experienced self-harm or completed a suicide. The level of representation of Aboriginal youth of, primarily First Nations, was about 60 percent in that cohort. This was a significant over-representation of Aboriginal Children and Youth with what is best described as varying degrees of compliance with the B.C. Ministry of Children and Family Development practice standards in these cases.

e. Aggregate Review- Vulnerable Infants

27. In January of 2011 I prepared another aggregate review for the Legislative Assembly of British Columbia derived from the number of reports of death of infants involved with the child welfare system. A copy of the aggregate review entitled "Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants" dated January of 2011 is attached hereto to this my Affidavit as **Exhibit "G"**.

28. This was an aggregate review of 21 infant deaths. As representative of youth and children we looked at their cases, some of which allegedly died because of sleeping issues as well as a range of other early childhood issues. 15 out of the 21 infants were Aboriginal, primarily First Nations and Métis. In this cohort, all 15 of the families had a documented history of abuse in the mother's

family. The report speaks to the interplay of poverty and lack of support services for Aboriginal women of reproductive age in terms of the nurse home visiting programs and so forth that are not there in their lives. Ultimately, it concluded that the level of support in B.C.'s child welfare system to counter the barriers and risk factors faced by the families dealt with in the review was insufficient. Efforts were ultimately required to improve preventative practice to address deep-seated intergenerational patterns.

f. Specific case examples and resulting reports

29. In attempt to illustrate the continuing issues with the B.C. child welfare system in my role as representative of children and youth, I've performed various case analysis' to shine a spotlight on the ongoing issues faced by Aboriginal youth involved with the child welfare system. One of my major works was the report entitled "Paige's Story: Abuse, Indifference and a Young Life Discarded," which I completed in May of 2015. A copy of this report is attached hereto to this my Affidavit as **Exhibit "H".**

30. The report documents the life of Paige, an Aboriginal girl from British Columbia who never received the nurturing or protection she deserved, despite coming in and out of child welfare system, being moved some 50 plus times between the ages of 14 to 16. Despite requiring supports, as a result of aging out of the program at the age of 19 she was forced out of one of her first stable environments at a foster home. As a result, she tumbled back into alcohol and drug abuse and died of an overdose shortly after her 19th birthday in downtown Vancouver. The story notes that her case effectively reflected professional indifference, indicative of the state of British Columbia's child welfare system. The purpose of the report was to determine what lessons could be learned from this case, how these tragedies could be prevented.

31. The report ultimately concluded that the outcome should have been preventable but was predictable. There were serious issues with respect to the fact that Paige required protection, but various parties' who had interactions with Paige failed to report her circumstances to the authorities. This non-reporting was troublesome, especially for Aboriginal children, especially as it normalized not-reporting their plights. Ultimately it appeared to me that there was a systemic level of discrimination with respect to Aboriginal children involved in the child welfare system,

which continues to affect Aboriginal children in the same cohort as Paige, including the fact that the child welfare system in B.C. has a high component of First Nations yet a child welfare system with lots of indifference and poor representation by Indigenous people.

32. As a follow up to Page's story, I also completed another report on a comparable vulnerable B.C. youth, entitled "Approach with Caution: Why the Story of One Vulnerable B.C. Youth Can't be Told" prepared in May of 2016, a copy of which is attached hereto to this my Affidavit as **Exhibit "I"**.

33. The youth on which this report focused was faced with a comparable situation as Paige, repeatedly being injured in the Downtown Eastside of Vancouver and in and out of the child care system. Ultimately, in my role as representative, my original investigation of this youth was not released in accordance with the request of the B.C. Ministry of Children and Family Development as it was viewed as potentially subjecting the youth to greater risk. Despite this, I wanted to ensure that it was noted that there was little positive to report since Paige's Story and my discouragement with the work done to protect the cohort of vulnerable young people. Despite the fact that the B.C. government purported to support change, no revamp of the provincial approach to youth mental health, addictions and homelessness were pursued and youth such as the one on which the investigation focused and the more than 100 others identified following the release of Paige's Story continue to remain in comparable straits.

34. Further on the theme of children being denied essential services despite the clear need for same and intervention, often jurisdictional conflict have resulted in children being denied the requisite supports. In my investigative report entitled "Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl," I noted a case wherein a First Nation youth was faced with a lack of services as a result of her First Nation community being in conflict with the B.C. child welfare regime. This child, who also suffered sexual abuse, sexual violence, had little to no assistance due to this conflict and understaffing of the local child welfare agency. Unfortunately as her needs were never addressed, she eventually committed suicide. A copy of my investigative report entitled "Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl" dated June 2014 is attached hereto to this my Affidavit as **Exhibit "J"**.

35. Another issue that child welfare agencies do not seem to give due consideration in their protection efforts for First Nation children is the issue of parental addiction. I addressed this in a special investigative report to the B.C. Legislative Assembly in June of 2014 entitled "Children at Risk: The Case for a Better Response to Parental Addiction." Ultimately the report reviewed the child welfare system to note that addiction responses in programming are not tailored to meet the needs of Aboriginal families as demonstrated in the context of this specific case. Addictions are one of the top factors present when children are involved in the child welfare system but the prevention lens is nowhere to be seen on the issue. Unfortunately, harsh intervention remains the response versus programs supporting addictions. The model does not reflect or respond to the unique circumstances of Indigenous families, nor do any of the risk assessment tools view culture as a protective factor. A copy of my report entitled "Children at Risk: The Case for a Better Response to Parental Addiction" and dated June 2014 is attached hereto to this my Affidavit as **Exhibit "K".**

36. With respect to the impacts of being in the child welfare system, I further explored the issue of the termination of services once youth involved with the child welfare system in British Columbia reach the age of 19, and the resulting withdrawal of services in my report entitled "On Their Own: Examining the Needs of B.C. Youth as They Leave Government Care" dated April of 2014. This was provided to the B.C. Legislative Assembly, a copy of which is attached hereto to this my Affidavit as **Exhibit "L:".**

37. The report ultimately noted that despite their being some improvements to the supports available to transition young people out of care and into independence, there remains much to be done to assist them to become full, contributing members of society. Those who leave prematurely or simply age out, are likely to experience immediate and longer-term difficulties in their lives. A stronger research base is needed in both B.C. and Canada on all aspects of transitioning young people out of care, especially the over-represented First Nations children and youth involved in the child welfare system.

Response to Representative Reports

38. Further to the reports provided to the Legislative Assembly of B.C. in my role as

Representative for Children and Youth, a report was prepared entitled "Not Fully Invested, A Follow-up Report on the Representative's Past Recommendations to Help Vulnerable Children in B.C." dated October 9, 2014 summarizing implementation of the recommendations made to the Legislative Assembly. A copy of this report is attached hereto to this my Affidavit as **Exhibit "M"**.

39. Said report identified that in the six-year period covered by the report, a total of 148 recommendations were made by the Representative for Children and Youth. The report demonstrated that some 72 percent of all recommendations had been substantially or fully implemented. The recommendations in question were based on a total of 22 reports provided from 2008 to 2013.

Final Thoughts

40. The bulk of my work to date clearly reveals that there is a humanitarian crisis with respect to the removal of First Nation children and issues with the child welfare system, especially when looking at the child welfare system through the international lens of the United Nations Declaration on the Rights of Indigenous People ("UNDRIP"), the Convention on the Rights of the Child, the international instruments around the prohibition of racial discrimination.

41. Solely focusing on UNDRIP, it is clear that Article 8 really identifies states having to take initiatives to prevent the forceful removal of children. These are serious issues which require evaluation from a human rights perspective.

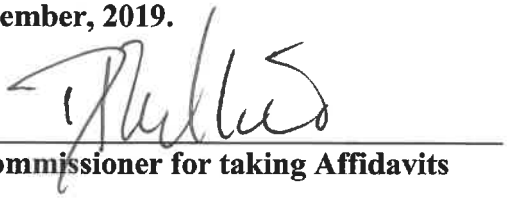
42. I make this Affidavit for no improper purpose.

~~SWORN~~/AFFIRMED BEFORE me at)
the City of Victoria)
Province of British Columbia)
this 7th day of November, 2019.)
)
)
A commissioner for taking Affidavits)

Mary Ellen Turpel-Lafond

DAVID M. ROBBINS
Barrister & Solicitor
200 – 1022 Government Street
Victoria, BC V8W 1X7

This is Exhibit "A" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, 2019.



A commissioner for taking Affidavits

Overview of the Child Critical Injury and Death Investigation and Review Process in British Columbia

February 2008

Prepared by The Children's Forum:
- BC Coroners Service
- Ministry of Children and Family Development
- Ombudsman
- Public Guardian and Trustee
- Provincial Health Officer
- Representative for Children and Youth

Overview of the Child Critical Injury and Death Investigation and Review Process in British Columbia February 2008

The purpose of this document is to summarize the roles and responsibilities of the Coroners Service, the Ministry of Children and Family Development, the Ombudsman, the Provincial Health Officer, the Public Guardian and Trustee and the Representative for Children and Youth in the review of critical injuries and deaths of children in British Columbia, and to describe how these public agencies collaborate to strengthen the system of supports for vulnerable children and youth.

Introduction

In British Columbia, several agencies examine the critical injuries or deaths of vulnerable children and youth. The BC Coroners Service (BCCS), the Ministry of Children and Family Development (MCFD), the Ombudsman, the Provincial Health Officer (PHO), the Public Guardian and Trustee (PGT) and the Representative for Children and Youth (RCY) all have legislative mandates related to reviewing critical injuries or deaths of children. Until recently, these agencies have acted largely independently of one another.

In the 2006 BC Children and Youth Review (the Hughes Review), the Honourable Ted Hughes found that the independence of these public bodies largely precluded the kind of cooperative relationships proven to yield systemic change and improvements to service delivery. He suggested that improved cooperation and collaboration between these public bodies could improve the system of supports and strengthen public accountability.

> This review has brought me to the belief that the primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented.
>
> I recognize that not every injury or death is preventable, but it is important to take advantage of every opportunity to learn about possible improvements to policy and practice. The systematic review of deaths and injuries is one such opportunity.
>
> A secondary purpose for reviewing children's injuries and deaths is one of public accountability. The death of a child who is in the care of the Ministry or receiving Ministry services is a rare but tragic event and the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right.
>
> The Hon. Ted Hughes, QC
> BC Children and Youth Review

The Hughes Review recommended that "the Ministry establish a forum or council, including the new Representative for Children and Youth, the Coroners Service, the Ombudsman and the Public Guardian and Trustee, that will meet regularly to review developments and issues of common concern" (BC Children and Youth Review, p. 108) in order to facilitate the collaborative relationships required for systemic reform.

In December 2006, MCFD held the first meeting of the Children's Forum with the Chief Coroner, the Ombudsman, the Public Guardian and Trustee and a representative from the Ministry of Health. In that meeting, it was recommended and agreed that the Representative for Children and Youth would be the most appropriate Forum Chair. The Representative chaired her first meeting in March 2007, and the Forum, comprising all of its recommended representatives, has been meeting quarterly since then.

The Ministry of Children and Family Development (MCFD)

MCFD provides services, including child protection services, through its regional offices, delegated Aboriginal agencies and contracted agencies. *The Child, Family and Community Service Act* (1996) provides the statutory authority for critical injury and death review and reporting.

The ministry provides and/or funds programs in the areas of youth justice, child and youth mental health, special needs as well as child welfare, which includes the guardianship of children in care. Each of these program areas have policy, including procedures for reporting and reviewing critical injuries and deaths of children and youth in care and/or receiving services.

MCFD policy requires staff to report a critical injury and/or death of a child who has been in care or received service through a ministry program within the 12 months preceding the injury or death. The policy related to each program area differs slightly, and different types of review and investigative processes can be undertaken in different program areas. MCFD is moving toward a process that is more standardized and integrated.

For children served by child protection services, it is the Director of Integrated Practice for the region or the Provincial Director of Child Welfare who must decide whether a further review of the critical injury or death should be conducted. In the child welfare and guardianship program area specifically, reviews are usually conducted when the injury has been determined to be non-accidental or unexpected. The Director must also indicate reasons for not conducting a further review of the incident. In June 2007, *Child, Family and Community Service Act* regulations were amended to mandate a review when the injury was deemed to be due to maltreatment and/or neglect.

Recommendations resulting from the review process are implemented by senior staff and community managers and these recommendations are tracked until they are completed. Public reporting includes the posting of fatalities, audits and case review summaries. The ministry's case review model is moving toward being more coordinated and integrated across program areas, as recommended in the Hughes Review.

Contact information:

The Ministry of Children and Family Development
PO Box 9970 Stn Prov Govt
Victoria, BC V8W 9S5
Ph, Victoria: (250) 387-7027
Ph, BC: 1-877-387-7027
E-mail: MCF.CorrespondenceManagement@gov.bc.ca

The Public Guardian and Trustee (PGT)

The Public Guardian and Trustee is a corporation established under the *Public Guardian and Trustee Act* (1996). Among its many roles regarding children, the PGT is the guardian of the estate of children who have been placed in continuing care. When a critical injury occurs and is reported to the PGT, a review of the circumstances of the injury is carried out to assess whether compensation may be available through civil action or other means. If so, the PGT may bring civil action for the injury. This may occur relatively soon after the injury or the legal proceeding may be postponed in order to more thoroughly consider the long-term impact on the life of the child so that appropriate compensation can be determined. If the injury is compensable, the PGT acts on the child's behalf and represents the child's legal interests. This particular role of the PGT is generally only applicable to children in continuing care.

Contact information:

The Public Guardian and Trustee of British Columbia
700 - 808 West Hastings Street
Vancouver, BC V6C 3L3
Ph: (604) 660-4444
Fax: (604) 660-0374
E-mail: mail@trustee.bc.ca

The BC Coroners Service (BCCS)

The BC Coroners Service is a public agency within the Ministry of Public Safety and Solicitor General. In British Columbia, all child deaths are reported to the Chief Coroner under Section 2 of the *Coroners Act* (2007). This includes all sudden and unexpected deaths as well as those deaths believed to be natural and expected.

On receipt of a report of child death, a Coroner will conduct an investigation and will determine who the child was, and how, when, where and by what means the child died. In the case of a natural and expected death, this investigation may be concluded shortly after the death occurred. In cases where the death was sudden, unexpected or unexplained, the investigation may take longer to complete. At the conclusion of an investigation, the Coroner will make a report to the Chief Coroner. The report may include recommendations or in some circumstances, the Chief Coroner may direct that an inquest be held.

At the conclusion of an investigation or inquest, the child death will be referred to the Child Death Review Unit (CDRU) of the BC Coroners Service. All child deaths are reviewed by case review specialists within the CDRU. During the course of the review, CDRU members may exercise the powers of investigation set out in Section 11 of the *Coroners Act* as if the member were a Coroner conducting an investigation.

Following each review of a child death, the CDRU will make a report to the Chief Coroner with findings respecting the circumstances related to the death and any recommendations respecting the prevention of similar deaths.

The Chief Coroner may establish a child death review panel to conduct further reviews of individual child deaths or a cluster of deaths. The child death review panel will provide the Chief Coroner with advice related to medical, legal, social welfare and other matters that may impact public health and safety and the prevention of child deaths.

The CDRU and child death review panel may make recommendations to the Chief Coroner respecting the protection of the health, safety and well-being of children generally but must not, in a report, make any finding of legal responsibility or express any conclusion of law.

Contact information:

The Chief Coroner's Office
Metrotower II Suite 800 - 4720 Kingsway
Burnaby, BC V5H 4N2
Ph: (604) 660-7745
Fax: (604) 660-7766
E-mail: BC.CorSer@gov.bc.ca

The Ombudsman

The Ombudsman is an independent officer of the Legislature operating under the *Ombudsman Act* (1996). The Ombudsman can investigate complaints about administrative decisions, actions, omissions and procedures by public authorities including the Ministry of Children and Family Development, the Office of the Public Guardian and Trustee, the Provincial Health Officer and the Coroner's Service. Normally this is done after internal dispute resolution processes have been fully utilized.

Ombudsman investigators work in a consultative manner to develop, wherever possible, a fair resolution to a complaint and identify ways to improve administrative systems. The Ombudsman can make findings that administrative decisions, actions, omissions, or procedures are contrary to law, unjust, oppressive, improperly discriminatory, arbitrary, unreasonable, unfair, done for an improper purpose, negligent, result in undue delay or are otherwise wrong, and recommend solutions. The Ombudsman can also issue public reports. The Office of the Ombudsman may review complaints about public authorities' handling of a critical injury or death and look at systemic issues that adversely impact service delivery to children and youth.

Contact information:
The Office of the Ombudsman
2nd Floor, 756 Fort Street
Victoria, BC V8W 9A5
Ph, Victoria: (250) 387-5855
Ph, BC: 1-800-567-3247
Website: www.ombudsman.bc.ca

The Provincial Health Officer (PHO)

The Provincial Health Officer collects and analyzes data on all child deaths that occur in BC. The analysis informs improvements to the child serving system in order to improve the health and social outcomes of all children.

The PHO's role is to provide a larger context for population health and well-being trends and for the causes of child fatalities. The PHO educates and recommends prevention strategies to improve children's health and brings profile to the health issues that arise for children generally and for vulnerable children in particular.

Contact information:
The Office of the Provincial Health Officer
4th Floor, 1515 Blanshard Street
Victoria BC V8W 3C8
Ph: (250) 952-1330
Fax: (250) 952-1362
Email: Andrea.Berkes@gov.bc.ca

The Representative for Children and Youth (RCY)

The Representative for Children and Youth, who is an independent officer of the Legislature, has a multifaceted mandate that includes advocacy, review and investigations of critical injuries and deaths, and the monitoring of the child serving system.

The Representative has a statutory mandate to review and investigate the non-accidental critical injuries and deaths of children who received designated government services (in areas such as youth justice, mental health and/or child protection) in the 12 months prior to the incident. The Select Standing Committee on Children and Youth (SSCCY) may also make referrals to the Representative to review and report on deaths, injuries or other matters pertaining to children in British Columbia.

The *Representative for Children and Youth Act* (2006) provides that the Representative must wait until a criminal process has been completed for the investigation to begin. If no criminal process arises following the child death or injury, then the Representative waits for MCFD and/or the Coroner Service to complete their work before commencing an investigation. The Representative is required by law to allow these agencies up to one year following the critical injury or death to complete their work before engaging in an investigation. Where no such reviews are conducted, the Representative's work can commence before the one-year period.

The RCY process is to collect the relevant documentation and conduct a preliminary review in order to determine whether the circumstances of an incident raise service delivery issues or present opportunities to consider strengthening the system of supports for vulnerable children and youth in British Columbia. The Representative then monitors the file until other reviews are completed. The Representative analyzes the file and circumstances and determines whether circumstances cited in Section 12 of the *Representative for Children and Youth Act* (service delivery issues and/or self-harm and/or suspicious circumstances) were involved in the incident and thus whether a full investigation, analysis and report are required.

Following the investigative process, the Representative may seek the advice of a multi-disciplinary team. This team, as established by the Representative's Office, comprises health and child welfare experts and community professionals who review the findings of the investigation and provide input on recommendations to improve the system.

The Representative reports findings and recommendations to the Select Standing Committee on Children and Youth of the BC Legislature, and to the public.

Contact information:
The Representative for Children and Youth
4th Floor, 1019 Wharf Street
PO Box 9207 Stn Prov Govt
Victoria, BC V8W 9J1
Ph, Victoria: (250) 356-6710
Ph, BC: 1-800-476-3933
Fax: (250) 356-0837
Email: rcy@rcybc.ca

Collaboration

Each of the offices and agencies involved in the Children's Forum interact extensively, as is appropriate, given their respective roles and responsibilities.

Where fatalities are concerned, a Memorandum of Understanding (MOU) between MCFD and the Coroners Service, in place since 1996, outlines the information-sharing process between the two organizations. If a child or youth dies, MCFD notifies the Coroner if the child has had involvement with the ministry or was in care in the 12 months preceding the incident. The same notification process is carried out by MCFD to the RCY. MCFD must also report critical injuries to the RCY. MCFD and the PGT also have a MOU that outlines how information is shared between them regarding children for whom they share guardianship. This includes delivery by MCFD to the PGT of all critical incident reports involving children in continuing care.

Upon completion of the MCFD review process, the review report is provided to the Coroner (in the case of a death) and to the RCY in order to facilitate their respective review and investigative processes.

On occasion, child deaths that have been referred to the Child Death Review Unit for a final review are subsequently referred to the RCY. Referrals to the RCY fall into two categories. The first category are those child deaths that occurred during the 2002-2007 transition period where there are unexamined child welfare issues. The second is where the death was intentional or occurred in extraordinary circumstances, where service or other systemic issues have been identified and it is in the public interest for the death to be further reviewed.

The RCY also has memoranda of understanding with MCFD and other organizations. These MOUs ensure that information-sharing protocols are in place to allow the RCY to accomplish its mandate while working collaboratively to strengthen the system of supports for vulnerable children and youth.

Conclusion

The child critical injury and death review process in British Columbia is undergoing significant changes to improve collaboration and cooperation among various review bodies in an effort to better protect the safety, health and well being of vulnerable children as well as improve their system of support. The Children's Forum and the individual members of the Forum look forward to their continued partnership on behalf of children.

Appendix: Resources

British Columbia. *Child, Family and Community Service Act.* R.S.B.C. 1996, c. 46.

British Columbia. *Coroners Act.* S.B.C. 2007, c. 15.

British Columbia. *Ombudsman Act.* R.S.B.C. 1996, c. 340.

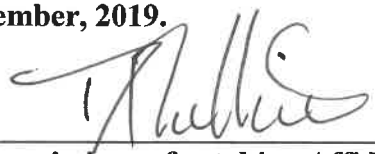
British Columbia. *Public Guardian and Trustee Act.* R.S.B.C. 1996, c. 383.

British Columbia. *Representative for Children and Youth Act.* S.B.C. 2006, c. 29.

Canada. *Criminal Code of Canada.* R.S.C. 1985, c. 2 (1st Supp.)

Hughes, T. (2006). *BC children and youth review: An independent review of BC's child protection system.* Victoria, BC: Ministry of Children and Family Development.

This is Exhibit "B" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, 2019.



A commissioner for taking Affidavits

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Final Progress Report on the Implementation of the Recommendations of the BC Children and Youth Review

("Hughes Review")

November 29, 2010

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Nov. 29, 2010

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, BC V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the Progress Report on the Implementation of the Recommendations of the BC Children and Youth Review to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 (2) (b) of the *Representative for Children and Youth Act*, which allows the Representative to make special reports to the Legislative Assembly.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. E. George MacMinn, QC
Clerk of the Legislative Assembly

Ms. Joan McIntyre
Chair, Select Standing Committee on Children and Youth

Contents

Part One – Overview

Background

In 2005 the Honourable Ted Hughes, QC, was asked by the provincial government to examine aspects of the child-serving system and make recommendations for improvement. The *BC Children and Youth Review: An Independent Review of BC's Child Protection System* (the "Hughes Review") was released in April 2006.

A key Hughes Review recommendation called for the creation of a new position and the appointment of a Representative for Children and Youth – an Independent Officer of the Legislature. The mandate of the Representative, as set out in the Hughes Review, was to include monitoring the child welfare system, reviewing child injuries and deaths and advocating on behalf of individual children and families and the systems that serve them.

Government endorsed all of the Hughes Review recommendations, and the Legislature appointed the first Representative on Nov. 27, 2006. The Office's oversight role came into force April 1, 2007.

This report marks the third time since being appointed that the Representative for Children and Youth has examined government's progress on implementing the Hughes Review recommendations. The purpose of these reports is:

- to determine what has been accomplished in repairing the system
- to compare what the Hughes Review recommended, with the reality of what has been achieved
- to look at "what is and what can be."

This ongoing monitoring of progress on Hughes recommendations looks closely to see if actual change is taking place – change that responds to the key areas identified in the Hughes Review. In other words, is government actually improving the system by addressing the issues raised in the Hughes Review?

Over the course of the Representative's four years of monitoring and assessment of progress on the Hughes recommendations, all but five of the 47 recommendations initially assessed as not complete have received two thorough assessments.

2007 Progress Report

In the Representative's first progress report, all 62 Hughes Review recommendations were reviewed. Fifteen were assessed as complete or fully operational, leaving 47 to be further assessed.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Insufficient information provided
62	15	3	11	8	22	3

2008 Progress Report

In the second progress report, the Representative re-examined 15 recommendations that had been previously assessed as not yet complete, leaving 32 to be further assessed.

These 15 recommendations were specifically chosen for evaluation in 2008 because the Representative believed them to be at the very core of the essential work required to improve and enhance the way the Ministry of Children and Family Development (MCFD) functions in serving B.C.'s vulnerable children and youth. These recommendations relate to the decentralization of MCFD, quality assurance and accountability, and MCFD's complaints processes.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Insufficient information provided
15	0	1	5	7	2	0

2010 Progress Report

This third progress report re-examines 27 recommendations that had been previously assessed as not yet complete, leaving five to be further assessed. MCFD was given the opportunity to review and comment on the Representative's assessments on two occasions – first in December 2009 and again in July 2010 – as part of the administrative fairness process.

These recommendations relate to case reviews, modern approaches to child protection, communication, information-sharing and privacy, and the external oversight role.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Implementation unsatisfactory
27	12	3	0	1	0	11

Five other recommendations will be evaluated in an upcoming broader review of services to Aboriginal children and families.

Moving Away from Hughes

When the Hughes Review was released, it was enthusiastically received throughout the province and by both government and the opposition. In the 2006 government budget, a significant infusion of new money was earmarked for the implementation of the Hughes recommendations and enhancements to child protection and family support services. In April 2006, the path ahead seemed very clear.

The Hughes Review is widely acclaimed as an incisive, accurate and thoughtful look at the challenges facing B.C.'s child welfare system, with the identification of practical, clear means to improve it. Mr. Hughes described his review as a blueprint "to allow for full repair of a system that has in recent times been battered on stormy seas." Many agreed then and many, including the Representative, agree to this day.

By mid-2007, MCFD had introduced their new *Good Practice Action Plan*. In Sept. 2007, MCFD's Deputy Minister reported to the Select Standing Committee on Children and Youth that the ministry's new action plan was "not a response to the Hughes recommendations or the Hughes report."

Unfortunately, in the 4½ years since the Hughes Review, there has been at times a lack of sustained action on the agenda that Mr. Hughes provided, and at other times outright government dismissal of the Hughes recommendations.

This Hughes progress report will be the last dedicated to examining progress on specific recommendations from the Hughes Review. The decision to make this the final Hughes progress update is not because the Hughes Review recommendations have been adequately addressed.

A new way of assessing progress is necessary because MCFD has now moved on to using other frameworks for change. To address this reality, a new approach to measuring progress is required in order to provide the public with an independent assessment of whether B.C.'s children and youth are better served today than when Mr. Hughes tabled his report.

Unfortunately, due to the immense amount of time and resources required to properly assess progress on each recommendation, it is not possible to definitively answer the key question: How many of the 62 Hughes Review recommendations are now complete? The Representative estimates that less than half of them are complete or fully operational. The disappointing reality is that far too many Hughes recommendations have never received the attention they deserve, and at this point likely never will.

Although the Representative will move to different methods of assessing improvements to the child welfare system, the Hughes Review and its recommendations will remain at the core of such work. A "touchstone" is defined as an excellent quality or example used to test the excellence or genuineness of others. The wisdom of the Hon. Ted Hughes and the Hughes Review will always be touchstones in the continuing work of the Representative.

A Detailed Look: MCFD's Response to Hughes

As mentioned, the Hughes Review was a plan for action – a comprehensive blueprint for legislative, policy and practice changes to improve the child-serving system. Instead of actively engaging in implementing the essential changes put forward in the review, MCFD's overall response has been the creation of alternative plans that make high-level reference to the Hughes Review yet offer no detailed information on the specific recommendations.

The Representative notes that these plans have a vague quality and a noticeable absence of detailed operational or budget documentation to support them, including information about the specific allocation of funding for new initiatives and means to achieve the vision of the alternative plans. There is no clear path involving legislative, policy or standards reform directed at measured improvement for children and youth.

After 4½ years, the opportunity to fundamentally change the child-serving system has not been realized. In July 2007, MCFD released the draft *Good Practice Action Plan* and then, in April 2008, released *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth*. These plans received qualified support from the Representative in prior updates. However, the concerns noted in 2007 and 2008 are still present – the plans remain, to this day, high level and aspirational. Concrete strategies for implementation are lacking. These alternative plans do not adequately embrace or address the Hughes Review recommendations, and the Representative does not consider them to be satisfactory substitutes.

The Hughes Review updates provided within the *Strong, Safe and Supported* document are brief and lack substance. The status updates for each recommendation are limited to a few sentences and do not contain sufficient detail or analysis of practice change. The Representative reviewed these updates and held back this report for a period to give MCFD the opportunity to showcase their achievements. The Representative's approach was one of encouragement, and it was openly stated on many occasions that the intent of the current update was to profile the ministry's achievements in effecting positive change for children.

The Representative repeatedly requested further information regarding the nature and extent of the service transformation approach that MCFD put forth as a response to the Hughes recommendations. The Representative and senior staff were provided a briefing on the

"practice framework" by the Deputy Minister. Unfortunately, this briefing failed to answer the fundamental questions of what exactly the transformation exercise is intended to accomplish, what will change, how it will be implemented and what outcomes it purports to address. Subsequent requests for this detailed information or further briefings about this important change initiative were rebuffed by MCFD. After a great deal of effort, the Representative was eventually provided with a binder containing "all the available information" concerning the new practice and assessment process.

Careful review showed that the binder was mostly material already provided to the Representative or publicly available on the MCFD website. Information about the practice framework was entirely conceptual, described in diagram rather than containing detailed information that would allow a careful and thorough analysis. This is an initiative that has been promised for more than four years. It is the cornerstone of the transformation approach, guided by MCFD's Deputy Minister. It is reasonable to expect that such an initiative could be succinctly described and that the written material would be readily available. The Representative is concerned that such a major government policy approach appears to have a weak foundation and has heard repeatedly from MCFD staff, service providers and related professionals that a considerable degree of confusion and frustration exists around transformation.

Implementation and effective change management are always central challenges of large transformation efforts in the public sector. Based on the material and briefings provided to date, the Representative sees no evidence that the practice framework exists beyond broad aspirational statements, even though specific policy changes that will impact hundreds of children and their families are premised on its existence. For example, see the Representative's recent report, *No Shortcuts to Safety: Doing Better for Children Living with Extended Family,* an audit report on the ministry's Child in the Home of a Relative (CIHR) program and kinship placements.

Only a limited amount of information was provided to the Representative that would showcase achievements of the ministry regarding either the transformation agenda or implementation of the Hughes recommendations. Today less than half of the Hughes recommendations are considered complete or fully operational. Major themes such as quality assurance, organizational learning, public accountability and decentralization continue to be inadequately addressed or are said to be restructured with lack of clarity about what will be measured or improved. Public reporting must be more consistent and detailed, particularly in the area of critical injuries and deaths.

The Representative is concerned that MCFD is now in a position, having moved off the Hughes recommendations, of promising great things but showing no evidence of improved outcomes. There is insufficient evidence of appropriate budgeting, workforce management or clarity around expectations for non-governmental service providers. All of this is compounded by recent budget pressures and new priorities on fiscal restraint.

The Representative is not expecting MCFD to achieve a standard beyond reach. There is no such thing as a perfect child welfare system. But an effective system has some essential characteristics, and these were articulated clearly in the Hughes Review. A well-functioning child welfare system meets the obligations established in legislation by:

- establishing a clear mandate
- guaranteeing children and families equitable and consistent access to core services
- establishing service expectations and standards to ensure consistency
- establishing effective structures and systems to support the services, including adequate supervision and ongoing training
- allocating appropriate resources, including adequate and qualified staff
- achieving reasonable outcomes
- reporting on outcomes achieved at the level of the child, particularly for children at risk
- maintaining transparency in the delivery of services, and
- monitoring performance and using data to improve services.

These are the fundamental elements of the system that the Representative will continue to monitor in the interests of transparency and public accountability. The Representative is not confident that these components are currently in place given the level of reporting and accountability the ministry has provided.

Part Two – Observations

This section examines a number of systemic concerns that have not been addressed, as well as ongoing barriers to the creation of real and sustainable change. These same concerns were noted in the Hughes Review itself, and it is unacceptable that none of these have been resolved to a satisfactory level. In Part Three of this report, the Representative looks at 27 specific recommendations.

MCFD Decentralization

The Hughes Review recognized that decentralization had the potential to better meet the diverse needs of children and youth across the province. The review supported the ministry's efforts to be innovative and to be responsive to local contexts. However, the review stressed the importance of regional practice and variations in service delivery occurring within a strong provincial framework of standards and oversight. Monitoring at a provincial level is essential to the delivery of consistent, high-quality services across all regions. As the Hughes Review noted, MCFD headquarters carries out a vital function in overseeing the regional operations of the ministry and in ensuring consistent delivery and availability of services across B.C.

MCFD remains committed to a form of regionalization. The Representative is concerned that this approach leads to inconsistency, reduced accountability for decision-making and a critical lack of oversight.

A number of frameworks and structures have been created to support the decentralized model, including the Integrated Case Review Framework; the Child and Family Support, Assessment, Planning and Practice framework; the Regional Executive Director (RED) Council; the Integrated Quality Assurance Team; and the Continuous Quality Improvement Strategic Working Group. The Representative is concerned that these frameworks lack the depth and the detail to adequately guide practice. In addition, insufficient evidence has been provided to illustrate that the provincial teams, councils and committees have held or can hold the regions accountable for practice deficiencies or non-compliance.

When a serious issue or conflict arises, will the collective and collegial style of MCFD's decentralized model be sufficient and effective? The ministry's recent review of the RED Council identified this same problem. It was noted in material provided by MCFD[1] that some Assistant Deputy Ministers (ADMs) were concerned that the council was not addressing issues of regional isolation and inconsistencies with defined provincial approaches.

[1] Ministry of Children and Family Development. *Regional Executive Director Council Review*. January 2009.

Furthermore, the question was raised as to how the Council would regulate itself. The Representative had serious reservations about that same question. The Representative is not clear on how the recent elevation of REDs to ADMs and the dissolution of the RED Council will address the need for consistent provincial oversight of regional practice and variations in service delivery. The Representative requested, but did not receive, information on how the oversight responsibilities previously ascribed to the RED Council were now being handled by either the MCFD Leadership Team or the new REDs. In fact, with the newest organizational structure, less detail is available on how the ministry monitors and enforces consistent practice than there was during the review period and the existence of the RED Council. Rather than addressing the concerns expressed about the potential ineffectiveness of the RED Council to police itself, yet another structure has been created in its place and, in the Representative's view, without an analysis of what is needed to adequately address regional inconsistencies and practice concerns.

Quality Assurance and Accountability

A decentralized model requires increased attention to accountability. The Hughes Review noted MCFD quality assurance suffered with the transfer of this function to the regions. A number of changes have occurred since that time, including:

- the creation of the Integrated Quality Assurance Team in headquarters and the Integrated Quality Assurance and Improvement Framework
- the initiation of the Integrated Practice Analysis Tracking (IPAT) system and the first Provincial Aggregate Analysis of Recommendations from practice audits and case reviews.

Despite these developments four areas of concern remain:

- an inherent conflict of interest between regional service delivery and regional responsibility for oversight and monitoring
- potential for uneven quality assurance practices across the regions depending on differences in resources and skill sets
- a lack of clarity about the roles, accountabilities and authorities of regional versus headquarters staff
- no agreement or direction at this point on what will be measured, by whom, at what intervals and to what end.

The overriding concern is how non-compliance or deficiencies in performance are identified and addressed. Insufficient evidence was provided of the provincial oversight role. Systems and structures are in place, but MCFD did not submit adequate documentation of monitoring the quality of regional practice or completed trend analyses that have led to knowledge transfer and system improvements.

Public Reporting

The Hughes Review called for clearer, more open public reporting. Increased transparency helps boost public confidence and provides a context for serious issues when they arise.

The changes made in public reporting have met neither the letter nor the intent of the Hughes Review, and in fact, the information publicly posted now is not as useful as it has been in the past. Prior to April 2008 MCFD posted aggregate reports that collated and analyzed information for all case reviews for the year. These reports used to include findings, areas in need of improvement and recommendations. Currently, information about case reviews is posted on a case-by-case basis.

The information on the website lacks important details such as timelines, updates on the achievement of recommendations, trend analysis and updates on changes to the system.

Provincial Director of Child Welfare

The oversight role of the provincial office to ensure accountability and performance management has been further compromised by the elimination of the position of a single Provincial Director of Child Welfare. With this change there has been a loss of important checks and balances. MCFD has also lost an important leadership perspective that not only takes into account the broader provincial context but also provides the objectivity that rises above regional interests and viewpoints. The Representative does not advocate for a hierarchical model characterized by micro-management and burdensome reporting requirements. However, some aspects of oversight are necessarily hierarchical as there needs to be that ultimate authority to oversee compliance, impose consequences and command practice change.

The multiple roles and structures created to support regionalization do not fill the gap left by the loss of a Provincial Director. They are a complex and confusing alternative to what was a pivotal position. The lines of authority within a child welfare organization cannot be unclear or administratively complex. The decisions are too important and sensitive to leave room for confusion or uncertainty. Changing administrative and delegation arrangements does not change the legal aspects of designation. Delegation of the Provincial Director's authority involves a sharing of the powers, duties and functions in the Act, not a transfer of authority. The sharing of such roles and responsibilities automatically increases the risks of inconsistency, non-compliance and conflict. MCFD has fallen short of creating a robust central role for overseeing regional performance in a decentralized system.

These concerns about a consistent standard of service, accountability and a fixed point of responsibility were articulated in Hughes Review Recommendation 21:

> "That the Ministry retain at its headquarters, the authority it needs to set and ensure compliance with provincial standards and to meet its responsibility for public accountability."

The Representative has identified ongoing concern about accountability in other reports released by the Office, including *Amanda, Savannah, Rowen and Serena: From Loss to Learning April 2008; Housing, Help and Hope: A Better Path for Struggling Families July 2009;* and *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence September 2009.*

The Representative's concern about MCFD's failure to move forward over the past 4½ years is well illustrated by the issue of measuring results. The Hughes Review highlighted in Recommendation 23 the importance of measuring actual results to give the ministry and the public a clear understanding of children in care and the impact programs and services had on their lives:

> "The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time."

In the Sept. 4, 2007, meeting of the Select Standing Committee on Children and Youth (SSCCY), a committee member questioned the ministry's progress in measuring important outcomes for children, youth and families. He raised the same important concern that Mr. Hughes did:

> "The question I have is around measuring success with regards to the delivery of services by those organizations within communities, making a real difference for children, making a real difference in families, showing that the services they're providing are actually making progress in the life of the child that's being impacted. What are your plans with regards to that kind of measurement or those kinds of goals, if you want to call them, in terms of success on the ground?" [2]

[2] Report of Proceedings (Hansard), Select Standing Committee on Children and Youth, Victoria, Tuesday, Sept. 4, 2007, Issue No. 7

In response, the Deputy Minister promised to address this area:

> "Once we have those standards clear for the entire continuum of services, we will be putting quality assurance processes and measures in place so that we are able to have a look at outcomes related to children, to family and to communities."[3]

However, the Representative's 2007 and 2008 Hughes progress reports noted that little progress was made in achieving this recommendation. The progress that was noted in 2007 was the creation of "draft plans for the development of an integrated quality assurance system by December 2008." In 2008 the Representative commented on MCFD's development of various lists of performance measures. The lists lacked the continuity and substance needed for effective accountability of a child welfare system. The Representative observed that the:

> "examples show that MCFD's performance measures change regularly and vary from document to document. As well, only a few of these current measures address the 'real and long-term impacts of its programs and services on children, youth and their families,' which the Hughes Review encourages in performance measures."

In *Strong, Safe and Supported,* MCFD again articulates a commitment to service development that is based on evidence gathered through a strong quality assurance system. One of the key actions identified in the fifth pillar of this plan is to increase reporting on important indicators of quality assurance and child and youth outcomes. Ministry updates on progress in this area are brief and lack substance.

In MCFD's *Progress Report – February 1, 2009 to May 30, 2009* brief mention is made of a new model being developed for the evaluation of child and youth outcomes. No detailed information is provided; nor are any actual measurements reported. In an update received after the data gathering phase of this progress review, MCFD reports that the ministry is a member of the Federal/Provincial/Territorial Child Welfare Outcomes Coordinating Committee, a national group with a goal to create and report on a common set of child welfare measures. MCFD currently reports on eight of the 10 National Child Welfare Outcomes Indicator Matrix ("NOM measures"). Consensus has not been reached by the participating provinces and territories on definitions of the remaining two measures. MCFD has reported on some of the common NOM measures in its service plans.

[3] Report of Proceedings (Hansard), Select Standing Committee on Children and Youth, Victoria, Tuesday, Sept. 4, 2007, Issue No. 7

In addition, some of the NOM measures or partial NOM measures were included in MCFD's first report that brings together all of the ministry's current measures into a single public document – inclusive of their service plan – the March 2010 *Public Reporting of Performance Measures*.

In the Representative's April 2008 report, *From Loss to Learning*, it was once again determined that comprehensive measures were not yet formulated. Robust and regular reporting on the safety, education status and well-being of children in care remained a serious concern. The type of regular public reporting that the Representative views as essential includes:

- data on the number of children in care
- continuing custody orders and Youth Agreements per region
- the percentage of plans of care that are up to date
- visits with guardianship workers, and
- educational outcomes for all children in care, not only those with continuing custody orders.

In *From Loss to Learning* the Representative made a specific recommendation on public reporting that built on the Hughes Review. Recommendation 7(a) addressed key timelines and specific reporting elements, including important child outcomes and practice standards.

MCFD did produce two reports – the first in December 2008 and the second in March 2010.

The December 2008 document was called *Report on Children in Care of the Ministry of Children and Family Development in the North*. The Representative applauded this move, as did a leading Canadian expert on child welfare. Professor Nico Trocmé of McGill University praised the ministry in the media for reporting on outcomes and posting the data on the public website of the ministry, with a commitment to continue to report.[4]

Trocmé identified the importance of following this data over the next few years to identify trends and issues. This was the purpose and intent of the Hughes recommendation, as reformulated again by the Representative. This was the ministry's first public report on the safety and well-being of a population of children in care in one region of B.C. The Representative expected the ministry to continue to report (at least twice a year) and to extend this to all children in care throughout the province, including those transferred to delegated Aboriginal Agencies.

[4]"Northern B.C. has higher rate of recurring child abuse:" News article, *Victoria Times Colonist,* March 30, 2009

On March 11, 2010, the second Children in Care in the North report was posted only on MCFD's internal intranet site. While the Representative is pleased to see a continuation in the monitoring of important child outcome measures in this region, this report falls short of the recommendations in *From Loss to Learning* in significant ways:

- The Representative recommended that the North region publicly report on key measures semi-annually. The timing of the second report suggests that reporting may be only on an annual basis.
- Important measures recommended by the Representative – participation in early childhood education, health status, advocacy services sought and received and measures of sustaining Aboriginal identity and connection to community – have still not been included.
- The measure regarding completed Comprehensive Plans of Care changed between the 2008 and 2009 reports. This can limit comparability and can be misleading in terms of understanding trends or changes.
- The Representative recommended that the ministry prepare a similar report for children in the care of delegated Aboriginal Agencies. This type of reporting has not occurred.
- In its 2008 report MCFD notes that it "will be producing similar material that is region specific on a regular basis." Reports have not been produced for other regions nor is there a mention of this plan in the 2009 report. In November 2009, the Representative was informed by MCFD via a brief email that in fact this additional reporting would not occur.

Building on the 2006 Hughes Review, the Representative made the recommendations in *From Loss to Learning* in 2008, with the realistic expectation that adequate reporting would be an entrenched practice by 2009.

In the Representative's view, the importance of reporting on children in care has resulted in a single report from one region and not a commitment to genuine and regular reporting on outcomes. More than four years after the Hughes Review and following specific recommendations to the point, with many commitments in ministry documents and plans, it has not launched even this basic level of regular and province-wide reporting. This is not acceptable in a ministry that remains badly in need of rebuilding public confidence.

Current Context

The very heart of the child protection system is the strong and compassionate people doing such essential work for B.C.'s children – child protection workers and others on the front line. The Representative echoes the word of the Hughes Review in expressing deep appreciation to them. The Hughes Review applauded their "toughness, warmth, intelligence, compassion, decisiveness and determination."

These people must be thanked, repeatedly and genuinely, for their continued commitment to protecting and nurturing our province's most at-risk children, youth and families. These skilled individuals address the devastating results of poverty, addictions and violence and make difficult, life-changing decisions every day. The Representative's Office hears frequently from members of the public, service providers and MCFD staff that today's hard economic times are making this difficult work even more challenging and that much more must be done with much less.

The Representative's Office has also heard from ministry staff that to their frustration, they lack a clear understanding of where the ministry and its transformation agenda are heading. For example, they've been told that they will have less paperwork to do in the future, but they know little more today about what that means than they did in 2006.

Important forward-looking initiatives such as the Integrated Case Management (ICM) system have been delayed. In the 2008 Hughes progress report the Representative provided positive recognition of the ministry's work in this area:

> "This is an important development and deserves acknowledgement as a positive indication of movement in the direction suggested by Mr. Hughes. To some, information systems may not seem important to children and youth. However, better accountability for what is done and more evaluation of the effectiveness, responsiveness and universality of programs and services is crucial to a strong, well-functioning child-serving system."

Two years later, the government is only in the first phase of a five-phase process. Phase 1 is slated to be completed at the end of 2010, with some assessment and planning functionality being implemented for MCFD staff during this time. It is reported that the majority of case management functionality for MCFD is to be implemented during Phase II and Phase III. Since ICM is portrayed as the lynch-pin of many other changes, the protracted pace of development is a significant concern, and the Representative encourages a full and timely implementation without further delays.

The ministry has fallen short of achieving the performance targets articulated in their service plans – targets set for increasing placements with extended families and reducing the recurrence of abuse and neglect. It will be an ongoing struggle to meet service plan goals given decreased budgets and potentially fewer staff. New measures are reportedly in progress. However, even though performance measures are at the core of the Representative's monitoring role, no consultations have been held with this Office on this vital topic.

Difficult economic times can mean harsher realities for many of B.C.'s families. Poverty will deepen for some, unemployment rates may climb, and previously successful families may struggle. Social services may be required more often, and community supports may disappear. Stagnant or decreasing budgets will not be able to address the needs of additional children and families.

The 2009/2010 overall government budget and the projected budget freezes for the next two fiscal years create a challenge for the system to adequately meet current needs and respond to anticipated increases in caseloads. MCFD has made some significant investments in staff training and knowledge transfer in previous years, and it is important to maintain these efforts.

Part Three – Analysis and Evaluation

This progress report is the third examination of the implementation status of Hughes Review recommendations to improve the child-serving system. The Office of the Representative has been systematically examining the progress of government in making the important changes and improvements in legislation, policy and practice called for in Hughes' recommendations.

This progress report considers the status of 27 of the recommendations that were assessed to be incomplete in the 2007 update. These recommendations relate to:

- MCFD's review of child injuries and deaths
- modern approaches to child protection
- communication, information-sharing and privacy
- external oversight.

MCFD was given the opportunity to review and comment on the Representative's assessments on two occasions – first in December 2009 and again in July 2010 – as part of the administrative fairness process.

Two of these areas, the internal injury and death review process and information-sharing and privacy, were highlighted in the 2007 review and profiled to the Select Standing Committee on Children and Youth as important areas that had not yet received the leadership from MCFD that was required.

The Hughes Review offered a "new approach to the issue of child death reviews" and called for improved consistency, clarity, timeliness and accountability. Little evidence was provided in 2007 of progress towards achieving these improvements, and the Representative remains concerned about limited change or the quality of the changes in this area.

The competing interests of the protection of privacy and the importance of sharing sensitive information were tackled in the Hughes Review. Recommendations were made for amendments to legislation and improvements to public reporting. As with case reviews, little progress was noted in 2007 in this area. Although key legislative changes have been implemented since then, the nature of public reporting is still an issue and cultural barriers to sharing information are still evident.

Methodology

The methodology used in this third progress report is consistent with the two previous reviews – a follow-up audit approach to measure the activity that has occurred towards implementation and the progress made in achieving the recommendations. The Representative's review procedures included document review, enquiry and discussion.

The Representative worked with MCFD in the process of gathering evidence for this update. Over 200 documents were submitted or referenced by MCFD during the conduct of this review. The ministry's Interface Team within the Integrated Quality Assurance Team was accommodating and well-organized in their response to requests for information, and the Representative is appreciative of this. The team also facilitated a number of meetings between MCFD and the Representative's Office to discuss and clarify information.

The key documents that were reviewed are listed in the Resource List: Documents and Sources section. Numerous documents were also accessed electronically and reviewed, including examples of training materials, information-sharing protocols, budget and staffing summaries, case review summaries and practice guidelines. The Representative's intent in conducting this review is to showcase, where possible, areas of accomplishment, in addition to challenges and any lack of progress.

The information received was evaluated against the standards of:

- sufficiency – was there enough evidence to support a conclusion that the recommendation had been addressed?
- relevancy – was the evidence logically related to the recommendation?
- competency – was the information valid and reliable?

As in previous reviews, verbal and written summary statements alone were generally not considered conclusive and needed to be supported by primary sources of information. Documentation and other evidence were reviewed to determine if the required change or improvement addressed in the recommendation:

- was made
- met the intent and spirit of the recommendation
- is being consistently implemented in practice.

Each recommendation was assessed on a six-point scale. This scale is the same scale used in the two previous reviews, with one change. The rating "insufficient information provided" has been deleted, and a new rating has been added – "implementation unsatisfactory." Previous RCY progress reports have measured the extent of the implementation of the recommendations. In this review the Representative is addressing not only the amount of activity related to implementation but the quality of the implementation and the actual change in practice. This new rating is used to address instances where MCFD determines the implementation to be complete but the Representative judges the quality of the implementation or the utilization of the changed practice to be insufficient or inadequate.

Rating Scale for Assessing Implementation

Rating	Definition
Limited or no progress	No documentation is available to indicate that work is being done towards implementing the recommendation. Generating informal or general draft plans is regarded as limited progress.
Planning underway	Specific plans for implementing the recommendation are being developed, and appropriate resources and a reasonable timetable for implementing the plans have been addressed.
Implementation underway	Activities beyond the planning underway process are occurring, such as hiring staff or putting in place the structures necessary to fully implement the recommendation.
Substantial implementation	Significant results have been achieved in implementing the recommendation, and full implementation is imminent.
Complete or fully operational	All actions required to satisfactorily implement the letter, spirit or intent of the recommendation are completed; structures and processes are operating as recommended and implemented fully in all intended areas of the organization.
Implementation unsatisfactory	Actions have occurred to achieve the letter of the recommendation, but those actions are insufficient to achieve the spirit or intent of the recommendation, are of a questionable quality or are not being fully implemented in practice.

Assessment Overview

Twenty-seven recommendations made in the Hughes Review and discussed in this progress report are assessed to determine how much progress has been made since the review was released in April 2006 and the sufficiency of the progress.

Of these, 12 are complete or fully operational, three are substantially implemented, one is underway and 11 are unsatisfactorily implemented.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	Limited or No progress	Implementation unsatisfactory
27	12	3	-	1	-	11

Case Reviews

(Recommendations 31–38, 40, 41, 48–53)

The task of examining and making recommendations to improve the ministry's system of reviewing child deaths was an important element of the mandate of the Hughes Review. In addition, the Hughes Review examined and made recommendations to improve the public reporting of child deaths. The issue of child death reviews was acknowledged by the Hughes Review as the most contentious aspect of the review. In this progress report the Representative continues to find this area to be significantly lacking in terms of the quality of the implementation of the recommendations.

The Hughes Review identified two important purposes for injury and death reviews:

- continuous improvement in policy and practice such that future injuries or deaths can be prevented, and
- public accountability to ensure British Columbians that the ministry has met its responsibilities.

A number of the specific recommendations addressed these two purposes, and in addition, the detailed recommendations addressed the need for clarity and consistency in the definition and conduct of case reviews.

MCFD has determined that the recommendations with respect to case reviews have been substantially implemented. This determination is based on the introduction of the 2008 Integrated Case Review Framework (ICR Framework) and the review of case review processes for all program areas. However, the Representative finds the 2008 framework and current practice to be inadequate in meeting the intent of the Hughes Review in the key areas of continuous system-wide improvement, public accountability, and clarity and consistency.

1. The opportunity for continuous learning and practice improvement is hampered by the structure of the review process. The abolishment of the Provincial Director of Child Welfare and the absence of a more robust provincial oversight role has created gaps in terms of objectivity and consistency. The important elements of a system-wide perspective and province-wide checks and balances have been weakened, and there is greater risk of regional variances. It is clear to the Representative that not enough is being done to benefit from the learning that is possible from the systematic review of child injuries and deaths.

   The ministry's recent review of all recommendations from case reviews for the period of June 2006 to November 2008 is limited. It falls short of a complete aggregate analysis of case reviews and as evidence that the ministry has acted upon the results of such an analysis. With respect to the new Continuous Quality Improvement Strategic Working Group, it is too early to judge the impact of this committee on quality improvement at a provincial level.

2. Changes to public reporting of case reviews fail to meet the Hughes Review's call for greater emphasis on public accountability in a decentralized system. The publicly posted case review information is inadequate:
   - reports on the achievement of timelines are not included
   - updates on the achievement of recommendations are not included
   - analyses of themes across reviews or updates on improvements to the system are not included.

3. The Hughes Review called for a review process that is "timely, thoughtful and impartial." In addition, it made specific recommendations to improve clarity and consistency. The introduction of the new ICR Framework and the continuation of existing standards and language for other reviews during a transition phase have not achieved this goal. There is still no comprehensive guide for all case reviews that clearly defines when to conduct a review, what type of review to conduct and how to conduct it.

In assessing this group of recommendations, a considerable amount of material was submitted to and reviewed by the Representative, including the 2008 ICR Framework, existing standards, examples of integrated case reviews, information-sharing protocols, staff training materials and a range of other regional materials. In addition, information was accessed from MCFD's intranet and website and the Representative's internal tracking systems.

Hughes Review Recommendation 31	2007	2010
That the Ministry adopt a common review tool to guide the conduct of case reviews across all program areas that are relevant to the life of a child who has died or been seriously injured.	planning underway	implementation unsatisfactory

The ICR Framework partially meets this recommendation in that the framework:

- requires the participation of all program areas involved with the child's life, including child welfare (child protection, family development, guardianship and adoption), delegated Aboriginal Agencies, Children with Special Needs, Child Care, Child and Youth Mental Health, Youth Justice and Provincial Services
- requires a review when a child is involved in more than one program or service at the time
- guides case reviews of both deaths and critical injuries.

However, this is a framework and not a common tool as specified by the Hughes Review. In the framework MCFD says there will be "subsequent, standard, policy, guideline and tool development, within the context of the framework, to reflect the specific services each area provides." Given the separate and potentially disparate guidelines, policy and criteria for program areas, it is the Representative's opinion that the development of a coherent review process has not been accomplished.

The specific concerns the Representative has with the framework are:

- the absence of clear criteria for when to go beyond an initial review or preliminary examination of an injury or death and conduct a case review
- a lack of clear criteria as to which type of review to conduct – file or comprehensive
- a role of provincial oversight that is unclear and limited.

The Representative is also concerned that the ICR Framework was established to define and guide "integrated" case reviews only, where the child is or was involved in more than one region or program area. As such, it is not a broader guide for all case reviews in all program areas. As of July 2009 the public postings of case review information utilized the language of the ICR Framework – "comprehensive" and "file" for all case reviews despite the more limited definitions for these terms contained in the ICR Framework.

As noted above, the framework defines integrated reviews for situations where the child was involved in more than one region or program area. The internal documentation and examples provided illustrate gaps, inconsistencies and the use of old and new language and terms (e.g., comprehensive, file, Director Review and Deputy Director Review), and there is a need to look in several places, including the ICR Framework and Quality Assurance Standard 2, to piece together a more comprehensive description of and guidelines for case review practice.

The Provincial Director of Child Welfare position was abolished and the Regional Executive Director Council created, yet the ICR Framework references the Provincial Director in many places. This is confusing, and the Representative questions why the language and processes in the framework were not amended to reflect these important organizational changes and to be as current and clear as possible.

Four examples of integrated case reviews were submitted to the Representative. Only two of these reviews clearly contained all elements of the new framework and demonstrated an integrated review practice. The Representative notes that four examples represent a very limited implementation of the framework over a 16-month period (March 2008 – June 2009).

Although the ministry reports that the provincial office reviews all case reviews, will provide feedback and may add further recommendations, there was little evidence that it monitors the consistency and the quality of the regional processes. In conducting this progress report review and through the Representative's critical injury and death review function, the Representative has observed that many of the case reviews routinely submitted by MCFD lack sufficient oversight in both the conduct and the content of the reviews. Many of the reviews are seen as limited in the analysis of circumstances and practice and do not identify or encourage understanding of broader issues. These limitations compromise the value of case reviews as a tool for accountability and for system learning.

In a review of the Regional Executive Director (RED) Council, MCFD identified the potential for regional variances and isolation resulting in the absence of a common approach. However, MCFD was confident that those could be dealt with through discussion and consensus building. The Representative's Office is not as confident in the capacity of a collegial and supportive approach to address serious concerns inherent in case reviews. The Representative shares a concern expressed in the ministry's review of the council that the purpose and roles of the RED Council might take on a personality consistent with its current members, as opposed to being more formally established. Notwithstanding that MCFD has since disbanded the RED Council and appointed regional Assistant Deputy Ministers, the Representative remains concerned about the ministry's approach to non-compliance and practice concerns. The approach appears now to be comprised of an increasing level of ambiguity with no evidence of a fixed point of accountability.

Hughes Review Recommendation 32	2007	2010
That the Ministry adjust its timelines for its internal reviews, ensuring timeliness but taking account of current capacity. Once established, the timelines should be made public.	implementation underway	implementation unsatisfactory

The Integrated Case Review Framework partially meets this recommendation in that it establishes adjusted timelines for both levels of *integrated* reviews – 11 months to complete a comprehensive review and six months to complete a file review. Existing standards – Quality Assurance and AOPSI standards – contain the unchanged timelines for reviews that are not integrated. The adjusted timeframes for integrated reviews are not identified on MCFD's website, where case reviews are defined and the summaries of individual reviews are posted. The adjusted timelines are found on the Hughes Update appended to the *Strong, Safe and Supported* update. Complete information is difficult to locate, and the Representative questions why all relevant information isn't found in one place, in one document. MCFD does not publicly post the achievement of timelines for individual case reviews and never has.

The Representative's Office tracks timelines achieved for the completion of case reviews and notes that the majority do not achieve the timelines – old or new. MCFD does not provide the Representative's Office with any details on what factors delayed the completion of specific case reviews, and therefore it is not possible to comment on what percentage were delayed as a result of criminal investigations, autopsy findings or court proceedings. In the end, the concern noted in the Hughes Review about establishing and then seldom meeting timeframes is still a significant issue. Although the provincial office monitors timelines on its electronic tracking system, there was no evidence of holding regions accountable for timelines not achieved and requiring follow-up action, nor is there a provincial mechanism for accomplishing this.

Hughes Review Recommendation 34	2007	2010
That the Ministry rename its internal injury and death reviews and clarify the scope of each.	planning underway	implementation unsatisfactory

The ICR Framework partially meets this recommendation in that the framework renames two types of *integrated* reviews – comprehensive and file. MCFD reports that it will use the existing standard and definitions for reviews that are not integrated until Quality Assurance Standard 2: Case Review is amended. In practice, however, the terms and language currently used are inconsistent and confusing. In many places MCFD has adopted the language of the ICR Framework – "file" or "comprehensive" – even though these terms have not been defined outside of the ICR Framework.

The Representative recognizes that this is a period of transition but sees the framework as an inadequate tool to manage the transition. The framework has created more confusion than it has resolved. A time of change demands more precision in language. The Representative was not informed of the June 1, 2009 change in the naming of all case reviews until March 2010. This change occurred without any changes to the supporting framework or standards.

In the ICR Framework the scope of each type of integrated review has been defined, including timelines, guidelines for methodology and content, dissemination of results, feedback to participants and the specifications for extracting best practices and what has been learned. The framework does not establish clear criteria that guide a decision as to which level of review to conduct – a comprehensive or a file review. Criteria that should be included but are not are the nature of the incident, the seriousness of the injuries and the length of involvement with MCFD. It appears that the decision as to which type of review to conduct is left to the discretion of the region.

A commitment is made in the framework for each region and the provincial office to establish a mechanism to decide to conduct a review and ensure the most appropriate type of review is conducted. The Representative is concerned about the loss of consistency across all regions and programs and the degree of regional and program discretion. In a decentralized system, strong and clear criteria must be in place to guide decisions when these decisions are being made by the same managers responsible for the oversight of services delivered when an injury or death occurred. There must also be a system of checks and balances in place to ensure that regional decision-making is consistent with provincial intent.

This Hughes recommendation was intended to accomplish clarity and simplicity in the practice of case reviews. This has not been achieved. The ICR Framework document lacks detail and clarity. Without a more comprehensive document that defines and delineates all reviews including criteria, content, methodology and oversight, guidance of the practice of case reviews is anything but clear, simple and rational.

Hughes Review Recommendation 36	2007	2010
That the Ministry develop clear criteria to guide the decision as to whether to review the death or critical injury of children who are receiving or have received Ministry services.	implementation underway	implementation unsatisfactory

The Representative is very dissatisfied by the work done in this area. Clear criteria have not been established in the ICR Framework to guide the decision as to whether to conduct a case review or not. The Representative sees the framework as a step backwards in this regard. MCFD reports that each region and the provincial office will establish a mechanism to decide to conduct a review and ensure the most appropriate type of review is conducted. The Hughes Review's intent was for a standard, high level of practice across all regions and programs. This level of discretion concerns the Representative with respect to consistency in practice.

The concern expressed in the Hughes Review that there is "no clear direction to the regions as to when to undertake a review and the level of review to be undertaken" has clearly not been addressed.

Hughes Review Recommendation 33	2007	2010
That the Ministry undertake reviews of critical injuries and deaths of children receiving services from any of its program areas.	planning underway	implementation unsatisfactory

Hughes Review Recommendation 35	2007	2010
That the death or critical injury of a child who is in care always be subjected to a review, regardless of the circumstances.	implementation underway	implementation unsatisfactory

Hughes Review Recommendation 37	2007	2010
That the Ministry review injuries and deaths not only of children who were receiving Ministry services at the time of the incident but also of children who had received Ministry services during the 12 months preceding, and in exceptional circumstances, going back even further.	limited or no progress	implementation unsatisfactory

MCFD reports full implementation in that all critical injuries or deaths are initially reviewed through a Reportable Circumstance Report, and the ICR Framework guides decision-making about whether an additional review is warranted. A number of sample protocols were submitted to substantiate the requirement to report a critical injury or death, including new protocols with the Coroners Service and an updated process with Vital Statistics. MCFD also reports that the IQA team reviews all Reportable Circumstance Reports.

In contrast to the ministry's assessment of compliance with these recommendations, the Representative is concerned about two serious gaps in implementation. MCFD acknowledges that policy, standards and procedures regarding the notification of reportable circumstances vary across program areas and that there are different criteria for reporting in different areas. The new framework does not address these variations, and the Representative is troubled by the persistence of differences in the requirement for an initial review across program areas.

The second area of concern is the framework itself. The ICR Framework partially meets these three recommendations in that the criteria for an *integrated* review include:

- program areas/service providers that fall within the categories of Child and Family Development, Aboriginal Regional Support Services, Provincial Services, Children and Youth with Special Needs and Community Living
- the death of a child in ministry care
- injuries or deaths that occurred in the preceding 12 months.

The language in the ICR Framework is not as precise as the criteria suggested in the Hughes Review. For example, although the framework's criteria covers all children receiving services, the framework does not specifically address critical injuries of children in care. The Hughes Review noted that the province is the guardian of a child in care, and like any caring parent, the ministry should have all questions answered about a critical injury. In addition, unusual circumstances are mentioned in the framework, but the criteria miss the point made in the Hughes Review in terms of including the discretion to review injuries or deaths when the child has not been involved with the ministry beyond the 12-month period, when circumstances warrant.

The framework does not include clear criteria to guide the decision to proceed to a case review. The written framework document is missing many important details – details more clearly defined in existing standards documents. The Representative is not convinced that the ministry is adequately ensuring that all regions appropriately review all injuries and deaths as recommended by the Hughes Review.

Hughes Review Recommendation 38	2007	2010
That the Regional Executive Director be responsible to decide whether a review should occur; record the reasons for that decision; establish the terms of reference for the review; decide who will do the review; and finally, sign off on the recommendations that result.	implementation underway	implementation unsatisfactory

The ICR Framework partially meets this recommendation in that it outlines a process where a number of different senior staff members, including the Regional Executive Director (depending on the program areas involved), could be responsible to:

- make the decision to conduct a review
- establish Terms of Reference for a review
- decide who will conduct the review
- sign off the recommendations.

However, the framework is confusing in regards to more complex situations. The Assistant Deputy Minister of integrated quality assurance, the director of a provincial program or the director of children's services with Community Living BC may be consulted regarding a decision to conduct a case review, but the framework does not speak to how the decision gets made. Decisions about case reviews for children and youth served by a delegated Aboriginal Agency are to be made by the Deputy Director Aboriginal Services and the Provincial Director – a position that no longer exists. Although Community Living BC no longer has jurisdiction for children with special needs and the Representative has been told that the First Nations Director has assumed the responsibilities of the former Provincial Director role as it relates to delegated Aboriginal Agencies, RCY is not aware of any updates or amendments to the ICR Framework that clarifies these changes in decision-making responsibility for ministry staff members.

The Representative highlights an important gap in the process: the requirement to record the reason(s) for the decision to conduct a case review or not. Although some regions submitted evidence of a regional documentation process, the practice is not formalized or consistent.

Hughes Review Recommendation 40	2007	2010
That the Ministry provide required orientation, training and mentoring for practice analysts who will conduct reviews; and maintain a list of qualified reviewers.	planning underway	complete or fully operational

MCFD provided documentation and samples of the various ways it supports practice analysts. Practice analysts tend to be senior, experienced staff members, and much of their training tends to be one-on-one mentoring. The IQA team hosted three two-day practice forums for provincial and regional analysts in 2008. There was broad participation in the forums, and good feedback was received from participants. In addition, practice analysts participate in regular teleconferences for support and new information. MCFD also submitted examples of follow-up training provided to practice analysts.

A bid for qualified reviewers was held in 2007. MCFD reported that there were 10 qualified external bidders to do case reviews in 2004, and 10 in 2009. In addition, there are 17 practice analysts on MCFD staff teams across the province.

Hughes Review Recommendation 41	2007	2010
That the Ministry make use of multi-disciplinary teams in its child injury and death review process.	limited or no progress	substantial implementation

There is no specific reference in the ICR Framework for the requirement for a multi-disciplinary team. In MCFD's *Strong, Safe and Supported* update, the ministry reports that the new framework and current practice are consistent with this recommendation, given that often many professionals and agencies are involved in a child's life. In three of the four integrated case reviews submitted there was sufficient evidence of a multi-disciplinary approach. In addition, a number of the regional submissions described the use of a multi-disciplinary approach in their practice. Compliance with this recommendation would have been clearer had the new framework been more explicit in this regard.

Hughes Review Recommendation 48	2007	2010
That the Child, Family and Community Service Act, *which sets out powers and duties of the Provincial Director, be amended to include the power to produce reports of internal child death reviews and to state that although the main purposes of the report is learning, public accountability is a purpose of these reports.*	planning underway	complete or fully operational

From a legislative point of view, there is substantial compliance with this recommendation. The creation of an express power to produce reports of internal child death reviews took place in two stages. Stage 1 was the enactment of s. 93.2 of the *Child, Family and Community Service Act (CFCSA)*, effective March 29, 2007. Stage 2 was the enactment of s. 19.1 of the Child, Family and Community Service Regulation, effective June 21, 2007.

Hughes Review Recommendation 49	2007	2010
That the Child, Family and Community Service Act *be amended to allow the Provincial Director to make information-sharing agreements with other agencies for the purpose of multi-disciplinary child death reviews.*	limited or no progress	complete or fully operational

Although an amendment was not made as recommended, other amendments were made that, combined with already existing powers, are adequate to achieve the legal purpose of this recommendation to ensure information-sharing agreements among public bodies. The collective effect of these provisions is to make it legally permissible for public bodies as defined in the *Freedom of Information and Protection of Privacy Act (FOIPPA)* to engage in meaningful participation on an internal child death review without fear that their information disclosures would be unlawful.

MCFD did not report any issues with using these legal provisions to their full extent in practice.

Hughes Review Recommendation 50	2007	2010
That the Child, Family and Community Service Act *be amended to require the Provincial Director to give, on a confidential basis, a complete copy of the final child death review report to all agencies that participated in the multi-disciplinary Child Death Review Team.*	limited or no progress	implementation unsatisfactory

There is partial compliance with this recommendation. Section 79(g.1), (g.2) and (k) of the *CFCSA,* added on March 29, 2007, confer discretion on the Director but do not *require* him or her to disclose the full and final report to participating agencies. The Director has discretion to refuse to do so. These provisions are also unclear as to whether release is intended to apply only to public disclosure or whether it was intended to apply to all outside agency participants on the internal review. If the ministry takes the position that s. 79(g.2) applies to the agencies too, then disclosure of the final report is not only discretionary but prohibited if the "unreasonable invasion of third-party privacy" test in *FOIPPA* is met. From a legal point of view, compliance with this recommendation is partial, as disclosure is not mandatory and may well be prohibited depending on how the ministry is interpreting and applying s. 79(g.2).

Hughes Review Recommendation 51	2007	2010
That in its annual reports the Ministry of Children and Family Development provide a statistical report on its reviews of deaths and critical incidents as well as the recommendations that resulted from those reviews, and a progress report on their implementation.	planning underway	implementation unsatisfactory

MCFD reports that the ministry's required format for an annual report is a standard government format and does not allow for this type of unique reporting. As an alternative to including this information in an annual report, MCFD posts a summary of each case review on its website. Although these postings include the recommendations for individual reviews, this alternate reporting format does not meet the recommendation in that:

- it is not a statistical or aggregate reporting that lends itself to comparisons to prior periods or that identifies trends
- it does not include progress reporting on the implementation of recommendations.

Prior practice (2007 and before) was to post annual summary reports. In this format information for all case reviews for the period was collated and analyzed, including trends in intakes, findings, recommendations and areas in need of improvement. This format provided more useful information.

Hughes Review Recommendation 52	2007	2010
That twice a year the Ministry of Children and Family Development publicly release a summary of each child death review it has completed during the previous six months. The summaries would contain no names, dates or places.	implementation underway	complete or fully operational

As noted above, MCFD posts summaries of all individual child death reviews every six months. These postings meet the recommendation in that the summaries:

- are released in a timely manner
- are publicly released
- contain no identifying information but sufficient detail for the public to know what happened and on what basis the recommendations were made.

Hughes Review Recommendation 53	2007	2010
That if the death of a child who was in care or known to the Ministry has already been disclosed by police, a court or the Coroner, the Ministry be permitted by the Child, Family and Community Service Act *to disclose the child's name and relationship to the Ministry and the contents of the Ministry's case review, to the extent necessary for accountability but without unreasonable invasion of privacy.*	limited or no progress	complete or fully operational

Sections 79(g.2) of the *CFCSA* and s. 25.1 of the Regulation comply with this recommendation.

Modern Approaches to Child Protection

(Recommendations 42, 45 and 46)

The Hughes Review acknowledged and supported the "service transformation" undertaken by the ministry to move away from traditional child protection work to more out-of-care options and alternate dispute resolution processes. The newer approaches were viewed as having significant potential to keep children safe within their families, achieve better outcomes and reduce costs over the long term. The Hughes Review cautioned that the fundamental change in practice required by the transformation must be supported up front with adequate resources and training. The need for an initial investment in the service system was repeated in the recommendation to revitalize the campaign for foster and adoptive parents.

Little or no progress in this area was noted in the 2007 update. At the time, the Representative received mostly draft plans, and there was limited evidence of changes in practice or skill sets.

In MCFD's recent progress report the recommendations in regards to modern approaches were rated as substantially implemented. In the conduct of this review the Representative notes significant progress and investment in the newer approaches and agrees with the ministry's evaluation. In addition, MCFD demonstrated that feedback from line staff was used to evaluate service options and to guide the reinvestment and redesign of resources and training.

There remains a significant risk that much of this progress and investment will be lost during current and anticipated periods of fiscal restraint. MCFD reported that staff development activities were curtailed during the last fiscal year, and the Representative is aware that auxiliary full-time equivalents (FTEs) have been lost. It was highlighted in the Hughes Review that

service transformation was introduced during a time of constant change and budget reductions in the ministry and that the implementation of new approaches suffered as a result. The Representative has not seen any evidence that the ministry has plans in place to safeguard the current status of these new approaches in the face of budget constraints.

In assessing this series of recommendations for the present review, a great deal of material was submitted and reviewed, including documentation of funding, staffing and training increases, curricula and documentation of program utilization rates.

Hughes Review Recommendation 42	2007	2010
That government provide sufficient funding, staffing and training to support its newer approaches to child protection work.	limited or no progress	complete or fully operational

Hughes Review Recommendation 45	2007	2010
That government provide training for current social workers and recruit individuals with the necessary mediation and counselling skills to support the service transformation initiative.	limited or no progress	complete or fully operational

Detailed evidence was provided to document ministry increases in funding, staffing numbers and training to support modern approaches over the 2006–2009 period. These investments were made in alternative dispute resolution processes, support to families and out-of-care options. Program utilization rates were provided that documented growth in these important strategies. There is also evidence of the critical analysis of these investments in terms of the utilization rates, staff feedback and barriers to utilization. MCFD used these analyses to change practice and adjust training opportunities.

Front-line staff positions increased modestly but consistently between June 2006 and June 2009 – from 2,868 FTEs in 2006 to 3,247 in 2009, an 11 per cent increase over the three-year period. A significant amount of staff training occurred during this time to improve staff understanding and use of the targeted approaches. Many examples of training materials and conference packages were submitted, as were detailed attendance records. MCFD reports

that in 2007/2008 the ministry delivered more than 1,000 distinct learning events – a total of over 40,000 training days to approximately 4,000 ministry and 1,500 partner staff members. Training opportunities were open to staff from delegated Aboriginal Agencies and contracted service providers. The Representative commends MCFD for this work.

Staff feedback on the training was routinely sought, and samples of these evaluations were provided. The core child welfare practitioner training has elements of modern approaches, as does the new competencies system that was introduced in 2007. MCFD also provided a copy of the curricula review of child welfare specialization in B.C. post-secondary institutions.

As previously noted, it will be a challenge to sustain adequate levels of staff training during a time of budget restraints and cuts. The ministry is currently utilizing and planning to expand alternative staff training methods based in adult learning research, including webinars for supervisors, videoconferencing, e-learning, mentoring and coaching.

Hughes Review Recommendation 46	2007	2010
That the Ministry reinvigorate its campaign to recruit foster and adoptive parents and ensure that it is funded so that it can respond to public interest and participation.	implementation underway	substantial implementation

Children belong in families, and when they cannot live with their family of origin, an adoptive or foster family establishes permanence and important life-long relationships. The recruitment of foster and adoptive parents requires ongoing reinvestment and reinvigoration to maintain and, it is hoped, increase the number of families available.

MCFD submitted evidence of funding for recruitment campaigns in 2006/2007 and 2007/2008 and examples of recruitment efforts. Although money and resources have been invested, evidence was not provided that outcomes for children and youth have improved. It is unfortunate to note that neither the adoption numbers nor the foster home numbers showed any real growth over the reporting period.

The Representative knows that this will continue to be an issue and calls for the ministry to rise to the challenge and find more creative and successful strategies to meet the demand for permanency.

Communication, Information-sharing and Privacy

(Recommendations 57, 60–62)

The Hughes Review noted the inherent tension and complexity in achieving the protection of individual privacy, the sharing of vital but sensitive information, and public accountability in the work of the ministry. This is a particularly difficult balance in a field such as child welfare where public interest is high and the information is personal and often very troubling. The review called for improved communication and coordination between all individuals and organizations involved in service provision.

In their most recent progress report MCFD reports that three of the outstanding recommendations in regards to information-sharing and privacy have been substantially implemented. The Representative agrees with this assessment.

Hughes Review Recommendation 57	2007	2010
That the Ministry of Children and Family Development, in collecting linked data from other public bodies for the purpose of decision making about individuals, ensure that the absolute minimum information is collected and that each linking is necessary to enable the Director to deliver mandated services, and that the highest privacy standards are met.	limited or no progress	complete or fully operational

MCFD submitted and referenced a range of documents and resources that addressed information-sharing and privacy. These included regulations, guidelines, staff training materials and information-sharing agreements. These submissions met the recommendation by addressing the following principles:

- Information is shared on a need-to-know basis in that the requestor has a very definitive purpose for knowing the information.
- Information requested is necessary for the Director to carry out a function or perform a duty that is mandated.
- When information is gathered about a person, it is protected, stored and disposed of properly.
- No more information is collected than is necessary.

In addition, the Privacy Impact Assessment Template that will be used for the Integrated Case Management system was submitted, and a Risk Assessment for the new system will be developed.

Hughes Review Recommendation 60	2007	2010
That the Ministry of Children and Family Development review the statutes that govern it to ensure that there are no statutory barriers to disclosure of information among program areas.	insufficient information provided	complete or fully operational

The Hughes Review called for the ministry to ensure that no legislative barriers remained to block the sharing of information across its program areas. The Representative is of the opinion that the legislative provisions are fully adequate to ensure that there are no statutory barriers to disclosure of information among the ministry's program areas. The important thing is for the ministry to fully and effectively use the legal authority it has. MCFD acknowledges the existence of staff behaviours and program cultures that are still barriers to sharing information between program areas. The Representative has observed these barriers during investigations of critical injuries or deaths. Clear and comprehensive policy can be in place, but if practice is not consistent with the policy, opportunities to provide the best service or supports are lost due to inadequate information-sharing.

Program areas can exchange information among themselves in accordance with *FOIPPA*. The only time this principle does not apply is where the particular statute has a provision expressly overriding *FOIPPA*. Provincial program areas can also exchange information with federal program areas where the relevant federal statutes make provision for this in their statutes, as with the *Youth Criminal Justice Act*, or where a written agreement regarding disclosure has been entered into *FOIPPA*.

Hughes Review Recommendation 61	2007	2010
That the Ministry of Children and Family Development review its privacy policy documents to ensure that they are current, accurate and easily useable by employees.	limited or no progress	complete or fully operational

This recommendation is viewed as complete based on the review of the following MCFD documents:

- Confidentiality and Disclosure of Information
- The Privacy Charter
- Information Sharing and Privacy – A Framework for Decision Making
- Segment 8 of the Child Welfare Practitioner Training – Child Welfare Legislation and Standards.

These resources were identified as current, and the Representative's Office found the materials to be readable and easy to use.

Hughes Review Recommendation 62	2007	2010
That the Freedom of Information and Protection of Privacy Act *be amended to incorporate the "unreasonable invasion of privacy" test in s. 33.2, which authorizes public disclosure of personal information under certain conditions.*	limited or no progress	planning underway

FOIPPA outlines to whom and for what purpose disclosure may take place, and the discretion to disclose is fairly broad. There is no "unreasonable invasion of a third party's personal privacy" provision written in that would forbid a public body disclosing information to another public body if it would be an unreasonable invasion of a third party's personal privacy. The Hughes Review recommended that there should be such a provision.

To date, this change has not been made, and *FOIPPA* remains "non-compliant" with this recommendation. The Representative questions whether this recommendation should be implemented as to do so might conflict with other key Hughes recommendations about the critical importance of avoiding cumbersome legal requirements and ensuring easy information-sharing between program areas as long as the information so disclosed is protected (which is required under *FOIPPA*, the *CFCSA* and the *RCYA*).

MCFD reports that these matters are "under consideration" by the Ministry of Citizens' Services. The Representative proposes that this recommendation be carefully studied before it is implemented to ensure it does not undermine the good progress that has been made in ensuring easier disclosure between program areas.

A New Plan for External Oversight

(Recommendations 16, 54, 56 and 58)

The 13 recommendations established in the Hughes Review for external oversight defined the framework for the Office of the Representative for Children and Youth. These recommendations were substantially complete in 2007, with four minor updates required for this report.

Hughes Review Recommendation 16	2007	2010
That at least one of the three senior positions at the new Representative for Children and Youth be held at all times by an Aboriginal person; and that the Representative actively recruit some Aboriginal staff at all levels of the organization.	substantial implementation	complete or fully operational

The situation in the RCY Office with regards to Aboriginal leadership is the same as was reported in the 2007 progress report: the Representative is a First Nations person from the Muskeg Lake Cree Nation. The Associate Deputy Representative (responsible for Advocacy, Aboriginal and Community Relations) is a member of the Nisga'a Nation. Two other staff members are of Aboriginal ancestry. A number of temporary or co-op staff members have been Aboriginal, and in some cases Aboriginal candidates have been specifically recruited for these positions.

Typically, RCY postings for permanent and short-term positions (at every level of the organization) include the phrase "preference may be given to applicants who are of Aboriginal descent." This encourages Aboriginal candidates to apply and allows RCY to take this into consideration when evaluating applicants.

The implementation of the recommendation is complete, but the Representative views this work as an ongoing commitment. The work of the Representative's Office includes outreach to many Aboriginal communities to increase awareness about the Office and encourage the engagement of children, families and other community members.

Hughes Review Recommendation 54	2007	2010
That the Representative for Children and Youth Act *contain an authority to collect information that is at least equivalent to s.11 of the* Office of Children and Youth Act; *provisions to ensure that the records it requests are delivered promptly and without charge to the Representative; and to permit public disclosure of personal information if it is in the public interest, necessary to support the findings and recommendations, and not an unreasonable invasion of privacy.*	substantial implementation	implementation unsatisfactory

There has been compliance with this recommendation except insofar as the Hughes Review recommended that government should be under an express duty to deliver records "promptly" and without charge. This has not been written into the legislation. The drafters likely considered these requirements to be unnecessary, since records would in fact be free and the ministry would be prompt in practice. An express legislative requirement to act promptly would assist in the administration of the *Representative for Children and Youth Act (RCY Act)*, and therefore the Representative concludes that there has been non-compliance with this part of the recommendation.

Hughes Review Recommendation 56	2007	2010
That the Representative, in collecting linked data from Ministry of Children and Family Development and other public bodies for the purpose of fulfilling its monitoring role, develop policies and practices to ensure that all identifying information is removed from public reports and that the highest privacy standards are met.	implementation underway	substantial implementation

The Representative's Office drafted and implemented a policy to comply with this recommendation, and information-sharing agreements are in place as necessary. RCY ensures all identifying information is removed from public reports, unless permitted by legislation, and that all applicable privacy standards are met. RCY will continue to refine internal procedures as the work with linked data from other public bodies expands.

Hughes Review Recommendation 58	2007	2010
That the Representative for Children and Youth Act *contain a provision similar to s.9 of the* Ombudsman Act, *requiring that information collected by the Representative be kept in confidence, with a limited right of disclosure.*	substantial implementation	complete or fully operational

Section 23 of the *RCY Act* fully complies with this recommendation. The small differences between s. 23 of the *RCY Act* and s. 9 of the *Ombudsman Act* flow either from recommendations made by the Hughes Review or the need to ensure that child protection comes first.

Concluding Remarks

This third and final progress report on the Hughes Review accomplishes three goals:

- It provides an update on 27 of the recommendations that were assessed as incomplete in the first progress report.
- It provides a review of the ministry's overall achievement in addressing the Hughes Review recommendations.
- It sets direction for future reporting by the Representative.

The Representative's assessment of government's progress in achieving specific recommendations is once again a mixed review. The good news is that 15 of the group of 27 recommendations specifically reviewed in this report are complete or substantially complete, and one recommendation is considered to be underway. Unfortunately, 11 have been judged to be implemented at an unsatisfactory level.

While MCFD sees all of these recommendations as complete, the Representative questions the quality of the implementation or does not see consistent utilization of the improvement in ministry practice.

Of greatest concern to the Representative is the lack of progress in improving the ministry's case review practice. The new Integrated Case Review Framework does not address all of the issues noted in the Hughes Review, in terms of clarity and consistency. As well, practice has not achieved the high professional standard called for by the Hughes Review in the areas of uniformity, timeliness and continuous learning.

Stepping back to again take a look at the full Hughes Review, the ministry's lack of overall success in meeting the aim of the review remains a major concern. Less than half of all the recommendations are judged to be fully implemented and major systems issues are not addressed to a satisfactory level. Oversight and quality assurance measures are insufficient. The development of a number of provincial frameworks and senior level councils and working groups do not demonstrate the required degree of monitoring and practice management to ensure a consistent quality of service across all programs and regions.

The Hon. Ted Hughes spoke clearly in his review of "the need for equilibrium and stability." He noted that the constant turnover in leadership, multiple changes in practice direction and budget cuts all took "a toll in terms of staff morale and the ministry's ability to set directions, frame goals and make progress." More than four years later, there is little to show that the ministry has learned to address these issues.

The ministry's executive team, for example, has been restructured several times since Hughes, with Assistant Deputy Ministers (ADMs) coming and going through the "revolving door" that Mr. Hughes urged should stop spinning. Currently there are 28 people on MCFD's "leadership team." Responsibility and accountability are divided for many programs – child care has three different ADMs, for example. The Representative has met with staff at all levels of the ministry and hears regularly of the frustration and unease caused by promises of change disconnected from the reality of the day-to-day experience and policy expertise of MCFD staff.

Stability from steady executive governance, detailed and meaningful planning, and adequate resources were of the essence if the Hughes recommendations were to be completed and this ministry's success ensured. Much has been promised and little delivered along the path of implementing the Hughes recommendations.

The Representative has been told by MCFD senior executives that transformation is more comprehensive and meaningful than Hughes, and will yield more significant improvement for children. Yet there is very little evidence on the ground in the form of new standards, practice or outcomes to support that ambitious claim, more than 4½ years after the Hughes Review. The Representative is left questioning the ministry's commitment to important changes to practice and, regrettably, has lost confidence in the ministry's capacity to achieve the intent and vision of the Hughes Review.

The systematic review of the Hughes recommendations has been an important undertaking. The Hughes Review stands as an excellent critical analysis of the child-serving system in B.C. While some of the issues or gaps have been dealt with and are essentially off the table, others are unresolved and must be monitored on an ongoing basis. These elements and others are identified and form the foundation of the Representative's monitoring and reporting work on a go-forward basis. The Representative's Office will continue to address issues such as consistency, outcomes, quality assurance and equity.

Since first assessing progress on the Hughes recommendations in 2007, the Representative has expressed concern about shifting priorities and timelines at MCFD. This concern has not diminished in subsequent years. The ministry must be responsive and effective in serving the children of British Columbia, with its activities and outcomes for children continually reported on for accountability purposes and also to ensure that its operations are improving over time in all places. The ministry has significant responsibilities to British Columbians and has entered a period of change that is incredibly ambitious and is certainly experimental.

Given the ambitious change agenda pursued, and the ministry's move away from the Hughes Review, the Representative would have preferred an open and transparent commitment to

explaining practice change, prevention work, and how it will ensure improvement to the situation of B.C.'s children and families, especially those at risk. Ambitious change agendas require vigorous management of change, sufficient resources for stability and increased scrutiny and reporting.

Unfortunately, this has not been possible on many fronts as the level of detail, reporting and evaluation by the ministry of its ambitious program is inadequate. The Representative has been rigorous in attempting to provide oversight, but has been unable to evaluate the "transformation" agenda because it lacks detail and proper explanation of what it means for service to children, especially vulnerable children.

Front-line staff are trying to respond to requests for service, although they too express their confusion and concern. They are unsure about what is happening with standards and operations, and they report that there is a lack of effective prevention services to respond to the presenting problems that families experience. They tell the Representative and her staff that they are concerned that high-level talk is not relevant to their tasks and expect more for the families and children they serve.

Youth, parents, front-line staff and an oversight body should not be left guessing and speculating. It must be shown, by quantitative measures, that this initiative will not only respond to, but will actually address the challenges faced by children and families.

Change is required, and those leading the change must demonstrate that this approach is working, or will work, through explaining how families are actually better served, and how children's risk is reduced. By failing to provide information, the ministry's leadership demonstrates they do not appreciate what Mr. Hughes called for — a new accountable approach, with full cooperation with oversight.

The failure of the ministry to provide such information is a failure in its duty to the children and youth of B.C., and others are urged to join the Representative in calling for change. Political leaders from both sides of the Legislature must demand a level of public accountability and regular reporting that permits rigorous scrutiny. Sadly this has not been the approach, but it is hoped this will change. This rigour is essential due to the immense impact these projects and initiatives have on the daily lives of B.C.'s children and youth.

The Representative will continue to monitor and comment on the issues of service transformation, child safety and accountability through regular reports, presentations to the Select Standing Committee on Children and Youth and public discussion. The Hughes Review themes will provide guidance for public reporting, even if such reporting out is not directed at specific recommendations.

The child-serving system remains a vital area of public service. Government has made ambitious commitments to "prevention" – without much analysis of what is causing the risk to children – largely to suggest that the system *itself* is the cause of risk to children, due to systemic approaches that are too intrusive and not necessarily "strengths based."

The Representative believes that this government approach requires an even higher level of accountability, to ensure that effective services are preventing children from risk, thus justifying a diminished focus on child protection. Given recent reductions in services, it is not clear that a new prevention focus, or a new practice framework, has yet been launched at the operational level. The presenting issues continue to challenge front-line staff – the very issues that families struggle with and that place children at risk – poverty, addictions, mental health concerns, and domestic and other violence.

Building on the blueprint provided by the Hughes Review, on the recently released *Growing Up in B.C.* report, and on specific recommendations made in her past reports, the Representative will implement a new reporting process. The focus will be on examining actual outcomes that make a real difference in the lives of children.

One of the ways to measure progress is through regular measurement of outcomes achieved. The Representative will use the strong work of the federal/provincial/territorial committee on child welfare outcomes to report on commonly accepted measures for child welfare.

The Hughes Review, as it does with many complex issues, articulates a straightforward vision of why we must measure progress – and the incontestable desired end result: "When programs and policies are introduced, the ministry and the public need to understand the expected results for children; and after implementation, they need to be able to tell whether those results are being achieved."

The Representative remains keenly committed to working with MCFD and others to set and understand expected results, to critically analyze if these are being achieved, and to help realize the successes that B.C.'s children and youth deserve, as envisioned in the Hughes Review.

Resource List: Documents and Sources

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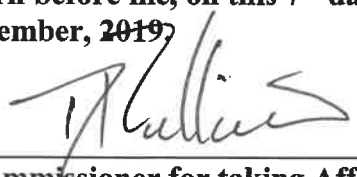
REPRESENTATIVE FOR
CHILDREN AND YOUTH

This is Exhibit "C" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, ~~2019~~ 2019.



A commissioner for taking Affidavits

CANADIAN COUNCIL OF PROVINCIAL CHILD AND YOUTH ADVOCATES
June 23, 2010

Aboriginal Children and Youth in Canada: Canada Must Do Better

> *It is to ensure that Aboriginal children grow up knowing that they matter - that they are precious human beings deserving love and respect, and that they hold the keys to a future bright with possibilities in a society of equals.* Royal Commission Report on Aboriginal Peoples, 1996[1]

Background

The Canadian Council of Provincial Child and Youth Advocates (the Council) is an alliance of government-appointed children's advocates from nine provinces and one territory. Each operates under a legislative framework unique to their province or territory, and their titles differ. Nine of the ten members are independent officers of their provincial/territorial legislatures.

As members of the Council, we share a common commitment to further the voice, rights and dignity of children. We are engaged with children and youth on a daily basis, and promote better outcomes for children and youth, as well as encourage their participation and involvement in a better society to meet their needs and aspirations.

Although our roles vary depending on their statutory mandates, we generally provide direct advocacy supports to children and youth, as well as systemic advocacy for improvements to the system of services and supports. Our respective offices conduct reviews, and make reports to governments and the public.

We play an important role in informing governments and the general public of concerns regarding the rights, status and well-being of vulnerable children, such as those living in state care, and in encouraging and supporting governments to adopt more effective and responsive strategies, giving full expression to the rights and protections for children and youth.

Through our participation in the Council, we identify issues of mutual concern and strive to promote improvements nation-wide. It is in this context that we have prepared this position paper on Aboriginal children and youth. The current circumstance for Aboriginal children and youth in Canada is a significant issue of national importance that requires urgent attention.

[1] http://www.ainc-inac.gc.ca/ap/pubs/rpt/rpt-eng.asp

Introduction

First Nations, Métis and Inuit children and youth (hereinafter identified by the collective term "Aboriginal") live in all provinces and territories in Canada. They are the population of children and youth in Canada that is increasing in number at by far the fastest rate of any identifiable group. The status and well-being of these children and youth, their rights and supporting their healthy development, is our concern today and into the future.

Aboriginal children, like all children in Canada, are rights holders. The *United Nations Convention on the Rights of the Child* has been ratified by Canada, and its measures at least partially implemented by each of the nations provinces and territories[2]. The *Convention* provides for a broad range of rights to health, safety, well-being and education of children. For Aboriginal children and Aboriginal communities in Canada, there is the additional imperative, enshrined in the *Convention*, of sustaining languages, cultures, and community strength.

The *United Nations Declaration on the Rights of Indigenous Peoples* also speaks to the rights of Aboriginal children. The *Declaration* has not yet been adopted by Canada.

Our view is that Aboriginal children and youth are a vital part of the social fabric of Canada. However, they are one of the most vulnerable populations of children. There are significant gaps between education, health and safety outcomes for these children and outcomes for other Canadian children and youth. Due to intergenerational disadvantages for Aboriginal peoples, their children require significant government support to achieve outcomes equal to their non-Aboriginal peers.

Aboriginal children and youth are overrepresented in the child welfare system. While estimates vary due to incomplete or inadequate reporting and information systems, analysis of data from the 1998 and 2003 Canadian Incidence Study of Reported Child Abuse and Neglect revealed that despite accounting for only 5 per cent of Canada's child population, Aboriginal children represent approximately 25 per cent of children in government care[3]. Indian and Northern Affairs Canada estimated that 6% of On-Reserve Registered Indian Children were in care in 2003-2004[4], substantially above the national rate of less than 1% estimated for the 2007 calendar year (9.2 children per 1000)[5].

While this in and of itself requires us to step back and consider the rights and well-being of this population of children, we know that in addition to this, the

[2] http://www.pch.gc.ca/pgm/pdp-hrp/docs/pdf/canada3-4-crc-reports-nov2009-eng.pdf
[3] http://www.irpp.org/choices/archive/vol14no7.pdf
[4] http://www.collectionscanada.gc.ca/webarchives/20071125233054/http://www.ainc-inac.gc.ca/pr/sts/bdd04/bdd04_e.pdf
[5] http://www.cecw-cepb.ca/sites/default/files/publications/en/ChildrenInCare78E.pdf

outcomes for Aboriginal children and youth in key domains like health, education and safety is one of the largest national, provincial, territorial and regional challenges faced by Canadian governments and Canadian society.

While we note the gap in outcomes in these key domains for Aboriginal children and youth, we do recognize from our work that these issues are complex and challenging, with uncertainties regarding which level of government bears primary responsibility for services, resources, or setting performance targets or measures for improvements for these children and youth.

However, we also know that the status of Aboriginal children and youth in Canada today is completely unacceptable.

> "To be an Indigenous child in Canada correlates with poverty-related barriers, including 'income, education and culture, employment, health, housing, being taken into care and justice.' The disparities among Indigenous and non-indigenous children and youth are alarming…[6]"

The information outlined in this paper is not new. However, as a society, Canadians and their governments continue to fail these vulnerable children. Despite spending millions of dollars each year, we see marginal, if any, impact on outcomes. Closing the gaps in at the current rate will take decades – far too long to meet our responsibilities to these vulnerable children.

We must act with urgency to provide effective supports, services and social conditions that will enable Aboriginal children and youth to achieve the developmental outcomes and level of well-being that all Canadian children should enjoy.

Leadership, coordination and sustained political will are required.

Understanding the Context

Aboriginal children and youth continue to bear the impacts of a "legacy of colonialism, racism and exclusion.[7]" In 1996, the Royal Commission report on Aboriginal Peoples acknowledged the numerous challenges that Aboriginal children face and advocated for collective efforts to address them. The Commission advised:

> The best interests of Aboriginal children will be served only by determined and sustained efforts on the part of Aboriginal and non-Aboriginal

[6] Mary Ellen Turpel-Lafond. *Protecting Rights of Indigenous Children*, page 172 in Realizing the UN Declaration on the Rights of Indigenous Peoples: Triumph, Hope, and Action.
[7] http://www.ncwcnbes.net/documents/researchpublications/ResearchProjects/FirstNationsMetisInuitChildrenAndYouth/2007Report-TimeToAct/PressReleaseENG.htm

governments, institutions, and people to recognize and support each other's contributions to the common goal[8].

Indicators continue to show Aboriginal children faring far worse then their non-Aboriginal peers, and these trends have continued with few exceptions since 1996. Aboriginal children comprise an increasing proportion of all children in Canada[9], but they also comprise a population continually overrepresented in statistics that consistently show them experiencing poor outcomes.

Canada championed the *United Nations Convention on the Rights of the Child.* Additionally, in registering two reservations and a statement of understanding when it signed the *Convention*, Canada also demonstrated an awareness of Aboriginal children's issues[10]. The twentieth anniversary of the *Convention* was marked in 2009, and although the *Convention* has been used to raise awareness of the inequality and violations of Aboriginal children's rights within Canada, it has not resulted in profound improvements. Regrettably, the goal of addressing the rights of Aboriginal children and their persistent disadvantages remains unrealized.

It remains one of our most significant tasks to give the *Convention* meaning in Canada, as well as to ensure that Aboriginal children and youth have a measure of equality to that of other children and youth in Canada, as the human rights considerations involve international, domestic and local norms and standards.

Despite being a signatory of the *Convention* and being among the most livable countries in the world, the figures and statistics of Aboriginal children living in Canada are startling. The Standing Senate Committee on Human Rights report "Children: The Silenced Citizens" observed that Aboriginal children are disproportionately:

- Living in poverty
- Involved in the youth criminal justice and child protection systems.
- Face significant health problems in comparison with other children in Canada, such as higher rates of malnutrition, disabilities, drug and alcohol abuse, and suicide[11].

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[8] VOLUME 3 Gathering Strength; Chapter 2 - The Family http://www.collectionscanada.gc.ca/webarchives/20071218071240/http://www.ainc-inac.gc.ca/ch/rcap/sg/si6_e.html

[9] http://www.statcan.gc.ca/pub/89-634-x/89-634-x2008001-eng.htm

[10] Mary Ellen Turpel-Lafond. *Protecting Rights of Indigenous Children*, page 180 in Realizing the UN Declaration on the Rights of Indigenous Peoples: Triumph, Hope, and Action.

[11] Canada, Standing Senate Committee on Human Rights, "Children: The Silenced Citizens: Effective Implementation of Canada's International Obligations with Respect to the Rights of Children" (2007), online: Standing Committee on Human Rights <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/huma-e/rep-e/rep10apr07-e.htm#_Toc164844427

These indicators and many more paint a bleak reality and future for Aboriginal children and youth. Aboriginal and non-Aboriginal organizations have galvanized to address some of these concerns. The Federal government apology for residential schools in 2008 and the resulting Truth and Reconciliation Commission present new opportunities to work towards a path of healing, reconciliation and renewal. Yet the path must be directly engaged with the well-being of children and youth as the focus in order to be successful.

Some Key Indicators and Gaps

A complete statistical picture of the well-being of Aboriginal children and youth in Canada is not possible at this time as limited administrative data is collected or analyzed as to their health, safety and well-being at a national level. In some provinces, better administrative data and projects matching data and outcomes have produced snapshots of what it means to grow up as an Aboriginal child in that province.

We emphasize the importance of collecting data and identifying leading indicators arising from key domains of well-being (health, education, safety, justice involvement and family status). Without such data, we cannot measure whether we are making progress in improving the outcomes for Aboriginal children and youth, or which initiatives are having an impact.

Such data also helps give profile to those communities that are thriving, and where children and youth enjoy good outcomes. These examples can help point the way to a better path for Aboriginal children and youth by using evidence to inform sound policy and rigorous performance improvement.

Better national coordination and promotion of better measures and data practices is required.

Aboriginal children are disproportionately living in poverty

Incidence of severe economic hardship is dramatically higher for Aboriginal children and their families. Information collected during the 2006 Census of Population reported by Statistics Canada revealed the following:

- Nearly half (49%) of off-reserve First Nations children under the age of 6 were in low-income families, compared to 18% of non-Aboriginal children;
- 57% of Off-reserve First Nations children living in large cities also lived in low income families
- Compared against Off-reserve First Nations children not living in low income families, Off-reserve First Nations children living in low-income

families were twice as likely to have parents or guardians dissatisfied with their finances and housing conditions[12].

The situation is not substantially different for First Nations children living On-reserve.

The Assembly of First Nations describes the poverty experienced by Aboriginal peoples as "the single greatest social injustice facing Canada[13]." While Canada's child poverty rate is higher than many similarly developed countries[14], Aboriginal children disproportionately experience its impacts. Bennett and Blackstock (2007) view poverty as a "contemporary legacy of colonization that undermines the ability of Aboriginal families to nurture and support their children[15]". The pervasiveness of poverty and its systemic impact has aptly been described as an "insidious poverty epidemic[16]".

The connection between poverty and child welfare involvement is well known in the literature and in experience. When deep intergenerational poverty persists, the default solution may become the child welfare system, with removals of children, inadequate opportunities to work to support family restoration or strength, and an acceptance of a rate of neglect or maltreatment of children that is unacceptable. Aboriginal children and youth in Canada have inadequate opportunities to exit the cycle of poverty.

Aboriginal children are disproportionately involved in the youth criminal justice system

In the area of criminogenic risk, which is related closely to safety, education and well-being, Aboriginal youth are grossly over-represented in the youth criminal justice system beginning at age 12 years. In Manitoba for example, Aboriginal youth represented 23 per cent of the provincial population aged 12 to 17 in 2006, but 84 per cent of youth in Sentenced Custody[17].

For Aboriginal children and youth in Canada, there is a greater likelihood of involvement in the criminal justice system, including detention in a youth custody facility, than there is for high school graduation[18]. This is a staggeringly negative outcome and appears to have increased, particularly in some provinces, over the past decade, even while youth criminal involvement has declined nationally.

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[12] http://www.statcan.gc.ca/pub/89-634-x/2008003/article/6500040-eng.htm
[13] http://www.afn.ca/article.asp?id=3635
[14] http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/pdf/cpho-report-eng.pdf 2
[15] http://www.fncfcs.com/pubs/vol3num3/Editorial_pp5.pdf
[16] http://www.fncfcs.com/pubs/vol3num3/Editorial_pp5.pdf
[17] http://www.statcan.gc.ca/pub/85-002-x/2009002/article/10846/tbl/tbl08-eng.htm
[18] Kids, Crime, and Care excerpt page 2.

In 2007/2008, over 4,700 Aboriginal youth were admitted to some form of custody and over 2,700 were admitted to probation[19]. In fact statistics indicate that since the implementation of the *Youth Criminal Justice Act*, this figure is increasing[20]. Aboriginal youth are overrepresented at various stages including remand, admissions to secure and open custody, and admissions to probation.[21] When policies and changes in criminal law move the system in the direction of greater emphasis on detention have a more immediate negative impact on Aboriginal children and youth than on any other group in Canadian society.

Social supports and improved education are central to lowering criminogenic risk factors early in life. However, no adequate and coordinated strategies are in place in Canada across jurisdictions, or in most places, within provincial or territorial jurisdictions for an effective social policy response to the elevated criminogenic risk to Aboriginal children and youth.

Aboriginal children are disproportionately involved with the child protection system

Aboriginal children and youth have a right to be safe and supported in their homes and in their communities. Serious systemic issues set the stage for disproportionate rates of child abuse and neglect.

Within the child protection system, Aboriginal children are also overrepresented in another form of custodial care[22]. In British Columbia, Aboriginal children are six times more likely to be taken in care than non-Aboriginal Children[23], and as of March 2010, represent 54% of the province's In-care child population[24].

Societal causes "such as poverty, multi-generational trauma and social dislocation" are not well considered[25] and this leads to a system whereby "taking a child into care becomes the default system when government is dealing with a family in strained and deprived circumstances."[26] The Royal Commission report

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[19] http://www.statcan.gc.ca/pub/85-002-x/2009002/article/10846-eng.htm#a9. Note: Probation totals exclude Prince Edward Island, Nova Scotia, Quebec, Northwest Territories and Nunavut; Remand totals exclude Prince Edward Island, Quebec, Saskatchewan and Nunavut, and Sentenced Custody totals exclude Prince Edward Island, Quebec and Nunavut.

[20] http://www.statcan.gc.ca/pub/85-002-x/2009002/article/10846-eng.htm#a9

[21] http://www40.statcan.gc.ca/l01/cst01/legal42a-eng.htm

[22] http://www.cecw-cepb.ca/sites/default/files/publications/en/AboriginalChildren23E.pdf

[23] Office of the Auditor General of British Columbia, *Management of Aboriginal Child Protection Services: Ministry of Children and Family Development* (Victoria: Office of the Auditor General of British Columbia, 2008) at 2, online: Auditor General of British Columbia <http://www.bcauditor.com/include/view_file.asp?id=10&type=publication>.

[24] Ministry of Children and Family Development

[25] http://www.fncfcs.com/docs/ISGReport.pdf 8

[26] http://www.rcybc.ca/Images/PDFs/Op%20Eds/Van%20Sun%20Op%20Ed%20Aug%202009%20FINAL.pdf

on Aboriginal Peoples concluded that "the continued high rates of children in care outside their homes indicate a crisis in Aboriginal family life."[27]

The causes of this over-representation are complex, but certainly there is an element of systemic disparity in the investigation, removal and breakdown of Aboriginal families to warrant new strategies more sensitive to these considerations.

Aboriginal children face significant health problems in comparison with other children in Canada

In the domain of health, Aboriginal children and youth again lag behind their peers as measured by key determinants. More Aboriginal children face dire situations and social conditions that not only threaten their birthright and future, but also contribute to unacceptable current living conditions.

A third of Aboriginal children live in low-income families where food security is a concern[28]. Aboriginal children disproportionately live in substandard housing that is characterized by "crowding, need for repairs and poor water quality.[29]" Infant mortality, obesity, respiratory illnesses all show Aboriginal children at a much higher risk compared to non Aboriginal children. These figures are compounded by geographical accessibility issues, cultural insensitivities and language barriers[30].

A point of note is that health outcomes for Aboriginal children and youth are not as positive as for other children and youth, including for those living in an urban area with access to primary, secondary and tertiary public health care supports. While some improvements have been seen in some regions of Canada, progress has been limited and in many instances stalled for some time[31].

Access to primary heath care, and prevention and support for children and youth with special needs such as developmental disabilities, is inconsistent, and not responsive to the need. Key health indicators, such as birth weights, infant mortality, progress in school, and teen pregnancy all suggest a gap with non-Aboriginal peers for these children and youth.

Many Aboriginal children and youth face the challenges and limitations of living with Fetal Alcohol Spectrum Disorders (FASD), and substance abuse is a factor in many young lives. Health Canada estimates that nine in every 1000 infants

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[27] VOLUME 3 Gathering Strength; Chapter 2 - The Family http://www.collectionscanada.gc.ca/webarchives/20071218071240/http://www.ainc-inac.gc.ca/ch/rcap/sg/si6_e.html

[28] http://www.stmichaelshospital.com/pdf/crich/ichr_report.pdf 3

[29] http://www.stmichaelshospital.com/pdf/crich/ichr_report.pdf 3

[30] http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/pdf/cpho-report-eng.pdf 3

[31] Add more here. BC Provincial Health Officer's reports 2004, 2009.

are born with FASD[32], and initial research suggests that occurrence of FASD is significantly higher among Aboriginal populations[33].

Opportunities for Aboriginal children and youth to participate in recreation and pro-social activity through sports, safe activity centres, and develop their physical strength and skills are limited in many respects. Poverty, poor facilities, and the absence of a national Aboriginal sport or recreation policy pose barriers for these children and youth to obtain key lessons in healthy living and self-care on an equal footing to other Canadian children and youth.

Aboriginal children lag seriously behind other Canadian children in educational achievement

The educational achievement of Aboriginal children, on key measures like readiness to learn, progress in school and high school graduation rates dramatically lags other Canadian children.[34]. Closing the gap in high-school graduation rates is seen as a critical component to address the economic and social challenges of the Aboriginal population[35]

Utilizing data gathered by the 2006 Census, Statistics Canada reported that 34% of Aboriginal persons 25 to 64 years of age had not completed high school, while 21% of Aboriginal persons 25 to 64 listed a high school diploma as their highest educational qualification[36]. In 2006, the proportion of the Aboriginal population aged 25 to 64 years without a high school diploma (34%) was 19 percentage points higher than the proportion of the non-Aboriginal population of the same age group (15%).[37]

Historic trends in education demonstrate that, with some exceptions, consistent poor outcomes have not been adequately addressed through innovation, attention to these outcomes, or measures to support achievement over the past few decades. Clearly, we must do more and find effective means of redressing what is one of the most limiting factors to future well-being for these youth, and for our society. The loss to Canada in productivity is staggering, and the cost of this loss will remain a significant drag on our economy for generations unless effective national action is taken.

While some efforts at First Nations control of education have occurred in recent years, the gap has not closed and this alone does not appear to be an effective response. We note that the majority of Aboriginal children and youth live in

[32] http://www.mcf.gov.bc.ca/fasd/pdf/Factsheet_FASD_Feb_2009.pdf
[33] http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/fasd-etcaf-eng.php
[34] http://www.cdhowe.org/pdf/commentary_276.pdf
[35] http://www.td.com/economics/special/db0609_aboriginal.pdf
[36] http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=29#M_4
[37] http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=29#M_4

urban centres and attend non-Aboriginal schools where they continue to lag behind their peers.

Education, like child welfare, is a provincial area of responsibility in Canada, although the federal government retains responsibility in areas where transfer agreements are not in place with provinces. In any case, the attainment of Aboriginal children and youth has important national dimensions. Education policy to support better achievements is patchwork and inconsistent. Strategies that work in some regions should be extended to others through positive social policy innovation, and national progress should be measured and promoted given the dimensions of the problem.

National attention and a consistent approach to improvement, with a strong emphasis on educational attainment and performance improvement in all regions are crucial to closing these gaps. No such agreement of national approach has been developed. Until such changes are realized, the "right to learn" for Aboriginal children and youth in Canada remains a hollow promise.

Aboriginal children are at high risk for sexual exploitation and violence

The adverse childhood experiences of many Aboriginal children and youth place them at high risk for exploitation and vulnerability into adulthood. For example, in British Columbia, there are estimates that the number of aboriginal sexually exploited youth ranges from 14% to 60%.[38] The Red Cross has cautioned:

> Intervention strategies and policy initiatives over the last 25 years have not helped in reducing the numbers, and there is a strong consensus across a broad spectrum of service providers and professional groups that the present situation cannot continue without serious consequences for both Aboriginal youth and Canadian society.[39]

The number of women in particular who have faced violence or unexplained disappearance is of great concern, and valuable campaigns for missing or murdered Aboriginal women have been launched in recent years. Many of the Aboriginal women who have been involved with the sex trade and many who have become victims of violence or homicide were formerly children in care, and had lives bereft of adequate support in childhood and youth. Many ended up in harm's way living on the streets of our cities.

We have come to understand their vulnerability as adults and have a greater awareness as a society of the opportunity to reduce these adverse childhood experiences to promote resilience and safer lives as they transition into adulthood, but must move from awareness to action.

[38] http://www.bcmj.org/commercial-sexual-exploitation-children-and-youth#Characteristics%20of%20children%20in%20the%20sex%20trade
[39] http://www.redcross.ca/article.asp?id=29873&tid=001

Death and injury rates for Aboriginal children and youth are disproportionately high

The overall suicide rates for Aboriginal youth are high, although they vary significantly among regions and communities. Untreated mental health concerns and general feelings of hopelessness and despair lead to suicide attempts and completed suicides. Suicide rates are five to seven times higher for First Nations youth than for non-Aboriginal youth[40]. Inuit youth suicide rates are among the highest in the world, at 11 times the national average[41].

Aboriginal children and youth represent a disproportionately large incidence of child deaths and critical injuries reviewed by those provincial advocates with authority to review and investigate or report on injuries and deaths of children receiving government services. These children suffer greater intentional and accidental injuries, experience neglect, and as adolescents may engage in more high-risk activities perilous to their safety, such as excessive alcohol consumption and unsafe driving.

Reviews and investigations of these cases tend to highlight service gaps and inadequate assessments and support to ensure better outcomes for healthy development at various stages of childhood and adolescence. However, the opportunity for learning and systemic improvement is limited by the lack of national strategies to champion them.

Addressing the Issues

In recent years there have been numerous initiatives to promote self-government and exercise of jurisdiction by Aboriginal governance authorities in the areas of education, child welfare and social services. These are based in the view that Aboriginal children's interests are best protected in "revitalized Aboriginal families, communities and nations."[42]

While it is likely that such initiatives will be an important component of a comprehensive approach, an effective response will require collaboration across governments and organizations, and it will require a shift from words to action to honor the rights of Aboriginal children and youth. An effective response requires that the focus be kept on the children. These children cannot be seen as the exclusive responsibility of one government or one organization. They are the responsibility of all Canadians, and they need our support.

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[40] http://www.hc-sc.gc.ca/fniah-spnia/promotion/suicide/index-eng.php
[41] http://www.hc-sc.gc.ca/fniah-spnia/promotion/suicide/index-eng.php
[42] http://www.collectionscanada.gc.ca/webarchives/20071218071240/http://www.ainc-inac.gc.ca/ch/rcap/sg/si6_e.html

Governments must confront institutionalized mechanisms that work against meeting the needs of Aboriginal children. One example is funding disparities. The First Nations Child and Family Caring Society of Canada reports that on reserve Aboriginal child welfare agencies receive approximately 22% less funding than provincial agencies.[43] Concerns about the Indian and Northern Affairs Canada funding for on reserve child welfare led the Auditor General of Canada to conclude that it is inequitable, outdated, not adapted to small agencies, and not properly coordinated.[44]

Another example is jurisdictional disputes over funding services to Aboriginal children. The Council is pleased to see the adoption the child-centred Jordan's Principle. Jordan was a First Nations child born with complex medical needs. During his short life, federal and provincial governments argued over who would pay for this at-home care. Sadly, because of the discord, Jordan passed away far from his family home. Jordan's Principle is that when a dispute arises between two government parties regarding payment for services for a Status Indian child, the government of first contact must pay for services without delay or disruption. Jordan's Principle was adopted in the House of Commons in December 2007, but remains to be fully implemented.

We believe that it is the responsibility of all Canadians and their governments to close the gaps for Aboriginal children and youth in the key domains of education, health and safety, criminal justice involvement, and social inclusion. New strategies and approaches will be required, and new mechanisms created to ensure a national, intergovernmental focus on vulnerable children. Oversight and reporting on progress must be an ingredient of a successful national strategy.

Recommendations

We, the members of the Canadian Council of Provincial Child and Youth Advocates, call on national, provincial, territorial and Aboriginal governments to take urgent, coordinated immediate action to improve the living conditions and well-being of Aboriginal children and youth in Canada. We are not endorsing specific organizations or activities, but we suggest progress could be made on a comprehensive strategy for Aboriginal children and youth in Canada if we take some key steps to build the foundation of that work.

We believe greater work is required at the national, provincial, territorial and regional levels, and a national plan is required. We offer the following recommendations as a framework for such a plan.

[43] http://www.fncfcs.com/docs/CHRCFactSheet.pdf
[44] http://www.oag-bvg.gc.ca/internet/docs/aud_ch_oag_200805_04_e.pdf 19-23

We believe that the response to these recommendations should be evaluated by a joint committee of the House of Commons and Senate to determine if they have been valuable or effective in increasing attention to the issues and improvement in the lives of Aboriginal children and youth in Canada.

We recommend:

1. Creation of a statutory officer independent from the Parliament of Canada, but accountable to the Parliament, a "National Children's Commissioner" with particular emphasis on Aboriginal children and youth and the national dimension of the work on programs, evaluation and outcomes [45].

2. A national initiative to measure and report on child welfare, education and health outcomes for Aboriginal children and youth. This will require creation and coordination of data, and clear assignment of roles and accountabilities.

3. Creation of a national Aboriginal children and youth participation initiative, with training on child and youth rights, leadership, voice, and civic participation, to fully implement the *United Nations Convention on the Rights of the Child* and reduce vulnerability.

4. That a special conference of Federal/Provincial/Territorial First Ministers, with Aboriginal leaders, and child and youth delegates, be convened to receive a report on outcomes for Aboriginal children and youth. A national plan to improve outcomes for Aboriginal children and youth would be a desired outcome of this process.

Conclusion

The healthy development of Aboriginal children and youth consistent with other Canadian children and youth requires dedicated and sustained efforts at the level of policy, resources and attention across all governments and communities in Canada. We emphasize that these are national issues, beyond any current intergovernmental process of forum. They require a clear, outcomes-directed, child-centred national plan. Additional supports for Aboriginal children and youth to protect and support their cultural identity, language and identity are required to fulfill their unique rights and freedoms.

As advocates for children and youth across Canada, we believe that urgent action required. We will continue to support Aboriginal children and youth in our respective roles in the provinces and territories.

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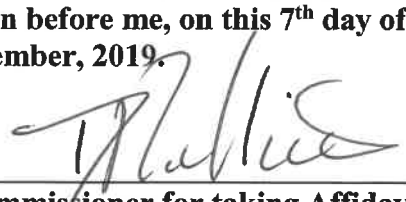
[45] The Commission des droits de la personne et des droits de la jeunesse of Quebec agrees with this recommendation, insofar as the National Children's Commissioner's mandate respects the constitutional distribution of legislative powers.

We will support the recommendations identified above in any way possible and encourage a more fully informed debate of the issues that underpin some of the important campaigns and political efforts to draw attention to particular problems and concerns.

We will continue in our individual capacities to report on issues for Aboriginal children and youth and share these amongst our colleagues and governments to support and inform more effective responses at the level of the child.

This is Exhibit "D" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, 2019.



A commissioner for taking Affidavits

REPRESENTATIVE FOR
CHILDREN AND YOUTH

When Talk Trumped Service:
A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.

Special Report

November 2013

November 6, 2013

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I have the honour of submitting this report, entitled *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.*, to the Legislative Assembly of B.C.

This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act*, which states that the Representative may make a special report to the Legislative Assembly if she considers it necessary to do so.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Ms. Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth

Mr. Craig James
Clerk of the Legislative Assembly

Contents

Executive Summary

The public policy concepts and practices that guide service to Aboriginal children, youth and their families are important to British Columbia. There is unequivocal support across all political parties, professional and service organizations – right down to the street-level of friends and neighbours – for the notion that this is an area in which we want to see good policy replace the failed policies that harmed previous generations of Aboriginal children and families.

Better lives for children and youth is a strong ethic for all British Columbians. It should infuse the delivery of public services and guide the effectiveness of government. Key public services – in child welfare, education, health and justice – must, at a minimum, level the playing field so that Aboriginal children and youth can grow and learn with their non-Aboriginal peers and be secure in their identity and connection to their culture and communities, feel no pre-ordained limits to their achievement and enjoy the freedom of a solid foundation in a society that can support good outcomes.

The Representative would go one step further – it is an *imperative* of B.C. public policy that such services to children and youth be effective, because the importance of improving the life circumstances of Aboriginal children and youth is vital to the success of our province as a society. Few greater priorities could be expressed right from the top political level of the Premier's Office, throughout government, down to the level of the neighbourhood and community.

B.C., more than any other province or territory in Canada, has worked to map the significant gaps in known outcomes (e.g., health, safety, school achievement, criminal justice system involvement, social inclusion) and experiences for Aboriginal children compared to other children and youth in B.C. This includes the key work of the Provincial Health Officer, analysts across government ministries and the collaboration of academic and policy institutions.

But there is still much we don't know. For example, who exactly are the Aboriginal children and youth most disadvantaged and facing violence, neglect, social exclusion and the poorest outcomes? Not all Aboriginal children fall into this category, as increasing numbers are finding success through more stability in their families and communities. We still know very little about what specific supports and services Aboriginal children require, or whether they receive them to level the playing field, keep them safe and healthy and ensure they can develop and thrive equal to their peers.

Governments have for some time recognized that past failed policies and practices needed to be addressed, and that outcomes for the lives of Aboriginal children need to change. Yet, for the significant number of Aboriginal children and youth who come into contact with the child welfare system, the improvement expected in their lives doesn't happen, or government cannot speak with confidence about what services they receive, how these children's basic needs are being met or whether services provided translate into improved life experiences.

Herein lies the problem that is the subject of this report, one of the most complex and difficult produced by the Representative: There could not be a more confused, unstable and bizarre area of public policy than that which guides Aboriginal child and family services in B.C.

This area is rife with perverse performance measures, the absence of any real incentives for change and no end-state goals on how services to Aboriginal children and youth will be improved. The Ministry of Children and Family Development (MCFD) has awarded money for projects but often assumed little or no management or responsibility for initiatives launched. There has been a significant expenditure on "talking" – with virtually no involvement by Aboriginal children and youth themselves – and without a single child being actually served.

The total spent by MCFD on Aboriginal governance endeavours over the past dozen years has been roughly $66 million. That is a conservative estimate, as the provincial government cannot provide a clear record of expenditures. The financial controls were initially dismal and unenforced. The policy context and administrative principles can only be termed chaotic and haphazard, and are prone to undue political influence and lobbying by consultants and others with the ability to convince government to become a funder of programs with questionable policy basis or outcomes. To be blunt, a significant amount of money has gone to people who provide no program or service to directly benefit children.

Nevertheless, this report is not about political will, public opinion or blame. This report attempts to answer the basic questions posed to the Representative repeatedly by members of the public, including elected members on both sides of the Legislative Assembly: "What happened here? What did we spend on that and what did it amount to?"

Because the Representative works for the children and youth of B.C., the report has scrutinized this issue closely from this lens – How did Aboriginal children and youth benefit from the various governance initiatives launched and re-launched over the past decade? While this report may simply confirm the deep cynicism people feel about the ability of government to achieve much for citizens, or with citizens, the Representative firmly believes that services are important and that we haven't actually seriously attempted to serve Aboriginal children and youth appropriately or with a solid policy framework that focuses on them.

The expenditure of $66 million – and maybe more – during a time when the most vulnerable Aboriginal children could find few appropriate residential services and supports, and few therapeutic child and family services to address their significant and known needs, is a colossal failure of public policy to do the right thing for citizens. It can be reversed and changed, but there will be significant dissent – the rewards given to initiatives and projects that have no chance of ever coming to fruition because they are fundamentally flawed have created an industry and forgotten the children and youth.

For example, nearly $35 million was spent discussing Regional Aboriginal Authorities, including large expenditures on paying people to meet, hiring consultants to facilitate those meetings, and producing materials of questionable practical value following

such meetings that almost never addressed the actual difficulties children and youth were experiencing in their lives – issues such as parental addiction, domestic violence, poverty, neglect and the need for mental health services or special needs supports. While government publicly applauded the imminent success of these talks, there was little or no evaluation of what was actually being achieved, no lens of public policy, and limited financial controls on these endeavours.

These approaches took a strong turn sideways in 2008, when MCFD decided that First Nations would write their own approaches, and that MCFD would get "out of their way" while at the same time promising to fund their initiatives. This produced several projects, under the rubric of a "Nation-to-Nation approach" with staggering expenditures, and a disconnect from the practicalities of the Aboriginal child welfare service-delivery system. It appears that MCFD charted a direct course into funding and encouraging jurisdiction and transfer of government powers discussions while having no practical or functional guidance from the Attorney General regarding the scope and implications of such negotiations. Many of these negotiations are not with "nations" at all, but with community organizations, urban groups and others who lack the representational capacity to enter into self-government negotiations. Nor is B.C. a nation. MCFD did not see this as a problem and believed it could support as many as 20 to 100 of such processes in its future.

This process had serious negative implications for the MCFD budget, as paying for these initiatives increasingly came out of direct service lines of MCFD operations so that all children and youth, including Aboriginal children and youth, who receive actual services paid the price and continue to do so. For example, there is no appropriate spectrum of residential services in B.C., something badly needed by many children including Aboriginal children, because significant money went to self-government planning projects.

Meanwhile, the people on the front lines of the system – the overburdened child welfare workers, the grandparents and extended family members, the foster parents, the hospital staff and the school staff – have seen their budgets, services and opportunities shrink, arguably all to the detriment of the children and youth who needed help.

This story may read more like fiction than truth, but the numbers speak for themselves. More than $66 million has been spent without any functional public policy framework, no meaningful financial or performance accountability, and without any actual children receiving additional services because of these expenditures.

There is also another $90 million being spent each year on delegated Aboriginal Agencies (DAAs) in B.C. There are 23 of these DAAs – 20 reserve-based and three urban agencies. All but one of these agencies operate as an exception to the federal government policy requiring that there be at least 1,000 children before a service agency can be formed. As this report details, another of these DAAs has received nearly $5 million over the last three years, despite having no open files as of March 2013. Within that DAA's area, the Representative knows that the demand for youth supports, mental health services, special needs supports, and school learning supports are significant. The big picture seems to have been lost here.

While significant resources were going out the door, the DAAs were mostly ignored and sometimes undermined as they struggled to provide services. Their list of service issues, which included about 30 major concerns at the beginning of this decade, seems to be pretty much the same today as it was then. No real progress has been made in getting through these issues, and the service is not marked by stability or clear policy.

Those DAAs with strong political connections applied for and received the Nation-to-Nation self-government discussions funds and have been planning to assume full "jurisdiction." This is highly confusing as delegated agencies do not exercise constitutional self-government powers in the proper sense of the word, as they are delegated entities. Nevertheless, these discussions have led to some of them holding the view that they will exist completely independent from MCFD in the near future. They have been led to believe this will occur, especially through the renewal of funds and encouragement by MCFD officials and their own consultants and advisors.

However, for many DAAs, the impact of this has been to stray away from services and to suffer from mandate confusion – believing they are DAAs but that they will become something else, making them exempt from normal operational expectations of MCFD or other oversight entities. They cannot be blamed for this view, as MCFD has funded them without having any working policy on what the exercise of self-government jurisdiction actually requires at the level of law-making, recognition, coordination or funding.

The 23 DAAs are also fraught with staff turnover and on-going struggles to find qualified staff, leading them to seek exemptions from workforce requirements to allow them to hire a larger portion of their staff who are not properly educated and trained to do the work. These kinds of pressures can result in poor service – and while MCFD "audits" the work of DAAs, it has actually done very little with the results of those audits as it, too, seemed to believe the big fix would come from the governance discussions and that it wouldn't be "fair" to have ordinary quality assurance processes (including re-audits and reporting steps such as removing delegation when it is clear that an agency cannot function).

The Representative recognizes that despite the many challenges, some notable progress can be achieved. For example, one DAA has recently managed to improve its compliance in completing Plans of Care to 97 per cent, in stark contrast to the provincial five per cent compliance rate noted in the Representative's 2013 report *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care.*[1]

The total amount spent by the federal government through Aboriginal Affairs and Northern Development (AAND) in B.C. over this same period is unknown. AAND's annual national budget for child welfare hovers around $640 million and the Representative's best estimate is that approximately $57 million went to B.C. DAAs in 2012/13.

DAAs and the Caring for First Nations Children Society maintain that they do not have money for prevention or to provide services at the same level as those provided to non-Aboriginal children. The Representative believes they are correct in that assertion but,

[1] B.C. Representative for Children and Youth, *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care.* (March 2013)

when total expenditures by the B.C. government and the federal government are factored in, the real issue is that the children and youth are not receiving the services, and that a significant amount of funding appears to be directed to "governance" or "initiatives" that do not bring any actual service to those who require them most. Many of these initiatives are so far outside a policy framework that they cannot be assessed.

MCFD and other government ministries do not have any overarching service agreement for Aboriginal children and youth and very little political or administrative effort has been expended in working out a consistent policy and performance framework for their services, alignment of services, or any evaluation of effectiveness. There are occasional meetings, letters and such, but nothing robust or meaningful for such a vital area of service improvement or cooperation. There is no stable policy framework with measurable outcomes identified.

The federal government suggests it is simply a funder while the province is the service-provider through delegation agreements with First Nations and Aboriginal agencies. This entire vision of public policy is fraught with fractured accountabilities, untethered initiatives and a decided absence of focus on children and youth. It isn't accurate, it is chaotic, and it seems to promote perverse performance measures and allow for poor service or no service to some of the most vulnerable children and youth.

The federal government must be encouraged to step up – although the Representative does note that B.C. has not made a sustained or serious effort to engage with the federal government on these issues. Instead, it has funded a range of initiatives as if there was no federal government, or as if the federal government could be told after decisions were made what would happen and be expected to simply fall in line.

The role of Aboriginal organizations – especially political organizations – has also been central, as they have entered into high-level agreements and have been willing participants in this public policy failure. Whether this is because they have been so over-burdened by many agendas (treaty-making, resource development, and other sectors of activity), or if they believe that they are actually making progress, the Representative is unsure. Certainly they must recognize that self-government jurisdiction over children being exercised by small non-profit organizations or entities is not consistent with their own positions on a range of issues, such as representational capacity.

Children are not being served and the political leadership does not seem to expect much change, or understand the lack of change, either. Real collaboration has not happened, but these areas have been passed around, indeed passed over, in the belief that someone else is doing the job. Sadly, there really isn't anyone on the ground resourced and supported to do the work and reporting on what they are doing in a robust fashion.

Apart from all of this, MCFD spends significant resources on services for Aboriginal children and youth, even if it does not have a strong or clear service-delivery policy, or a defined self-government jurisdiction framework. Areas such as child protection mediation have seen some very good work undertaken by justice officials, child welfare officials and trained mediators. The Representative notes, however, that the child protection mediation budget is always in danger as it resides in the Ministry of Justice

and is not a fixed annual budget within MCFD. It is one of the initiatives that seems to have worked, is within the core mandate of improved service to children, but got pushed aside by these other new and vague initiatives.

MCFD does pay for services for Aboriginal children and youth both off and on-reserve (on a case-by-case basis) for special needs and mental health, and does so on other than a cost-recovery basis from the federal government. Whether it pays enough, gets good results, or is leveling the playing field for Aboriginal children, is unknown, as the ministry is either so pre-occupied with the big fix elsewhere, or impacted by how this has played out, that it has frankly lost its way in this area.

Can things change? Of course they can. But not if government keeps repeating this failed pattern, and not unless it has executive leadership that connects firmly with the front lines and really speaks about the work for and with Aboriginal children and youth and their families and communities. Work they are doing together – not passing responsibility away and taking no accountability for the fact that no one is actually helping the child. The government must also set out some clear policy foundations for this work and bring its initiatives back into line with public law and functional requirements. Good policy will also give prominence to ensuring cultural connection for children to their communities.

This report offers an opportunity for discussion, learning and change. The Representative believes the policy framework can be strengthened, service obligations clarified and actual services delivered, evaluated and progress made. The Representative does not believe that can happen until we face up to the utter chaos and confusion that has guided this area for more than a decade.

There is no public administration model or theory to support what happened here. It didn't work, and it didn't work for a reason. There were so many exceptions made to the rule that the entire area is one big set of exceptions with no solid basis of what is possible, practical or achievable.

Senior bureaucrats and others in government must return to a model of public service and accountability that permits good collaboration but doesn't abdicate control or send a massive chunk of the budget out to a sector that will provide no service but appears to make everyone feel good, or provides an illusion of progress where there is none.

Maybe this is as it has always been in British Columbia and it works at some level to fund discussion so people keep talking to each other. But surely our objective cannot be this low. We need to improve the lives of some of the most vulnerable citizens in B.C. by actually providing them with the support they need and deserve – a properly functioning residential system of care, mental health supports, special needs supports, and an unwavering commitment to their personal safety.

Children and youth deserve better, and the best contrition for this rather shameful debacle would be a real effort to improve the outcomes for those children by actually knowing what they require and what works to support them – to stop directing the money into the big theoretical fixes, and instead shore up the front lines of the system, especially in those places where the paved roads end in B.C. The five recommendations in this report offer a start in this direction.

Introduction

This is a Special Report under s. 20 of the *Representative for Children and Youth Act (RCY Act)* outlining the findings of the Representative's review of Aboriginal child welfare services in B.C.

The Representative has a mandate under the *RCY Act* to monitor, review, audit and conduct research on the provision of designated services for the purpose of making recommendations to improve the effectiveness and responsiveness of those services, and to report publicly on her findings.

Under this mandate, the Representative has a particular focus on services to Aboriginal children and youth. Given their significant vulnerabilities, special attention is warranted to understanding how the needs of Aboriginal children and youth are being met.

This focus stems from the findings and conclusions of the *BC Child and Youth Review (2006*) undertaken by the Hon. Ted Hughes, who recommended the creation of the Office of the Representative to provide independent oversight and monitoring of the provincial child welfare system.

In his report, Hughes commented specifically about the circumstances of Aboriginal people, Aboriginal child welfare service delivery and the disproportionate representation of Aboriginal children and youth in the child welfare system. It was explicitly recognized that a significant part of the Representative's work would focus on Aboriginal child welfare matters and that Aboriginal children and families would form a large part of the Representative's constituency.

Consistent with this, to ensure the credibility of the Representative's Office and its ability to be effective in its work by understanding the experience and perspectives of Aboriginal people, Hughes recommended that a senior person in the Office be Aboriginal and that a concerted effort be made to retain Aboriginal staff at all levels. The need to ensure an Aboriginal perspective is enshrined in the *RCY Act*, which requires the Representative to consider, when appointing a deputy representative, *"the skills, qualifications and experience of the person, including the person's understanding of or involvement in the lives of Aboriginal children and their families in British Columbia."*

Related RCY Reports and Activities

Several reports by the Representative have explored the well-being of Aboriginal children and framed the key challenges:

- *Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces* (2013)
- *Much More Than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care* (2013)
- *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Childre*n (2013)
- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (2012)
- *So Many Plans, So Little Stability: A Child's Need for Security* (2011)
- *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Children* (2011)
- *Growing Up In B.C. Joint Report with the Office of the Provincial Health Officer* (2010)
- *No Shortcuts to Safety: Doing Better for Children Living with Extended Family* (2010)
- *Housing, Help and Hope: A Better Path for Struggling Families* (2009)
- *Kids, Crime and Care: Youth Justice Experiences and Outcomes: Joint Report with the Office of the Provincial Health Officer* (2009)
- *Health and Well-Being of Children in Care in B.C.: Educational Experiences and Outcomes* (2007)
- *Health and Well-Being of Children in Care in British Columbia: Report 1 on Health Services, Utilization and Mortality: Joint Report with the Office of the Provincial Health Officer* (2006)

In addition to these reports, the Representative:

- made a submission to the Truth and Reconciliation Commission titled *Aboriginal Children: Human Rights as a Lens to Break the Intergenerational Legacy of Residential Schools* (2012);
- presented a paper at the International Summer Course on the Rights of the Child in Moncton, N.B., *Making Human Rights Relevant to Children* (2012); and
- as a member of the Canadian Council of Child and Youth Advocates, released a *Special Report, Aboriginal Children – Canada Must Do Better: Today and Tomorrow* (2011)

Scope of Review

For the purposes of this report, "child welfare" means the services mandated under the *Child, Family and Community Service Act (CFCS Act)* and which MCFD delivers under its Child Safety, Family Support and Children in Care service line.

MCFD also provides service to Aboriginal children, youth and their families under its other service lines, but these are not included in the scope of this review.

As established by the *CFCS Act*, Child Safety, Family Support and Children in Care Services include: family support services, including agreements with families regarding the care of a child; youth transition support services, including agreements with youth regarding services and supported living arrangements; and child protection services, including responding to and investigating child protection reports, undertaking cooperative planning regarding a child's care and taking protection action including going to court for an Interim, Temporary or Continuing Custody Order.

The *CFCS Act* also establishes distinct principles regarding Aboriginal child welfare service delivery:

- Aboriginal people should be involved in the planning and delivery of services to Aboriginal families and their children;
- services should be planned and provided in ways that are sensitive to the needs and cultural, racial and religious heritage of those receiving the services; and
- for an Aboriginal child, the importance of preserving the child's cultural identity must be considered in determining the child's best interests.

MCFD'S SIX CORE SERVICE LINES

- Child Safety, Family Support and Children in Care Services
- Early Childhood Development and Child Care services
- Services for Children and Youth with Special Needs (CYSN)
- Child and Youth Mental Health (CYMH) services, including community-based CYMH services and the Maples Adolescent Treatment Centre
- Adoption Services
- Youth Justice Services

The majority of programs and services are delivered regionally through four geographic service regions: Coast Fraser, Interior, North and Vancouver Island. Some programs are delivered at the provincial level, including child care operation and subsidy funding, CYSN autism and medical services, services for deaf and hard of hearing, the Maples Adolescent Treatment Centre, Youth Custody Services, and Youth Forensic Psychiatric Services. Services are delivered directly by MCFD or through contracted community service providers, and Aboriginal children and families may be served by delegated Aboriginal Agencies (DAAs).

Methodology

This review examines and reports on MCFD's current system of Aboriginal child welfare service delivery and the Aboriginal governance and service-delivery change initiatives undertaken over the last decade:

- The MCFD Core Review initiative begun in fiscal year 2001/02 and completed by 2004/05
- The Regional Aboriginal Authorities initiative undertaken during the period from fiscal year 2001/02 to 2008/09
- Nation-to-Nation pilots, now called Indigenous Approaches, subsequent to the end of the Regional Aboriginal Authorities initiative and occurring from 2009/10 through present day.

MCFD's system of child welfare service delivery and the Aboriginal governance and service-delivery change initiatives were assessed against widely articulated and accepted attributes of sound government program performance management and accountability.[2] These include:

- A clear vision, goals and objectives outlining what the program intends to achieve in meeting the needs of its client population; defined outcomes and a set of measures for assessing program efficacy; and well understood and accepted strategies for achieving the program's vision, goals and objectives and meeting its defined outcomes
- Program delivery and management supports, including comprehensive and appropriate policies, standards and practices to guide program delivery that are consistent with and supportive of the goals, objectives and strategies; and ongoing program leadership, including that the program is adequately resourced and effectively managed
- Program performance measurement through audits and evaluations, and tracking, monitoring and analyzing data and information to measure and understand the effect and impact of programs and services and the achievement of defined outcomes
- Results management, including taking corrective action where necessary to modify, alter or even cancel programs that do not achieve intended outcomes or the reallocation of resources between programs and to new programs that will have a greater impact; and
- Accountability through open, honest and transparent reporting to government and to the public on how programs are provided, what they are intended to achieve, and the results of programs in achieving the intended outcomes.

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[2] Government of BC, Core Policy and Procedures Manual, http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/CPMtoc.htm; http://gww.fin.gov.bc.ca/gws/OCG/Resources/files/ServicePlanGuidelines.pdf, http://gww.lcs.gov.bc.ca/cs/about/planning_performance/service_planning.html and http://www.fin.gov.bc.ca/ocg/fmb/manuals/cpm/performance_mgmt_context.pdf
Office of the Auditor General of British Columbia, Public Sector Governance – *A Guide to the Principles of Good Practice*, Report 13, December 2008, and *Strengthening Public Accountability*, Report 1, April 2006.

Figure 1: Performance Management and Accountability Cycle

A comparison of MCFD child welfare-related plans and policies, programs and services and its change initiatives with general principles of effective program management and accountability enabled the Representative to arrive at some conclusions about how well MCFD is meeting its mandate to provide culturally appropriate child welfare services and respond to the unique needs of Aboriginal children and youth.

Information Sources

An extensive amount of information was collected, compiled and reviewed in developing this report. This includes publicly available data, statistics, material and reports, and information requested from MCFD related to three major Aboriginal governance and service-delivery change initiatives.

The Representative began gathering information on the Aboriginal child welfare governance and service-delivery initiatives in 2008/09. The information received presented significant analytical challenges due to its sheer volume, the lack of organization or time-sequencing of the information, time gaps in the materials provided, and difficulty in distinguishing final documents from drafts. The Regional Aboriginal Authorities initiative alone yielded 46 boxes of files from MCFD containing approximately 76,000 pages of information.

The Representative employed the services of a professional records manager to organize and inventory the documents and develop a historical sequence of events. Considerable resources were also expended on sub-reviews, including a financial review to examine ministry funding, and a review of the policy basis or framework and project management of the Aboriginal service-delivery initiatives. (Appendix 1 is a list of all documents, information and reports compiled and reviewed as part of this review.)

Following the initial assessment of the information, additional requests for information were made and a number of meetings held with MCFD staff to ensure a full and accurate understanding of the course and progress of the initiatives, the allocation of operational budgets, MCFD operational practices and policy, and the role of various stakeholders. Several briefings have been held with MCFD executive to discuss the analysis of the information and the preliminary findings of the review.

MCFD was given the opportunity to review and provide comments on the facts in the report for the purpose of administrative fairness.

Background

Aboriginal People in British Columbia

The Aboriginal population in B.C. is growing, youthful, diverse and widely dispersed.

Although relatively small in absolute numbers, the B.C. Aboriginal population is the second largest in Canada. In 2011, 232,290 individuals (or about 5.4 per cent of the provincial population) identified themselves as Aboriginal.[3] In 2006, 195,000 individuals (or about 4.5 per cent of the provincial population) identified as Aboriginal.[4,5] Of the total number of individuals identifying as Aboriginal in 2011, 155,015 (or 67 per cent) self-identified as First Nations, 69,475 (or 30 per cent) identified as Métis and the remaining identified as Inuit or with multiple Aboriginal identities.[6] Of those identifying as First Nations, 112,400 (or 72.5 per cent) were Status Indians.[7]

Definitions

In this report the term Aboriginal includes individuals who identify as being First Nations, Status Indian, non-Status Indian, Inuit or Métis.

The term First Nations is used to refer to individuals who have identified as having a specific First Nations ancestry.

The term Status Indian refers to a person registered under the federal *Indian Act* and recognized as legally entitled to a range of programs and services.

Métis is used to describe individuals who have identified as having Métis ancestry.

The Aboriginal population is much younger than the overall population in B.C. The median age is 28 for First Nations people and 32 for Métis people. In comparison, the median age of the non-Aboriginal population in B.C. is 42.[8]

Aboriginal children and youth account for more than eight per cent of the total population of children and youth ages 0 to 18 years living in B.C.[9] Aboriginal youth are the fastest growing population group province-wide. Although the size of the overall child and youth population declined in the last decade – by about 4 per cent between

[3] Statistics Canada, National Household Survey, 2011, Analytical document - Aboriginal Peoples in Canada: First Nations People, Métis and Inuit.

[4] BC Stats. Census 2006 – *Aboriginal Profiles – Aboriginal/Non Aboriginal – British Columbia*. http://www.bcstats.gov.bc.ca/StatisticsBySubject/AboriginalPeoples/CensusProfiles/2006Census.aspx

[5] The 2006 Aboriginal population figures cited were drawn from the Statistics Canada Census 2006 whereas the 2011 figures cited were drawn from the Statistics Canada, 2011 National Household Survey. The 2006 Census and 2011 National Household Survey are based on different methodologies and direct comparison should not be made.

[6] Statistics Canada, National Household Survey, 2011, Data tables.

[7] Statistics Canada, National Household Survey, 2011, Analytical document - Aboriginal Peoples in Canada: First Nations People, Métis and Inuit.

[8] Statistics Canada, National Household Survey, 2011, Analytical document - Aboriginal Peoples in Canada: First Nations People, Métis and Inuit.

[9] BC Stats. BC Population by 5 years age group projections; and Stats Canada. Projections of the Aboriginal Populations of Canada, Provinces and the Territories – 2001-2017.

2001 and 2009 – the size of the Aboriginal child and youth population increased by about 11 per cent in that same period.[10] Over the next few years, the Aboriginal youth population is projected to grow at twice the rate of the overall youth population.[11]

In 2011/12, 61,399 school-age Aboriginal children attended provincial public and independent schools.[12] This included 8,830 Aboriginal children who live on-reserve. Another 4,788 school-age children ordinarily resident on-reserve attended band-operated schools.[13]

First Nations people in B.C. speak 32 of the First Nations languages and 59 of the dialects in Canada.[14] One-third of the approximately 600 First Nations in Canada are in this province.[15]

In 2011, about 78,670 people, both Aboriginal and non-Aboriginal, lived in First Nations reserve communities. Of those, just over 49,700 are Status Indians, accounting for about 44 per cent of the total Status Indian population in the province. About 17,000 Status Indian First Nations people living on-reserve are between the ages of birth and 19 years, including about 10,500 Status Indians who are school-age.[16] Many First Nations communities are isolated and remote and have a population of fewer than 200 people.[17]

Of those Aboriginal people not living on-reserve, about 60 per cent live in urban areas, particularly the cities of Vancouver, Victoria, Prince George and Kamloops.[18]

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[10] Ibid.
[11] Ibid.
[12] BC Ministry of Education, 2011/12 Summary of Key Information, *Aboriginal Students 2002/03 to 2011/12 (Public and Independent)*.
[13] Aboriginal Affairs and Northern Development Canada, *Federal Funding Levels for First Nations K-12 Education (updated version using 2011/12 Data).*
[14] Report on the Status of B.C. First Nations Languages 2010, First Peoples' Heritage, Language and Cultural Council.
[15] Ministry of Aboriginal Relations and Reconciliation. *Frequently Asked Questions*, http://www.gov.bc.ca/arr/treaty/faq.html#top
[16] Statistics Canada, National Household Survey, 2011, Analytical Document - Aboriginal Peoples in Canada: First Nations People, Métis and Inuit.
[17] BC Stats. 2011 Census Total Population Results, Indian Reserves, http://www.bcstats.gov.bc.ca/StatisticsBySubject/Census/2011Census/PopulationHousing/IndianReserves.aspx
[18] Government of BC, Urban Aboriginal People, http://www.newrelationship.gov.bc.ca/success_stories/urban_aboriginal.html

Many Aboriginal people face chronic and deep poverty and live in inadequate and crowded housing. A recent study found that while the average poverty rate in B.C. for non-Aboriginal children is 17 per cent, the poverty rate for Aboriginal children is 28 per cent and for Status Indian children it is 48 per cent – nearly three times the average for non-Aboriginal children.[19] Aboriginal people also have poorer health, lower educational achievement, higher rates of incarceration, higher unemployment and higher reliance on income assistance than non-Aboriginal people.

The diversity of experiences, languages and the many scattered locations of B.C. First Nations mean challenges for policy and service. As well, the necessity of completing the treaty-making process in B.C. has prompted ongoing shifts in the children's agenda with priorities vacillating between negotiation tables and front-line service provision.

The Aboriginal Child Welfare Experience

Until the 1950s, there was no child welfare service regime for on-reserve First Nations people as the *Indian Act* of 1876, Canada's oldest piece of legislation, did not contemplate child welfare. Although there was a certain level of activity being undertaken by both the federal and provincial governments, there was no clear legal authority or delineation of responsibilities. In 1951, the *Indian Act* was amended to make Status Indians living on-reserve subject to provincial laws of general applicability. Since that time, the province has been responsible for the child welfare needs of all children in B.C., including Aboriginal children whether they live on- or off-reserve.

Only one per cent of children and youth in care in Canada in the 1950s were Aboriginal.[20] As of March 2013, more than 52 per cent – or about 4,450 out of the total of 8,106 children in care of the B.C. government – were Aboriginal.[21]

Although the overall number of children in care has declined over the last decade, since 2006/07, the proportion of children in care who are Aboriginal has remained at more than 50 per cent.

[19] Canadian Centre for Policy Alternatives and Save the Children, June 2013, Poverty or Prosperity: Indigenous Children in Canada, prepared by David MacDonald and Daniel Wilson.

[20] Office of the Provincial Health Officer, *Health, Crime, and Doing Time – Potential Impacts of the Safe Streets and Communities Act (Former Bill C-10) on the Health and Well-being of Aboriginal People*. Special Report, March 2013, page 3.

[21] Ministry of Children and Family Development Corporate Data Warehouse.

Figure 2: Map of Aboriginal Peoples of B.C.

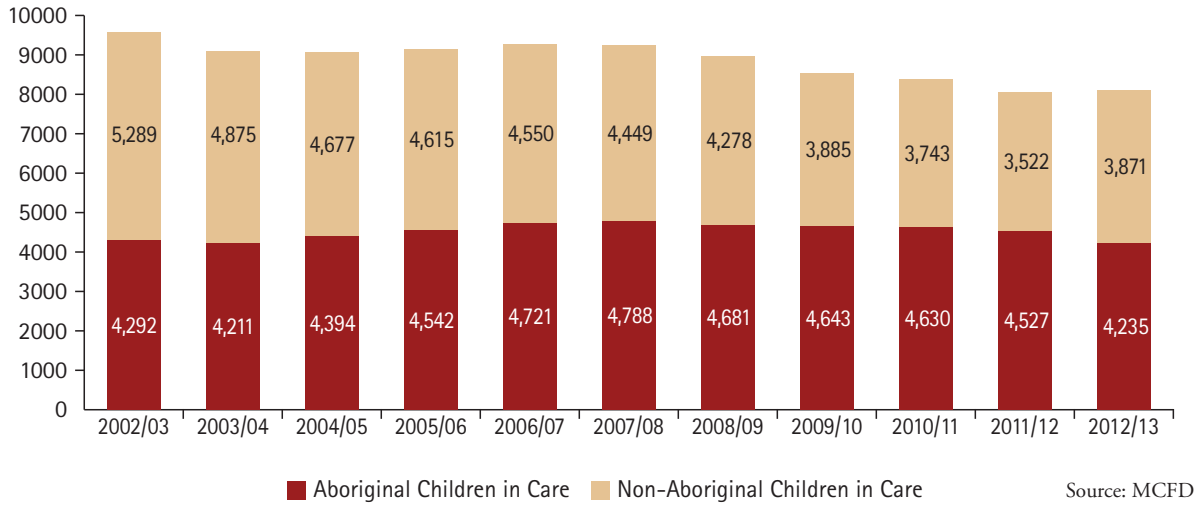
#	First Nation Name
501	Taku River Tlingit (see footnote 1)
504	Dease River (see footnote 1)
530	Moricetown
531	Gitanmaax
532	Kispiox
533	Glen Vowell
534	Hagwilget Village
535	Gitsegukla
536	Gitwangak
537	Gitanyow
538	Heiltsuk
539	Nuxalk Nation
540	Kitasoo Band Council
541	Oweekeno/Wuikinuxv Nation
542	Saulteau First Nation
543	Fort Nelson First Nation
544	Prophet River Band
545	West Moberly First Nations
546	Halfway River First Nations
547	Blueberry River First Nations
548	Doig River First Nation
549	Burrard Band (Tsleil-Waatuth First Nation)
550	Musqueam Indian Band
551	Sechelt Indian Band
552	Homalco Indian Band
553	Klahoose First Nation
554	Sliammon First Nation
555	Squamish First Nation
556	N'Quatqua Band
557	Mount Currie Band Council
558	Aitchelitz Band
559	Chehalis Indian Band
560	Kwikwetlem First Nation
561	Douglas First Nations
562	Skatin First Nation
563	Katzie First Nation
564	Kwantlen First Nation
565	Matsqui First Nation
566	New Westminster Indian Band
567	Samahquam First Nation
568	Scowlitz First Nation
569	Semiahmoo First Nation
570	Shx'wha:y Village
571	Skowkale First Nation
572	Soowahlie First Nation
573	Skwah First Nation
574	Squiala First Nation
575	Tzeachten First Nation
576	Yakweakwioosse
577	Tsawwassen First Nation
578	Sumas First Nation
579	Leq'a:mel First Nation
580	Kwaw-kwaw-a-pilt First Nation
581	Seabird Island Band
582	Skawahlook First Nation
583	Chawathil Band
584	Cheam Indian Band
585	Popkum Band
586	Peters Band
587	Shxw'ow'hamel First Nation
588	Union Bar Indian Band
589	Yale First Nation
590	Bridge River Indian Band
591	Cayoose Creek Band
592	Xaxli'p First Nation
593	T'it'q'et
594	Ts'kw'aylaxw First Nation
595	Seton Lake Band
596	Osoyoos Indian Band
597	Penticton Indian Band
598	Lower Similkameen Indian Band
599	Upper Similkameen Indian Band
600	Spallumcheen Indian Band
601	Westbank First Nation
602	St. Mary's Indian Band
603	Tobacco Plains Indian Band
604	?Akisq'nuk First Nation
605	Shuswap Indian Band
606	Lower Kootenay Indian Band
607	Lake Babine Nation
608	Takla Lake First Nation
609	Tsay Keh Dene Band
610	Kwadacha Band
611	Lheidli-T'enneh Band
612	Nadleh Whut'en Band
613	Stellat'en First Nation
614	Nak'azdli Indian Band
615	Saik'uz First Nation
616	Okanagan Indian Band
617	Tl'azt'en Nation
618	McLeod Lake Indian Band
619	Burns Lake Indian Band
620	Cheslatta Indian Band
622	Campbell River Indian Band
623	Cape Mudge Band
624	Comox Indian Band
625	Kwicksutaineuk/Ah-Kwa-Mish Tribes
626	Kwakiutl Band Council
627	Gwawaenuk Tribe
628	Kwiakah First Nations
629	Mamalilikulla-Qwe'Qwa'Sot'Em Band
630	Mowachaht/Muchalaht First Nations
631	'Namgis First Nation
632	Tlatlasikwala Band
633	Quatsino First Nation
634	Ehattesaht First Nation
635	Da'naxda'xw First Nation
636	Tsawataineuk Indian Band
637	Tlowitsis First Nation
638	Ka:'yu:'k't'h'/Che:k:tles7et'h' First Nation
639	Nuu-chah-nulth Tribal Council
640	Beecher Bay First Nation
641	Chemainus First Nation
642	Cowichan Tribes
643	Lake Cowichan First Nation
644	Esquimalt Nation
645	Halalt First Nation
646	Lyackson First Nations
647	Malahat Indian Band
648	Snuneymuxw First Nation
649	Nanoose First Nation
650	Penelakut Indian Band
651	Qualicum First Nation
652	Pauquachin First Nation
653	Tsartlip First Nation
654	Tsawout First Nation
655	Tseycum First Nation
656	Songhees First Nation
657	T'Sou-ke Nation
658	Pacheedaht First Nation
659	Ahousaht First Nation
660	Tla-o-qui-aht First Nation
661	Hesquiaht First Nation
662	Ditidaht First Nation
663	Huu-ay-aht First Nation
664	Hupacasath First Nation
665	Tseshaht First Nation
666	Toquaht First Nation
667	Uchucklesaht Tribe
668	Ucluelet First Nation
669	Old Masset Village Council
670	Skidegate Band Council
671	Gingolx First Nation
672	Gitxsaata Nation
673	Metlakatla Band
674	Laxkw'alaams Indian Band
675	Hartley Bay Village Council
676	Kitamaat Village Council
677	New Aiyansh Village Government
678	Laxgalts'ap Village Government
679	Gitwinksihlkw Village Government
680	Kitselas Indian Band
681	Kitsumkalum Band
682	Tahltan Indian Band
683	Iskut First Nation
684	Adams Lake Indian Band
685	Ashcroft Indian Band
686	Bonaparte Indian Band
687	Skeetchestn Indian Band
688	Kamloops Indian Band
689	Little Shuswap Indian Band
690	Neskonlith Indian Band
691	Simpow First Nation
692	Oregon Jack Creek Band
693	Coldwater Indian Band
694	Cook's Ferry Indian Bands
695	Lower Nicola Indian Band
696	Nicomen Indian Band
697	Upper Nicola Band
698	Shackan Indian Band
699	Nooaitch Indian Band
700	Boothroyd Indian Bands
701	Boston Bar First Nation
702	Whispering Pines/Clinton
703	High Bar First Nation
704	Kanaka Bar Indian Band
705	Lytton First Nation
706	Siska Indian Band
707	Skuppah Indian Band
708	Spuzzum First Nation
709	Alexandria Indian Band
710	Alexis Creek
711	Esketemc First Nation
712	Tl'etinqox-t'in Government
713	Canim Lake Indian Band
714	Xeni Gwet-in First Nations Government
715	Red Bluff Indian Band
716	Soda Creek Indian Band
717	Stone Indian Band (Yunesit'in)
718	Toosey Indian Band
719	Williams Lake Indian Band
720	Nazko Treaty Office
721	Kluskus Indian Band
722	Ulkatcho First Nations
723	Canoe Creek Indian Band
724	Gwa'sala-'Nakwaxda'xw Nation
725	Wet'suwet'en First Nation
726	Nee-Tahi-Buhn Band
728	Yekooche First Nation
729	Skin Tyee Band
1059	Daylu Dena Council (see Notes 1 and 2)

Based on map produced by
Professional and Technical Services,
Indian and Northern Affairs Canada, May 2007

Notes:

1. Band or group is administered from INAC Yukon Region. Main community is located in BC.
2. Daylu Dena Council (1059) is not registered as a band under the *Indian Act.* However, they do function as an independent band and sign separate funding agreements with INAC. All registered Indians in this group appear under Liard First Nation (502) in the Indian Register.

Figure 3: Aboriginal Children in Care and Non-Aboriginal Children in Care, Fiscal Year End



Source: MCFD

Aboriginal children are also more likely to have encountered the child welfare system. In 2010/11 in B.C., an Aboriginal child was 4.5 times more likely to have a protection concern reported than a non-Aboriginal child, 6.1 times more likely to be investigated, 8.2 times more likely to be found in need of protection, 7.4 times more likely to be admitted into care, and 13.4 times more likely to remain in care.[22]

The disproportionate representation of Aboriginal children in the child welfare system can be partly attributed to the historic legacy of discriminatory government policies that undermined Aboriginal culture, traditions and language. This began with the "take the Indian out of the child approach" – the residential school experience that led to multi-generational impacts that have had a profound, lasting effect on Aboriginal people, communities and families. Residential schools resulted in generations of Aboriginal people growing up without parental support. A national report found that almost half of First Nations residential school survivors living on-reserve in Canada identify that the experience had a negative impact on their health and well-being. Of the survivors' children living on-reserve, more than 40 per cent believe that their parents' attendance at residential schools negatively affected the parenting they received.[23]

Successive government policies and actions have also contributed to the high numbers of Aboriginal children in the B.C. child welfare system. In the 1960s, the application of provincial child welfare legislation to Aboriginal children on-reserve led to the apprehension and coming into care of significant numbers of Aboriginal children – the so-called "60s Scoop" – primarily related to perceived neglect due to conditions of poverty. Coupled with the 1980s moratorium on placing Aboriginal children for adoption in non-Aboriginal homes, there has been a steady increase in the number of Aboriginal children coming into government care with little promise of finding a permanent home through adoption.

[22] MCFD, *Aboriginal Children in Care Report*, January 2011.
[23] Reading, CL., Wein, F. Health inequalities and social determinants of Aboriginal people's health. Ottawa. ON: National Collaborating Centre for Aboriginal Health, 2009.

The current emphasis on reconciliation with First Nations has led to a confusing approach to Aboriginal child welfare in which federal/provincial roles are blurred with the end result being that the best interests of the child are not placed at the centre.

Federal child welfare funding policy has also had an influence on children coming into care rather than on prevention activities.

This legacy, combined with current poverty, poor housing and substance abuse, all contribute to family disruption, including child neglect – the primary reason Aboriginal children are reported to child welfare authorities.[24]

The high rate of Aboriginal children in contact with the child welfare system is of specific concern given evidence showing poorer outcomes related to education, health and well-being for children and youth in care or receiving child welfare services than the general child and youth population.[25]

Many Aboriginal children already experience significant vulnerabilities that are compounded by their involvement in the child welfare system.

Aboriginal children in general have lower educational attainment than non-Aboriginal children in B.C., with lower results on the B.C. Foundation Skills Assessment (FSA) tests, delayed advancement (the extent to which schools keep students in school and progressing in a timely manner to completion of their diploma) and lower high school completion rates.[26]

Aboriginal children in care fare even worse. A joint report prepared by the Representative and the Provincial Health Officer found that the school completion rate for Aboriginal children in continuing custody was 21.7 per cent, compared to 34.1 per cent for non-Aboriginal children in continuing custody.[27] Little is known about the achievement of children on-reserve as the tracking and reporting of outcomes is limited.[28]

A recent review by the Representative on suicide and self-harm among youth receiving MCFD services found that Aboriginal children were significantly more likely to commit suicide or demonstrate self-harm behaviour than non-Aboriginal youth – eight out of 15 youth who died of suicide were Aboriginal and 44 of 74 youth who sustained self-harm injuries were Aboriginal. Many of these Aboriginal youth were receiving MCFD services as a result of safety and well-being concerns such as neglect, exposure to violence in the home, or physical or sexual abuse.[29]

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[24] First Nations Child and Family Caring Society of Canada, Wen: De: We Are Coming to the Light of Day, 2005, page 18.

[25] Representative for Children and Youth. Office of the Provincial Health Officer. *Growing Up In B.C.* (2010).

[26] Fraser Institute, *Report Card on Aboriginal Education in British Columbia 2011*.

[27] Representative for Children and Youth. Office of the Provincial Health Officer. *Growing Up In B.C.* (2010).

[28] Fraser Institute, http://www.fraserinstitute.org/report-cards/school-performance/aboriginal-education.aspx

[29] Representative for Children and Youth, *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self Harm* (November 2012)

Aboriginal youth are five times more likely to be incarcerated, and Aboriginal youth involved in the justice system are significantly more likely to have been in government care at some point in their lives.[30]

The policy foundation for service to Aboriginal children and families has been unclear for some time with key shifts, multiple political promises and virtually no assessment of outcomes, leaving many gaps in knowledge. We do not fully know the results for Aboriginal children as we have no reliable child welfare data for Aboriginal children on-reserve.

Changing Relationship with Government

Over the past decade, a number of initiatives have occurred that changed the nature and course of the relationship between Aboriginal people and governments in Canada. These initiatives have been both a recognition of the failed past and a commitment to doing things differently in the future – the federal settlement and apology with regard to residential schools of particular note. The policy concerns regarding children are both federal and provincial, with the fallout of failed policies, such as residential schools, having a continuing impact on families. Many of these political agreements were directed at children and sought to change how policy and administration worked to improve the lives of Aboriginal children. B.C. has been active in such initiatives, with a former B.C. premier making a dramatic shift from initially opposing the Nisga'a treaty and seeking a public referendum on treaties, to later embracing principles for treaty-making and calling for a new relationship and transformative change.

The 2006 Indian Residential School Settlement Agreement, including the establishment of the Truth and Reconciliation Commission, followed by the 2008 Prime Minister's apology on behalf of Canadians for Indian residential schools, represented an acknowledgement at the national level that child and family policies of the past were failures with lasting impacts. This was cemented by the federal government reversal in 2010 of its 2007 decision regarding the endorsement of the *United Nations Declaration on the Rights of Indigenous People* in recognition of the new relationship between Canada and Aboriginal people.

For B.C., several key changes occurred during the past decade. A seminal point in the relationship between B.C. Aboriginal people and the provincial government was the 2001 B.C. Treaty Referendum. Following the referendum, the B.C. government made a commitment to change its relationship with provincial Aboriginal people in various areas of provincial responsibility. That commitment has been reflected in a number of subsequent memoranda, accords and agreements, many of which specifically consider the issue of Aboriginal child welfare:

- The *Tsawwassen Accord*,[31] signed in 2002, the culmination of a landmark meeting of provincial leaders from government, the First Nations Summit Child Welfare Committee, the Union of BC Indian Chiefs, United Native Nations, Métis Provincial Council of BC, bands, tribal councils and Aboriginal service-delivery organizations. The Accord reflected a unanimous position regarding Aboriginal

[30] Child and Youth Officer (2006), Issue Paper 5, *Aboriginal Youth and the Youth Criminal Justice System*
[31] The Tsawwassen Accord, http://www.ubcic.bc.ca/files/PDF/Tsawassen_Accord.pdf

peoples' inherent authority over the lives of their children and families. It focused on organizational governance and not services or service delivery. Representatives from these organizations supported a resolution that "unequivocally" called for a series of Aboriginal authorities.

- The *New Relationship*[32] entered into in the summer of 2005 by leadership of the First Nations Summit, the Union of BC Indian Chiefs, the BC Assembly of First Nations and the Premier of B.C., setting out a vision for improved government-to-government relations with First Nations with the goal of establishing new processes and structures for working on decisions principally regarding the use of land and resources. Some of the specific agreements negotiated at this time dealt with Aboriginal children, youth and families.
- The November 2005 *Transformative Change Accord*,[33] entered into by the province, the federal government and the First Nations Leadership Council for the purpose of closing the social and economic gaps between First Nations and other British Columbians, reconciling Aboriginal rights and title with those of the Crown, and establishing a new relationship based upon mutual respect and recognition.
- The *Métis Nation Relationship Accord*,[34] signed in May 2006 between the province and the Métis Nation of British Columbia, establishing mutual goals between the province and Métis people in B.C., including collaboration to close the gap in quality of life between the Métis and other citizens of the province.
- The *Strong, Safe and Supported Action Plan*,[35] unveiled by MCFD in 2008, that included the Aboriginal Approach as one of five pillars for the child welfare system in the province. The Aboriginal Approach was based on the desired outcome that Aboriginal children, youth and their families would receive services through an Aboriginal service system that strongly connects children and youth to their culture and tradition.
- *Jordan's Principle*, endorsed in January 2008 by Premier Gordon Campbell, is a child-first approach that commits the provincial government to ensure that jurisdictional funding disputes do not prevent or delay First Nations children from accessing available health and social services. Under *Jordan's Principle*, if B.C. has first contact with an Aboriginal child, it will pay for the services and seek reimbursement later to ensure that a child receives equitable service in a timely way.

The Representative notes that, with the exception of the Tsawwassen Accord and the Transformative Change Accord, the federal government had no involvement in any of these initiatives. The Representative interprets the federal government's public stance on Aboriginal child welfare as being that it does not bear any obligation beyond serving as a funder.

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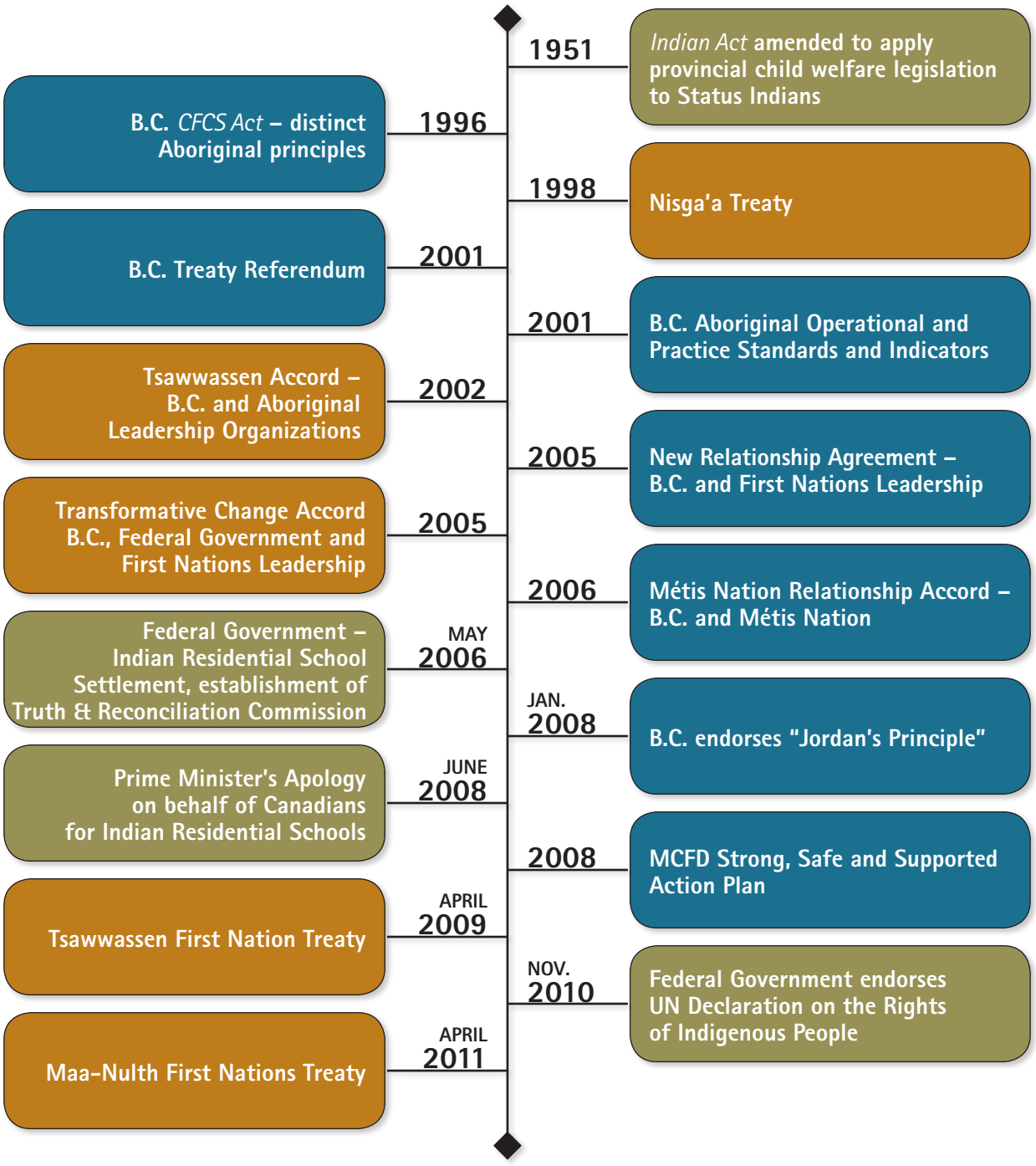
[32] The New Relationship, http://www.newrelationship.gov.bc.ca/agreements_and_leg/new_relationship_agreement.html

[33] The Transformative Change Accord, http://www.newrelationship.gov.bc.ca/agreements_and_leg/trans_change_accord.html

[34] The Métis Nation Relationship Accord, http://www.newrelationship.gov.bc.ca/agreements_and_leg/metis_relationship_accord.html

[35] MCFD *Strong, Safe and Supported Action Plan, 2008.*

Figure 4: Significant Aboriginal Milestones In and Affecting B.C.



Legend

- Federal/Provincial Political Agreements and Treaties
- Federal Government Initiatives and Actions
- B.C. Government Initiatives and Actions

In addition, over the past 10-plus years, three First Nations have negotiated treaty agreements with the provincial and federal governments – the Nisga'a Nation in 1998, the Tsawwassen First Nation in 2009 and the Maa-Nulth First Nations in 2011. These agreements include authority over child welfare, although to date none of these First Nations Treaty governments have exercised this authority. Through her work with these communities, the Representative understands this is due to scope and capacity, funding and liability considerations.

The various accords and agreements between government and Aboriginal leaders chart a new policy platform holding out a promising foundation for a new approach to addressing various social issues and conditions – one based on a partnership to achieve shared interests. They have also brought a focus to the issue of Aboriginal child and family welfare, the need to take action, and the role of Aboriginal communities in caring for their children, youth and families. The degree to which political promise has been realized in policy and practice is the key concern of the Representative. How are these promises and commitments being realized? What outcomes have resulted? Has measurable progress been made in achieving the goals outlined in the accords? What has changed for the lives of Aboriginal children in B.C.?

Aboriginal Child Welfare Framework in B.C.

Aboriginal Child Welfare Service-Delivery Structure and Funding

In addition to MCFD, which has legal authority and overall responsibility for the delivery of child welfare services for all B.C. children, youth and their families, there are two other key players in the delivery of Aboriginal child welfare services in the province:

- delegated Aboriginal Agencies (DAAs), which are authorities delegated by MCFD to deliver child welfare services to Aboriginal children, youth and families. There are two types of DAAs:
  - agencies that are governed by a First Nations band and that provide child welfare services to band members on-reserve (band-operated);
  - agencies that are constituted as societies and are governed by an independent board and that provide child welfare services to Aboriginal children and families, including Status Indians who do not live on-reserve (urban);
- the federal department of Aboriginal Affairs and Northern Development (AAND), which provides funding for child welfare services for Status Indians living on-reserve. In 2011/12, AAND spent $640 million nationally on child and family services under its Social Development program and was budgeted to spend $644 million in 2012/13.[36]

DAAs

DAAs are the key vehicle employed by MCFD to *"return historic responsibilities for child protection and family support back to Aboriginal communities."*[37] The goal of moving responsibility for Aboriginal child welfare has been ongoing since 1986, with the establishment of the first DAA. Today there are 23 DAAs located throughout the province.[38] Twenty are associated with bands serving 116 of the approximately 200 First Nations in B.C. and three serve Aboriginal children and families in urban areas.[39] As of March 31, 2013, DAAs were responsible for almost 47 per cent of Aboriginal children in care.

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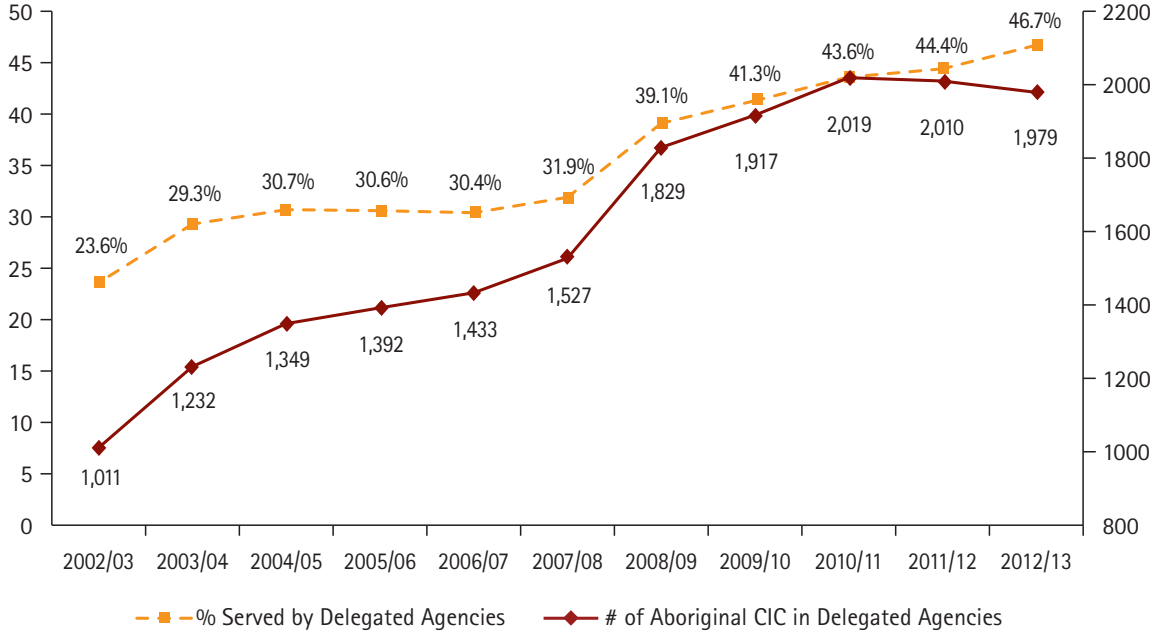
[36] AAND Canada, *2013/14 Financial Overview, July 2013,* http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ-AI/STAGING/texte-text/ai_arp_fin_2013-2014_april2013_1363097691734_eng.pdf

[37] MCFD, *Delegated Child and Family Service Agencies,* http://www.mcf.gov.bc.ca/about_us/aboriginal/delegated/index.htm

[38] This includes the Nisga'a Nation, which has a self-government agreement but has not taken down child welfare powers and continues to operate under an MCFD delegation agreement. The Splatisn First Nation (formerly Spallumcheen) is funded under Directive 20-1, but operates outside the provincial *CFCS Act* under a band-by-law under the *Indian Act* giving it authority over child welfare services.

[39] MCFD, *Delegated Aboriginal Agencies Status Sheet*, June 2013.

Figure 5: Per Cent and Number of Aboriginal Children in Care who are Served by Delegated Aboriginal Agencies



The DAA model is based on the Provincial Director of Child Welfare[40] granting authority under the *CFCS Act* for child welfare to Aboriginal agencies and their employees to undertake the administration of all or parts of the *CFCS Act*.

There are three tiers of delegation, each providing for an increasing, cumulative range of service responsibility:

- *voluntary service delivery* such as support service to families and voluntary care agreements, including temporary out-of-home placements and special needs agreements;
- *guardianship services* including the development, monitoring and review of Plans of Care for Aboriginal children in care, permanency planning, transitional services for children moving out of the protection system and management of out-of-home services; and
- *child protection services*, including child protection investigation and enforcement of the *CFCS Act*.

[40] Under the *CFCS Act*, the Minister of Children and Family Development designates a Provincial Director of Child Welfare with overall authority for child welfare and protection under the *CFCS Act*.

Figure 6: Delegated Aboriginal Agencies of B.C.

Level C6*

1. Lalum'utul' Smun'eem Child & Family Services (Duncan)
2. Knucwentwecw Society (Williams Lake)
3. Ktunaxa/Kinbasket Child & Family Services (Cranbrook, Creston, Windermere)
4. Nlha'7kapmx Child & Family Services Society (Lytton)
5. Scw'exmx Child & Family Services Society (Merritt)
6. Secwepemc Child & Family Services Agency (Kamloops)
7. Nuu-Chah-Nulth Tribal Council Usma Family and Child Services or Usma Nuu-Chah-Nulth (Port Alberni)
8. Fraser Valley Aboriginal Children and Family Services Society Formerly Xyolhemeylh Child & Family Services or Sto:lo Nation (Chilliwack, Mission, Agassiz, Abbotsford, Langley)
9. Métis Family Services also known as La Societe de les Enfants Michif (Surrey)
10. Vancouver Aboriginal Child and Family Services Society (Vancouver)

Level C4**

11. Ayas Men Men Child & Family Services (West Vancouver)
12. Carrier Sekani Family Services (Prince George, Burns Lake, Vanderhoof)
13. Gitxsan Child & Family Services Society (Hazelton)
14. Kwumut Lelum Child & Family Services (Nanaimo, Penelakut Island)
15. Nezul Be Hunuyeh Child & Family Services Society (Fort St. James, Prince George)
16. Nil/Tu,O Child & Family Services Society (Saanichton)
17. Nisga'a Child & Family Services (New Aiyansh, Prince Rupert, Terrace)
18. Northwest Inter-Nation Family and Community Services Society (Terrace, Prince Rupert)
19. Surrounded by Cedar Child and Family Services (Victoria)

Level C3***

20. Denisiqi Services Society (Williams Lake)
21. Haida Child and Family Services Society (Old Masset, Skidegate)
22. Heiltsuk Kaxla Child & Family Service Program (Bella Bella)
23. K'wak'walat'si ('Namgis) Child and Family Services (Alert Bay)

* C6 - Full child protection services

** C4 - Guardianship services for continuing custody wards

*** C3 - Resource development and voluntary service delivery

Each level of delegation has specific operational and practice standards that an agency must meet in order to progress to the next level.[41] Because the Provincial Director delegates authority to individuals, each individual agency worker must receive the appropriate delegation to undertake the applicable level of child welfare service.

Before receiving delegation for child welfare services, band-operated DAAs must enter into a detailed Delegation Enabling Agreement (DEA) with MCFD and AAND outlining the roles and responsibilities of the parties, the level of delegation approved by the Provincial Director's authority under the *CFCS Act*, and operational, administrative and funding requirements and arrangements. The ministry has entered into individual agreements with the three urban agencies, Vancouver Aboriginal Child and Family Services Society, Surrounded by Cedar and Métis Family Services.

Each DEA is negotiated individually and they differ from one another. AAND requires an agency be providing services to 1,000 Aboriginal children in order to enter into a DEA, unless granted an exception. All but one B.C. DAAs operate under such an exception. The delegation process is complex and can be lengthy. The delegation matrix is detailed and the DEA outlines in formal contractual language the agreement with the DAA respecting operational service-delivery requirements; policy standards; monitoring and reporting; reviews, audits and evaluations; information management; dispute resolution; financial arrangements; and liability issues. After demonstrating operational readiness through a successful program review, a DAA may begin the delivery of delegated services.

Currently, four DAAs have delegated authority for voluntary service delivery; nine have additional delegation to provide guardianship services; and 10 have full delegation authority including child protection and authority to investigate reports and remove children.[42] An additional three organizations are actively involved in planning for delegation.

The following table lists the current DAAs, by level of delegation, the communities they serve, 2012/13 funding and the number of open case files by type as of March 2013.

[41] MCFD, http://www.mcf.gov.bc.ca/about_us/aboriginal/delegated/delegation_process.htm
[42] Delegated Aboriginal Child and Family Service Agencies Status, http://www.mcf.gov.bc.ca/about_us/aboriginal/delegated/pdf/agency_list.pdf

Table 1: Delegated Aboriginal Agencies and Communities Served[43]

Name of Agency	Affiliated Communities		2012/13 MCFD Expenditure	# Open Files (March 2013)			
				In Care	Youth Agree.	Family Service	Total
Voluntary Service Delivery							
DENISIQI SERVICES SOCIETY	- Alexandria - Alexis Creek (Tsi Del Del) - Anaham (Tl'etinqox) - Nemiah (Xeni Gwet'in)	- Stone (Yunesit'in) - Toosey (Tl'esqotin) - Ulkatcho	$975,807	0	0	0	0
HAIDA CHILD AND FAMILY SERVICES SOCIETY	- Old Masset Village Council	- Skidegate Band	$615,610	0	0	0	0
HEILTSUK KAXLA CHILD & FAMILY SERVICE PROGRAM	- Heiltsuk		0	0	0	1	1
K'WAK'WALAT'SI ('Namgis) CHILD AND FAMILY SERVICES	- 'Namgis	- Tlowitsis-Mumtagalia	$400,224	0	0	1	1
Voluntary Service Delivery and Guardianship Services for Children in Continuing Care							
AYAS MEN MEN CHILD & FAMILY SERVICES (SQUAMISH NATION)	- Squamish		$1,677,052	70	1	63	134
CARRIER SEKANI FAMILY SERVICES	- Burns Lake - Cheslatta - Lake Babine - Nadleh Whut'en - Nee Tahi Buhn - Skin Tyee	- Stella'ten - Saik'uz - Takla Lake - Wet'suwet'en - Yekooche	$6,594,113	79	0	0	79
GITXSAN CHILD & FAMILY SERVICES SOCIETY	- Kispiox - Glen Vowell - Gitsegukla	- Gitwangak - Gitanyow	$486,038	10	0	3	13
KW'UMUT LELUM CHILD & FAMILY SERVICES	- Halalt - Lake Cowichan - Lyackson - Malahat - Stz'uminus First Nation	- Nanoose - Penelakut - Qualicum - Snuneymuxw	$1,655,440	67	0	4	71

[43] MCFD, Delegated Aboriginal Agencies Status, June 2013 and DAA File Counts, March 2013.

Name of Agency	Affiliated Communities		2012/13 MCFD Expenditure	# Open Files (March 2013)			
				In Care	Youth Agree.	Family Service	Total
NEZUL BE HUNUYEH CHILD & FAMILY SERVICES	- Nak'azdli	- Tl'azt'en	$2,390,498	64	0	18	82
NIL/TU,O CHILD & FAMILY SERVICES SOCIETY	- Beecher Bay - Pauquachin - Songhees	- Tsartlip - Tsawout - T'sou-ke	$726,179	20	2	0	22
NISGA'A CHILD & FAMILY SERVICES	Citizens of the Nisga'a Lisims Government including villages of: - Gingolx (Kincolith)	- Gitlakdamx - Lakalzap - Gitwinksihlkw	$2,230,970	26	0	6	32
NORTHWEST INTER-NATION FAMILY AND COMMUNITY SERVICES SOCIETY	- Hartley Bay - Iskut - Kitamaat - Kitkatla - Kitselas	- Kitsumkalum - Lax-kw'alaams - Metlakatla - Tahltan	$1,509,849	34	0	0	34
SURROUNDED BY CEDAR CHILD AND FAMILY SERVICES	Victoria Urban		$2,606,164	64	0	1	65
Voluntary Services, Guardianship Services and Full Child Protection Services							
LALUM'UTUL' SMUN'EEM CHILD & FAMILY SERVICE	- Cowichan		$2,055,105	87	0	30	117
KNUCWENTWECW SOCIETY	- Canim Lake - Canoe Creek	- Soda Creek - Williams Lake	$360,470	15	2	18	35
KTUNAXA/KINBASKET CHILD & FAMILY SERVICES	Métis E. Kootenay Region - Columbia Lake/ ?Akisq'nuk - Lower Kootenay	- Shuswap - St. Mary's - Tobacco Plains	$4,075,074	55	7	88	150
NLHA'7KAPMX CHILD & FAMILY SERVICES SOCIETY	- Cook's Ferry - Kanaka Bar - Lytton	- Nicomen - Siska - Skuppah	$35,663	18	1	13	32
SCW'EXMX CHILD & FAMILY SERVICES SOCIETY	- Coldwater - Lower Nicola - Nooaitch	- Shackan - Upper Nicola	$380,775	44	0	49	93

Name of Agency	Affiliated Communities		2012/13 MCFD Expenditure	# Open Files (March 2013)			
				In Care	Youth Agree.	Family Service	Total
SECWEPEMC CHILD & FAMILY SERVICES AGENCY	- Adams Lake - Bonaparte - Kamloops - Neskonlith	- North Thompson - Skeetchestn - Whispering Pines	$4,333,484	150	8	122	280
NUU-CHAH-NULTH TRIBAL COUNCIL USMA FAMILY AND CHILD SERVICES Or Usma Nuu-chah-nulth	- Ahousat - Ditidaht - Ehattesaht - Hesquiaht - Mowachaht/ Muchalaht - Hupacasath - Nuchatlaht - Tla-o-qui-aht - Tseshaht	Maa-nulth Treaty: - Huu-ay-aht - Ka:'yu:k't'h'/ Che:K:tles7et'h - Toquaht - Uchucklesaht - Ucluelet	$4,293,571	129	0	103	232
FRASER VALLEY ABORIGINAL CHILDREN AND FAMILY SERVICES SOCIETY Formerly XYOLHEMEYLH CHILD & FAMILY SERVICES Or STO:LO NATION	- Aitchelitz - Chawathil - Cheam - Kwantlen - Leq'a:mel - Popkum - Shxw'owhamel - Shx'wha:y Village - Skawahlook	- Skowkale - Skwah - Soowahlie - Squiala - Sumas - Tzeachten - Yakweakwioose	$17,561,323	468	21	277	766
MÉTIS FAMILY SERVICES Also known as LA SOCIETE DE LES ENFANTS MICHIF	Métis (Simon Fraser/ South Fraser)		$5,369,594	145	2	45	192
VANCOUVER ABORIGINAL CHILD AND FAMILY SERVICES SOCIETY (VACFSS)	Vancouver Urban (Vancouver/ Richmond)		$30,620,015	439	0	486	925
Total Open Files (March 2013)				**1,979**	**44**	**1,353**	**3,376**
Total Expenditures DAAs (March 2013)			**$90,953,018**				

Note:

1. Figures are as of March 31, 2013.
2. Figures for In Care and Youth Agreements are month end caseloads.
3. Figures for Family Service are total served during the month.

Source: Ministry of Children and Family Development

Attaining and maintaining a required level of service delivery and achieving successive levels of delegation can be challenging, particularly for smaller DAAs given issues of scope and scale, adequate resources, and difficulties in recruiting qualified Aboriginal staff. Over the years, some DAAs have lost their delegation status and gone out of business. Complicating the issue, since 2006 MCFD has had a limited quality assurance program with audits continuing but no action taken to address the identified deficiencies in practice and operations of DAAs.

The Partnership Forum, made up of directors of the DAAs and representatives from MCFD and AAND, provides oversight and a link between DAAs and government. The Forum meets periodically and has developed a comprehensive agenda of issues and matters to be addressed, but does not appear to have made a lot of progress on issues and, in the Representative's experience and as noted by the Auditor General of B.C., is *"used more to air concerns than seek solutions."* [44]

Service-Delivery Structure

The delivery of and funding for Aboriginal child welfare services in B.C. is based on a combination of the child's status, where the child resides, the existence of a DAA in that community, and the agency's level of delegated authority:

- Child welfare services for Status Indian children living on-reserve, in a reserve community served by a DAA, are delivered by the DAA in accordance with the agency's level of delegation, through funding provided by AAND in accordance with departmental Directive 20-1 and through supplementary resources provided by MCFD;
- Child welfare services for Status Indian children living on-reserve, in a reserve community not served by a DAA, are delivered by MCFD, and AAND reimburses MCFD for some but not all of its costs;
- Child welfare services for Aboriginal children who are not Status Indians but live in a reserve served by a DAA, are delivered by the DAA in accordance with the agency's level of delegation, through funding provided by MCFD;
- Child welfare services for Status Indian children not living on-reserve and for other Aboriginal children not living on-reserve are delivered by MCFD or an urban DAA (if there is one in the community in which the child resides) in accordance with the agency's level of delegation, through funding provided by MCFD;

Directive 20-1

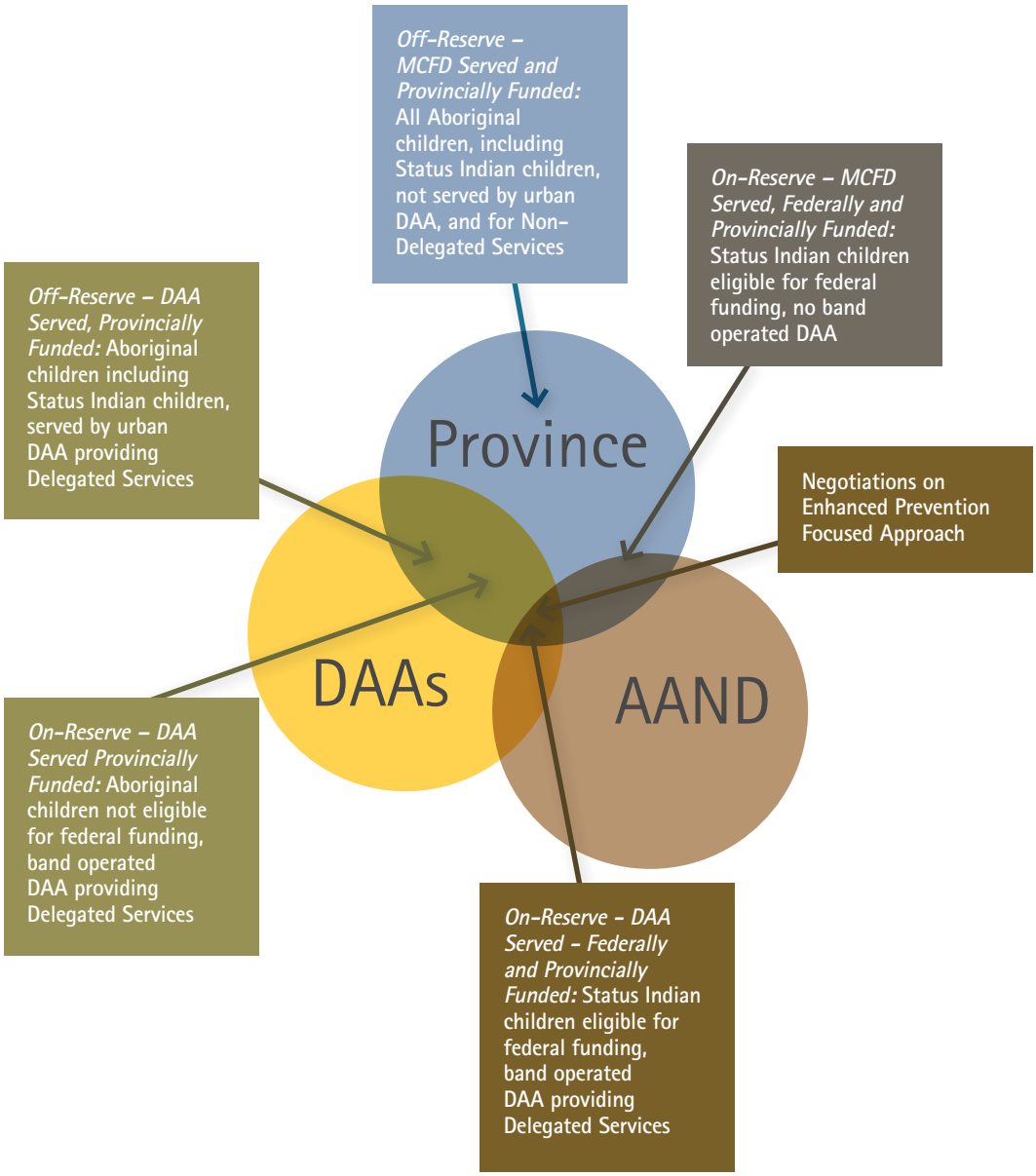
Directive 20-1 is the federal Department of Aboriginal Affairs and Northern Development policy for administering funds for child welfare services to First Nations child and family service providers. The Directive has likely contributed to greater numbers of First Nations children being taken into care, rather than being served through alternative care options or early intervention and prevention models, because it provides more funding for in-care options.

[44] Auditor General of British Columbia, *Management of Aboriginal Child Protection Services*, 2008/09, Report 3

- Child welfare services for "non-delegated services" – child welfare services for which a DAA has not been delegated by MFCD – are delivered and funded by MCFD for all Aboriginal children whatever their status and wherever they are located except in cases where the child is a Status Indian living on-reserve in which case AAND reimburses MCFD for some but not all of its costs.

The following diagram illustrates the complexity of the system of delivering child welfare services to Aboriginal children and youth, and their families.

Figure 7: Aboriginal Child Welfare Service-Delivery System



Service Levels

First Nations children living on-reserve and served by a DAA are intended to have access to a level and quality of services comparable with that provided to other children in the province. However, based on the funding eligibility requirements under Directive 20-1, federal funding for on-reserve services for Aboriginal children and families has tended to focus on protection with little emphasis on prevention or out-of-care options. The result is an inequitable level of services available to on-reserve Status Indian children served by a band-operated DAA as compared to other Aboriginal children, including Status Indian children living off-reserve served by MCFD or an urban DAA, and Status Indian children living on-reserve but served by MCFD in the absence of a DAA in that community. For example, there are no distinct CYMH or CYSN Aboriginal programs and services on-reserve with a focus on children and youth from birth to age 19, although in some cases MCFD may provide specific CYSN supports to individual children.

Although both federal and provincial funding has increased during the past few years, funding is not considered adequate to support the delivery of a full range of quality child welfare services by Aboriginal agencies.[45]

Tables 2 and 3 outline total funding to B.C. DAAs made by AAND (for 2006/07 to 2011/12) and by MCFD (for 2008/09 to 2012/12). The table outlining ministry funding to DAAs also includes child welfare contract funding provided by MCFD to Aboriginal Friendship Centres.

Table 2: Total AAND Funding to B.C. DAAs (in millions)[46]

2006/2007	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012*
$37.688	$49.782	$52.095	$50.354	$52.544	$56.665

(*2011/2012 figures are the latest available for AAND funding)

[45] Auditor General of British Columbia, *Management of Aboriginal Child Protection Services. 2008/09*, Report 3.

[46] Aboriginal Affairs and Northern Development Canada, *Better Outcomes for First Nation Children: Aboriginal Affairs and Northern Development Canada's Role as a Funder in First Nation Child and Family Services*. http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/cfsd1_1100100035211_eng.pdf

Table 3: Provincial Funding for DAAs[47]

Regions/Delegated Aboriginal Agencies	Adjusted 2008/09	Adjusted 2009/10	Adjusted 2010/11	Adjusted 2011/12	Preliminary Adjusted 2012/13
Coast Fraser					
Ayas Men Men Child & Family Services	514,102	679,253	926,171	1,270,538	1,677,052
Fraser Valley Aboriginal Children and Family Services Society	16,331,733	17,488,085	18,695,135	17,503,168	17,561,323
Heiltsuk Kaxla Child & Family Services	42,183	17,000	138,801	6,957	0
Kaxla Child & Family Services	0	0	0	405,316	0
La Societe De Les Enfants Michif	2,300,438	2,321,240	2,874,261	3,637,316	5,369,594
Sechelt Indian Band, Department of Child and Family Services	316,492	281,519	0	0	254
Vancouver Aboriginal Child and Family Services Society (VACFSS)	26,252,072	28,607,536	29,941,638	30,623,082	30,620,015
subtotal	45,757,019	49,394,633	52,576,006	53,446,377	55,228,238
Interior					
Denisiqi Services Society	951,992	894,342	1,071,804	902,045	975,807
Knucwentwecw Society	194,863	106,968	257,473	429,109	360,470
Ktunaxa/Kinbasket Child and Family Service Society	4,079,478	4,688,862	5,231,953	4,186,583	4,075,074
Nlha'7Kapmx Child & Family Services	109,439	55,053	269,834	62,524	35,663
Scw'Exmx Child & Family Services Society	397,987	352,413	376,007	225,114	380,775
Secwepemc Child and Family Services Agency	1,966,164	3,739,105	4,676,655	4,136,958	4,333,484
subtotal	7,699,923	9,836,743	11,883,726	9,942,332	10,161,273
North					
Carrier Sekani Family Services a Branch Society of the Carrier Sekani Tribal Council	3,614,040	4,564,945	5,882,376	5,069,687	6,594,113
Gitxsan Child & Family Services	445,317	384,112	615,022	692,613	486,038
Haida Child & Family Services Society	507,546	775,918	931,993	640,273	615,610
Nezul Be Hunuyeh Child & Family Services Society	430,805	472,969	2,825,317	1,826,022	2,390,498
Nisga'a Nation	1,216,504	1,475,412	2,235,716	2,270,817	2,230,970
Northwest Inter-Nation Family & Community Services Society	1,126,978	1,633,878	2,147,373	1,617,622	1,509,849
Nisga'a Lisims Government	0	0	0	128,167	0
Nisga'a Child & Family Services	0	0	0	2,500	0
subtotal	7,341,190	9,307,235	14,637,797	12,247,701	13,827,078

[47] The ministry has indicated that it did not collect and compile aggregate provincial level data on DAAs until 2007/08.

Regions/Delegated Aboriginal Agencies	Adjusted 2008/09	Adjusted 2009/10	Adjusted 2010/11	Adjusted 2011/12	Preliminary Adjusted 2012/13
Vancouver Island					
K'Wak'Wala'Tsi Child & Family Services	0	17,000	57,000	0	0
Kwumut Lelum Child & Family Services Society	1,529,636	1,465,170	1,516,234	1,706,788	1,655,440
Lalum'Utul Smun'Eem	0	0	241	30,000	5,579
Lalum'Utul Smun'Eem Child & Family Services	1,691,640	2,125,100	2,230,982	1,751,767	2,055,105
Namgis First Nation	362,421	364,041	391,937	389,223	400,224
Nil/Tu,O Child and Family Services Society	730,129	604,783	854,401	670,562	726,179
Nuu-Chah-Nulth Tribal Council	2,801,382	3,046,574	3,871,825	4,261,998	4,293,571
Surrounded By Cedar Child & Family Services Society	1,040,321	1,033,494	1,765,920	2,398,029	2,606,164
USMA Nuu-Chah-Nulth Community & Human Services		17,964	10,335	274	0
subtotal	8,155,529	8,657,126	10,641,875	11,208,641	11,742,262
Total Before Adjustments	68,953,662	77,195,737	89,739,403	86,845,051	90,958,851
Adjustments	-65,000	-792,999	-4,656,167	-961,360	0
Comparable Adjusted Totals – DAAs	**$68,888,662**	**$76,402,738**	**$85,083,236**	**$85,883,691**	**$90,958,851**

BC Association of Aboriginal Friendship Centres	Funding 2008/09	Funding 2009/10	Funding 2010/11	Funding 2011/12	Funding 2012/13
Contracts in Provincial Office	400,458	748,148	8,281,300	6,315,000	6,745,000
Contracts in Regional Offices	185,875	185,000	270	0	290
Totals – Friendship Centres	**$586,333**	**$933,148**	**$8,281,570**	**$6,315,000**	**$6,745,290**
Total - DAAs and Friendship Centres	$97,704,141	$77,335,886	$93,364,806	$92,198,691	$97,704,141

Note: Adjustments refer to changes to totals for all DAAs to account for things such as one-time infrastructure grants, repayments of over-payments, etc.

To recognize the importance of prevention services in supporting improved outcomes, and to redress the discrepancy in the level of services available to on-reserve and off-reserve First Nations children, youth and families, in 2007 AAND (then called Indian Affairs and Northern Development) launched a new funding approach. It is called the Enhanced Prevention Focused Approach and is designed to ensure that *"enhanced prevention practices were brought to reserves."* Under this model, negotiated at an individual province level, additional funding is provided by AAND to support prevention-focused activities for children and family services on-reserve. Today, the model is being applied in six provinces – Alberta, Saskatchewan, Nova Scotia, Québec, P.E.I. and Manitoba – covering 68 per cent of Status Indian First Nations children ordinarily resident on-reserve.[48] Although there are plans to comprehensively evaluate the model and some assessment of its implementation and efficiency has been undertaken,[49] to date there has been no evaluation of the model assessing its effectiveness.

In 2008, negotiations under the Enhanced Prevention Focused Approach began between AAND, MCFD and the First Nations Child and Family Services Agencies Directors' Forum (Directors of DAAs providing services to band members). The B.C. Enhanced Prevention Framework was drafted with the goal of providing *"First Nations children, families and communities with a comprehensive and seamless range of services based on their culture, values and customs."* Under the framework, funding was to be provided to DAAs delivering services on-reserve *"to allow them to deliver preventive strategies comparable to the levels delivered by the ministry."* Agencies would not be required *"to mirror the services being offered by the Province*," but rather, develop a *"network of prevention services … reflective of the specific culture and traditions of each individual community."* [50]

Since that time, limited progress has been made in implementing the approach in B.C. In January 2013, MCFD, AAND, the First Nations Child and Family Services Agencies Directors' Forum and the Aboriginal Wellness Council met to renew efforts in this area. It was agreed that a new process would be put in place to guide the initiative and that the B.C. Enhanced Prevention Framework would be revised to better reflect the unique needs of First Nations in B.C. A Tripartite Steering Committee and a Technical Working Group, composed of representatives of MCFD, AAND and First Nations, were established in March 2013 with the goal of developing a revised framework by October 2013.[51]

[48] Aboriginal Affairs and Northern Development Canada, *Better Outcomes for First Nation Children: Aboriginal Affairs and Northern Development Canada's Role as a Funder in First Nation Child and Family Services*, http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/cfsd1_1100100035211_eng.pdf

[49] AAND, First Nation Child and Family Services Program, http://www.aadnc-aandc.gc.ca/eng/1100100035204/1100100035205

[50] *British Columbia First Nations Enhanced Prevention Services and Accountability Framework*, September 2008.

[51] Enhanced Prevention Framework Workshop Notes, Jan. 29 and 30, 2013, prepared by AAND.

Meetings of the Tripartite Steering Committee are ongoing and work has been undertaken on a *"current state"* agency scan that includes demographics, funding sources and identification of future aspirations. The next step is to canvass DAAs about prevention services they currently provide to identify gaps and to provide the necessary information for developing business plans once an Enhanced Prevention Framework agreement is negotiated. A particular issue to be addressed is developing an effective and efficient method for AAND to fund those First Nations that are not represented by a DAA that takes into account economy-of-scale issues.

Aboriginal Child Welfare Strategy, Policy and Standards

The ministry's current approach to Aboriginal child welfare services is outlined in a number of MCFD materials and documents including the ministry website, its annual multi-year Service Plan and its *Operational and Strategic Directional Plan, 2012/13 – 2014/15.*

The MCFD Service Plan establishes the ministry's core position that *"Aboriginal people need to have responsibility to design and deliver their own child and family service and [the ministry] is committed to implement changes and new approaches to improve the care, safety and well-being of Aboriginal children and families."*[52] It contains broad statements about the ministry's focus on partnership with DAAs in the delivery of services and with Aboriginal communities *"to improve services and outcomes for Aboriginal children, youth and families with the vision of Aboriginal children and youth living in healthy families strongly connected to their culture, language and traditions."*[53]

The ministry Service Plan includes one performance measure for Aboriginal child welfare services related to the proportion of *"Aboriginal children cared for through Aboriginal communities and providers."* The belief appears to be that if Aboriginal children who have had to leave their parental home receive services through an Aboriginal service system, so that the connection to their culture and tradition is maintained, this may over time help to reduce the percentage of Aboriginal children in care.[54]

To support and guide the ministry in achieving its goals and objectives, MCFD has developed an *Operational and Strategic Directional Plan 2012/13 – 2014/15.* The *Operational and Strategic Directional Plan* also contains high-level statements about the ministry's commitment to work in partnership with DAAs and other community partners in parallel to strengthen MCFD practice and to ensure that Aboriginal communities have access to a full range of quality services – effective, client-centred, safe, accessible and appropriate services – that reflect and support culture and tradition.[55] As well, it outlines the ministry's intention to engage in and support community development to help communities build healthy families through strengthening their culture, language and tradition and to work to *"continually clarify and strengthen [its]*

[52] *MCFD, 2012/13 – 2014/15 Service Plan.*
[53] *MCFD, 2012/13 – 2014/15 Service Plan.*
[54] *MCFD, 2012/13 – 2014/15 Service Plan.*
[55] *MCFD Operational and Strategic Directional Plan 2012/13 – 2014/15.*

meaningful, practical and functional partnership with Aboriginal leadership and their communities that is responsive to the evolving legal and political aspirations related to self-governance and jurisdiction." [56]

The *Operational and Strategic Directional Plan* was preceded by the MCFD *Strong, Safe and Supported Action Plan* (2008) that also included a specific focus on Aboriginal children, youth and their families.[57] High-level actions articulated under that plan included supporting Aboriginal leaders and service providers including DAAs in achieving governance of Aboriginal child welfare, and continuing the devolution of decision-making and service delivery through mechanisms such as DAAs and the proposed Aboriginal Authorities. However, the Representative notes that within the same year that *Strong, Safe and Supported* was unveiled, the Aboriginal Authorities initiative was halted. This left a formal policy vacuum that has continued to the present.

The *Operational and Strategic Directional Plan* outlines some *"key actions"* in the area of child welfare to be taken to improve outcomes for Aboriginal children and families, including:

- building cultural competencies into practice;
- increasing community-based initiatives;
- working with DAAs and AAND to advance the implementation of a more effective funding approach for First Nations on-reserve voluntary and non-voluntary services to improve access and close the gap in service quality; and,
- establishing effective partnership forums to ensure full engagement of Aboriginal communities, DAAs and Aboriginal community service agencies in planning for services for Aboriginal children, youth and families.

Another key action area outlined in the *Operational and Strategic Directional Plan* is to work with community partners to clarify outcomes and measures of success for Aboriginal children, youth and families.

To support effective decision-making at all levels, the ministry is supposed to produce a report, semi-annually, outlining a range of operational and performance indicator data. The first two *Operational Performance and Strategic Management Reports*, posted April 9, 2013 for the reporting period April to September 2012, and Oct. 4, 2013, for the reporting period October 2012, to March 2013, contain some limited data and miscellaneous information relating to Aboriginal services. In these reports, the ministry indicates that it needs to work with DAAs and community social service providers to fill the data shortfalls regarding Aboriginal service delivery.

[56] MCFD *Operational and Strategic Directional Plan 2012/13 – 2014/15.*
[57] MCFD *Strong, Safe and Supported Action Plan, 2008.*

Aboriginal Policy and Practice Standards

MCFD has in place comprehensive Child and Youth Safety and Family Support Policies and Child and Family Development Service Standards that guide practice for the delivery of child welfare services by the ministry. Incorporated within these policies and standards are broad requirements to meet the *CFCS Act* requirements of ensuring that services are provided in a culturally sensitive and appropriate way. There are also established policies and practices for involving Aboriginal families and communities in planning for a child.

In the 1990s, DAAs were given the choice of developing their own child welfare standards. They were to be equivalent or better than the ministry's. DAAs chose to develop their own standards and, in 1999, a draft of the Aboriginal Operational and Practice Standards and Indicators (AOPSI) was implemented. AOPSI was revised in 2005.

In spring 2009, a review of AOPSI, led by the Caring for First Nations Children Society, was initiated with the goal of revising the standards to reflect an Indigenous worldview and consideration of Aboriginal beliefs, values and cultural traditions, *"while also meeting legislative requirements."*[58] This process produced a re-draft of AOPSI in May 2012.

MCFD has recently proposed integrating the revised final draft of the AOPSI into an overarching Aboriginal Practice Framework that it is proposed will guide child welfare services to Aboriginal children in B.C. DAAs and MCFD are developing terms of reference and a project charter to guide this work. The results of this collaborative project to amend and combine AOPSI and ministry standards are intended for public release when complete.[59] The Representative notes that it is unclear when this will happen, as this process has been slowed by MCFD changing direction repeatedly over the past 15 years.

Compliance with standards is audited by MCFD's case practice audit program. The audit program is intended to support and improve practice by social workers in delivering child welfare services by identifying practice strengths, areas requiring improvement and supporting ongoing development of good practice and individual and organizational learning.

DAAs are also subject to regular audits conducted on a three-year cycle. The DAA audit process is not integrated into the ministry's quality assurance program.

Practice audit results for DAAs are posted by MCFD on the First Nations Directors' Forum website (the Directors' Forum is comprised of executive directors of First Nations Child and Family Service Agencies in B.C.) The latest audit posted was for an audit completed in October 2012.[60] A Feb. 1, 2012 overview note about DAA case practice audits posted on the Forum website notes the compliance challenges for DAAs such as that "the analysis of compliance rates for agencies is complex given the levels of delegation and unique challenges of social work in a delegated agency; there are also unique challenges to service delivery including: large geographic service areas,

[58] *Starting from a Traditional Place: Aboriginal Operational and Practice Standards and Indicators*, May 2012.
[59] MCFD information, August 2013.
[60] First Nations Directors' Forum, http://www.fndirectorsforum.ca/quality-assurance/audit-process/agency-audits

isolation, and limited community resources; delegated Aboriginal Agencies also operate independently of one another, further increasing differences in compliance."[61]

Despite the compliance challenges with practice standards for DAAs, some notable progress has been achieved. This includes Kw'umut Lelum Child and Family Services that, within six months of having its completion of Comprehensive Plans of Care tracked by MCFD, increased its completion rate for plans for children it serves by 97 per cent. This is in stark contrast to the five per cent provincial compliance rate for children in care of the ministry and DAAs noted in the Representative's 2013 report *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care.*[62]

Over the past decade, the ministry's quality assurance function has suffered periods of inattention and inactivity resulting in a rupture in accountability. Between April 2003 and June 2005, during the period of decentralization and transfer of responsibility to the regions, practice audits were suspended and there was a backlog in case reviews. Insufficient resources, lack of planning and training for the transfer of this responsibility to the regions, and inadequate capacity in MCFD headquarters led to these deficiencies.[63] Following a renewed focus in June 2005 on the quality assurance function, the volume of case practice audits declined substantially when the ministry began the redesign of its quality assurance program in 2007/08. This redesign led to the development of the Service Quality Evaluation process, which was never implemented because it was determined by both the deputy minister of MCFD at the time and the Representative that it was insufficient to assess good practice.

MCFD is currently in the process of redesigning its case practice audit program and has developed a new compliance-based practice audit program with four components: family service, child service, resources and adoptions. Case practice audits are to be conducted by regional auditors on a three-year cycle in accordance with standardized methodologies, procedures and tools. The family service audit program was piloted provincially in November and December 2012. A three-year cycle of family service practice audits commenced in March 2013, as well as pilots for the child service, resources and adoption practice audits.[64] The application of the new compliance-based practice audit program to DAAs is still under consideration.

[61] Posting of Delegated Aboriginal Agency Case Practice Audits Confidential Overview Note, February 1, 2012, http://www.fndirectorsforum.ca/downloads/posting-audits-overview-note-feb-2012-2.pdf

[62] B.C. Representative for Children and Youth, *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care.* (March 2013)

[63] Hughes Review, page 30.

[64] MCFD website, Case Practice Audits, http://www.mcf.gov.bc.ca/about_us/case_practice_audits.htm

Aboriginal Child Welfare Governance and Service-Delivery Initiatives

MCFD Core Review Service Changes, 2001 to 2005

Significant changes to the child welfare system as a whole occurred as a result of the provincial government's Core Review and Deregulation Task Force process (Core Review) in 2001.

The change in government in 2001 came with a fundamental shift in philosophy about what business government should be in and how government services should be delivered. This resulted in a significant impact on service delivery for all ministries. The government's intent was to decentralize, focus on core services and get out of providing services that one could find in the Yellow Pages. It looked to reduce the overall costs of government significantly, move delivery of services as close as possible to the community where the services were needed, and move from in-house government delivery of public services to delivery by external providers. This shift was designed to achieve efficiencies and provide greater competitive opportunities to the non-profit or private sectors to compete for service-delivery contracts.[65]

In 2001, MCFD, like all government ministries and agencies, went through an initial Core Review process to determine the most efficient and effective way to provide services. The Core Review concluded that the systems in place to support and care for vulnerable children and families were dysfunctional and unsustainable over the long term and MCFD was directed by government to implement a new vision and six *"strategic shifts"* to its multi-year Service Plan. These included: building capacity within Aboriginal communities to deliver a range of services; creating a community-based service-delivery system promoting choice, innovation and shared responsibility; and enabling communities to develop and deliver services within a consolidated, community-based service system. Another strategic shift was one from intervention to prevention.

The Core Review also had a focus on deregulation across government intended to streamline government requirements and processes and eliminate red tape. For MCFD, this deregulation focus meant moving away from centrally controlled processes and extensive reporting and monitoring to a more decentralized and less regulated approach to the delivery of services. Prescriptive language was removed from policies and standards.

The Core Review direction and the six strategic shifts were built into MCFD's 2002/03 to 2004/05 Service Plan. Based on a series of discussions and decisions at the Cabinet level, a vision of a new service-delivery model was conceived that would see the establishment by spring of 2004 of five Non-Aboriginal Regional Authorities, five Aboriginal Regional Authorities, a Community Living Authority (an independent body

[65] New Era and Core Review and Deregulation Task Force documentation.

responsible for services for children and adults with cognitive/developmental disabilities), and a Shared Services Provincial Authority (to provide finance and administrative services to the Regional Authorities).

By April 2002, MCFD had reduced its number of administrative regions from 11 to five, paving the way for the move to a Regional Authorities structure and continued to plan for a move to a community-based delivery system. In line with the deregulation and decentralization philosophy and approach, MCFD provided greater local authority to the regional leads. In 2008, the position of Provincial Director of Child Welfare was abolished. (This position was re-established in March 2011 to ensure province-wide integration of policy and service standards.[66])

A mid-term review in 2003 of MCFD's Core Review progress resulted in a significant number of course corrections.[67] The ministry was found to have placed too much emphasis on its regional governance initiatives and was directed to refocus its efforts on transforming MCFD service delivery and achieving budget reductions. As part of this redirection, the concept of moving to Non-Aboriginal Regional Authorities and the creation of a Shared Services Provincial Authority were abandoned. The commitment to the concept of Aboriginal Regional Authorities was confirmed but was refocused on building Aboriginal capacity to ensure the readiness of Aboriginal communities to assume responsibility for service delivery and governance of the Aboriginal child welfare system.

The government's overall objectives for MCFD based on its Core Review were to significantly reduce the overall cost of delivering child welfare services by 23 per cent or more by 2004/05, transform service delivery, and decentralize the welfare delivery system by moving to regional delivery within a more compact ministry regional structure.[68] Aside from the establishment of Aboriginal child welfare authorities (discussed below), these activities were largely achieved by 2005. The ministry's regional structure was streamlined, Community Living BC was established, the role of alternative service providers was enhanced, prescriptive policy and standards were reduced and controls decentralized, the program focus was changed from intervention to prevention, and extensive budget reductions had occurred.

Regional Aboriginal Authorities, 2002 to 2009

A key element of MCFD's Core Review service-delivery initiative was to move to a community-based service-delivery model through the establishment of Regional Authorities. It was envisioned that regional Non-Aboriginal and Aboriginal Authorities would be responsible for child welfare service delivery at the community level in order to promote choice, innovation and shared responsibility.

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[66] BC Government Newsroom. "New Provincial Director of Child Welfare appointed," http://www.newsroom.gov.bc.ca/2011/03/new-provincial-director-of-child-welfare-appointed.html

[67] Undertaken by Sage Group Management Consultants.

[68] MCFD, Child and Family Development Budget Management Plan Presentation to Regional Planning Chairs, January 2003.

At the beginning, planning activities were focused at the regional community level and Aboriginal communities were empowered to develop custom service-delivery and governance options reflecting community needs. Despite the Core Review direction about the need for Aboriginal capacity building, this was not a focus in the early stages of the initiative.

External consultants involved in the mid-term Core Review advised the ministry that the Aboriginal governance project initiative should be delayed until MCFD's new service-delivery model, budget reductions and financial controls were in place. Following this, a more streamlined governance structure could then be considered.[69] The ministry did not take this advice, but rather shifted its focus from organizational governance structuring to service-delivery modeling and capacity building. Building capacity with Aboriginal communities to deliver a range of services became important readiness criteria that would have to be met before any Aboriginal Authority was established. In addition, appropriate service-delivery models were to be developed prior to finalizing governance structures.

In late 2003, the ministry also contemplated replacing the concept of five Regional Aboriginal Authorities with one provincial Aboriginal/Non-Aboriginal Authority,[70] but this blended model was not supported by the Aboriginal leadership. As an alternative, the government then suggested establishing two provincial authorities – one Aboriginal and one Non-Aboriginal, but the concept never materialized and the ministry continued with its plan for five Aboriginal Authorities.[71]

By spring 2004, the ministry was beginning to fully grasp that the *"magnitude of the change was truly immense."* The ministry refocused on Aboriginal capacity building and placed a greater emphasis on service delivery and introduced a three-year phased-in approach to Aboriginal governance.[72] While the ministry continued to support the concept of establishing Aboriginal Authorities for the balance of the project, timelines for establishing permanent authorities shifted to 2007.[73] In addition, the earlier regionally based approach to planning and project management was replaced by a more centrally controlled province-wide approach.

Prior to the 2004/05 fiscal year, the Regional Aboriginal Planning Committees had been empowered to drive the planning process. Extensive community consultation processes had occurred during this early period resulting in the development, in some cases, of initial business plans and conceptual service-delivery and governance models that were not approved by the ministry and/or found to be of unacceptable quality.

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[69] New Era and Core Review and Deregulation Task Force documentation.
[70] MCFD. Briefing Note. Nov. 21, 2003, Topic: Formation of provincial Interim authority(ies) for Aboriginal child and family development.
[71] MCFD. Letter to Joint Aboriginal Management Committee from Honourable Gordon Hogg. Nov. 27, 2003.
[72] MCFD. Decision Note, Topic: Prepared for Minister Christy Clark for Decision with regards to the approach for governance. March 11, 2004.
[73] MCFD Transition Binder. September, 2004.

A provincial Joint Multi-Year Plan Towards Regional Aboriginal Authorities and accompanying Joint Multi-Year Master Project Plan developed by MCFD and the Aboriginal leadership by the end of 2004 called for each region to develop and undertake activities over a three-year period to achieve the five Regional Aboriginal Authorities. The joint multi-year plan outlined the necessary elements, activities, timelines and commitments required to achieve five permanent Regional Aboriginal Authorities:

Phase 1 – 2004/05: Develop and confirm service-delivery models

Phase 2 – 2005/06: Develop service-delivery plans

Phase 3 – 2006/07: Commence the incremental transfer of operational responsibility to the five Regional Aboriginal Authorities based on a joint determination of readiness[74]

The deliverables associated with each phase were soon behind schedule. For example, the delivery date for the service-delivery models was moved from 2004/05 to 2005/06.

In 2005, the five Regional Aboriginal Planning Committees that had been established to plan for the implementation of the Interim Regional Aboriginal Authorities were required to sign a protocol, a financial management and business plan and budget agreements with the ministry to ensure that accountability, transparency and performance targets were met. Budgets were not approved without an approved annual business plan for each of these five committees. These five committees were financially supported by the ministry until very late into the project – the 2008/09 fiscal year.

Regional Aboriginal Planning Committees and the subsequent Interim Authorities were expected to have an inclusive planning and consultation process with every individual First Nation and DAA, as well as Métis and urban organizations, in their particular region. The intent of the process was to ensure that permanent authorities and/or other community-based decision-making structures would meet the needs of Aboriginal communities. To become Interim Authorities, the planning committees were expected to establish financial controls, have an approved service-delivery model and have negotiated agreements on infrastructure, accountabilities, communication, and selection and appointment processes.[75]

In January 2007, Cabinet approved the creation of Interim Authorities for the Vancouver Island and Fraser Regions.[76] These two Interim Authorities were in place by June 2007 and were set up as Crown Agencies reporting directly to the Minister of Children and Family Development, Treasury Board and the Legislature. A government-approved Shareholder's Letter of Expectation for each Interim Authority outlined its mandate to plan for the creation of permanent authorities including the transfer of responsibilities and resources from MCFD. All the implementation planning was to be completed by March 31, 2008.[77]

[74] MCFD, PowerPoint Presentation. Joint Multi-Year Plan Toward Regional Aboriginal Authorities. Aboriginal Chairs Caucus. Sept. 27, 2004.

[75] MCFD Decision Note. Topic: Prepared for Deputy Minister. Decision with regards to establishing five Regional Interim Aboriginal Authorities pending achievement for five prerequisite factors. Jan. 18, 2005.

[76] MCFD Information Note: Prepared for Minister for Decision. May 31, 2007.

[77] MCFD Government's Letter of Expectation between Minister of Children and Family Development and the Chair of the Fraser Region Aboriginal Authority. Sept. 16, 2007.

The two Interim Authorities remained focused on planning and never did deliver services. The other three regional planning committees continued to work towards achieving the same recognition as an Interim Authority, but never achieved that status.

Between 2003 and 2008, attempts were made to develop and introduce legislation enabling the establishment of permanent Regional Aboriginal Authorities throughout the province. The *Community Services Interim Authorities Act,* allowing for the creation of Interim Authorities in each of the five regions in preparation for the transfer of authority to permanent regional authorities, had been passed and proclaimed in October 2002. To support the initial aggressive 2004 timeline for the establishment of permanent Regional Authorities and the Provincial Common Services Authority, the proposed *Community Services Authority Act* was introduced in 2003. This legislation was soon placed on hold.

In March 2006, a subsequent attempt at legislation, the proposed *Regional Aboriginal Authority Act*, was also placed on hold. In spring 2008, MCFD again developed and presented to Cabinet legislation to enable the establishment of permanent Aboriginal Authorities. A plan to introduce the proposed bill in the Legislature was abandoned at the last minute.

None of the attempts in the spring of 2003, 2006 and 2008 to establish legislation supporting the creation of permanent Aboriginal Authorities succeeded. In the end, the *Community Services Interim Authorities Act* was the only legislation passed respecting the initiative. The 2006 and 2008 attempts were shelved because the Aboriginal leadership felt that more consultation with Aboriginal communities was required prior to their introduction.

In 2008, the Aboriginal Leadership Council opposed further attempts to create the Regional Authorities or any additional Interim Authorities or boards until further consultation occurred.

Although the 2003 mid-term review had reaffirmed the commitment to Regional Aboriginal Authorities, by the spring of 2007 the ministry was openly recognizing that *"progress towards Aboriginal governance of child and family services has been slower than anticipated…."*[78] The ministry began to question whether or not regional authorities were the best approach to regional governance and was considering alternative models.[79] In March 2009, the two existing Interim Authorities and their boards were formally dissolved and the initiative was abandoned.

In the end, $34.679 million was expended on the Regional Aboriginal Authorities initiative. No change was implemented. There is no documentation to indicate that children received any additional services as a result of these expenditures.

[78] MCFD, Questions and Answers related to the establishment of Interim Authorities. May 15, 2007.
[79] MCFD. Questions and Answers related to the establishment of Interim Authorities. May 15, 2005.

Table 4: Regional Aboriginal Authorities Initiative, Expenditures 2002/03 to 2008/09

	Expenditure ($millions)							
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Total
Aboriginal Planning Committees and Interim Authorities								
Vancouver Island Region	0.680	0.191	0.320	0.506	1.587	0.318	–	3.602
Interim Authority VIATA	–	–	–	–	–	1.366	1.630	2.996
Northern Region	0.830	0.204	0.369	0.601	0.500	1.000	0.460	3.964
Fraser Region	0.630		0.302	0.506	1.312	0.487	–	3.237
Interim Authority FRIAA	–	–	–	–	–	0.813	0.920	1.733
Interior Region	0.860	0.290	0.395	0.601	1.331	1.000	0.750	5.227
Vancouver Island Coastal Region	0.860	0.345	0.015	0.506	0.825	1.000	0.438	3.989
Sub-total	**3.860**	**1.030**	**1.401**	**2.720**	**5.555**	**5.984**	**4.198**	**24.748**
Aboriginal Political Organizations*	0.800	–	0.280	0.280	0.350	0.350	0.350	2.410
MCFD Assigned / Dedicated Staffing Costs**	0.210	0.292	0.375	0.640	0.656	0.672	0.688	3.533
Pilot Projects***	–	–	–	–	0.746	1.301	1.941	3.988
Total Funding Aboriginal Authorities Initiative	**4.870**	**1.322**	**2.056**	**3.640**	**7.307**	**8.307**	**7.177**	**34.679**

* BC First Nations Summit, BC Assembly of First Nations, Union of BC Indian Chiefs, United Native Nations and Métis Nation of British Columbia were funded to assist these organizations in participating in Aboriginal Caucus Committee and Joint Aboriginal Management Committees.

** During the initial years, staff were also responsible for Community Living British Columbia devolution and non-Aboriginal governance issues in addition to Aboriginal governance matters.

*** From fiscal year 2006/07, additional pilot projects and activities were supported to explore and guide Aboriginal governance issues. The focus for funding was on the development of community-driven service-delivery approaches involving First Nations people and elders.

Indigenous Approaches, 2009 ongoing

While abandoning the Regional Aboriginal Authorities model, the ministry did not abandon its commitment to the transfer of responsibility for Aboriginal child welfare to Aboriginal communities, and its commitment to Aboriginal jurisdiction over Aboriginal services.

In 2006/07, notwithstanding that its Regional Authority initiative was still ongoing, the ministry began accelerating the transfer of child welfare services to DAAs. The ministry also continued to expand its options for Aboriginal child welfare service delivery through Aboriginal foster care providers or Aboriginal friends and family, with the stated objective being to *"increase the number of Aboriginal children who remain connected to Aboriginal caregivers."* MCFD Service Plans and other planning documents[80] continued to affirm the ministry's recognition and support for Aboriginal peoples' jurisdiction in delivering child and family services.

In 2009, First Nations leadership (comprised of First Nations Chiefs from each of the regions) established the Interim First Nations Child and Family Wellness Council to explore models for exercising Aboriginal jurisdiction, including what was called a Nation-to-Nation model for working with the ministry to develop capacity in their communities. Subsequently, MCFD and

[80] MCFD, *2010/11 to 2012/13, 2011/12 to 2013/14 and 2012/13 to 2014/15 Service Plans; Strong, Safe and Supported Action Plan, 2008*.

the First Nations Summit, the Union of BC Indian Chiefs, and the BC Assembly of First Nations – collectively referred to as the First Nations Leadership Council – jointly signed the *Recognition and Reconciliation Protocol on First Nations Children, Youth and Families,*[81] which underscored the shift in governance approach from a focus on Regional Aboriginal Authorities to one focused on Nation-to-Nation jurisdiction over Aboriginal child welfare services.

The First Nations Child and Family Wellness Council led the development and implementation of an *Indigenous Child at the Centre Action Plan*. The Action Plan, adopted by the First Nations Leadership Council, has the following six goals:

- To create a safe, nurturing environment for the health and well-being of First Nations children, youth, families and communities
- To enable First Nations governance and nation-building
- To participate in the on-going development of culturally appropriate policy and legislation
- To acquire appropriate financial resources and build human resource capacity
- To build effective relationships and partnerships
- To enable information and data development and sharing.

In 2009/10, MCFD proceeded with its Nation-to-Nation initiative, now called Indigenous Approaches, to support the transfer of authority over child welfare services to individual First Nations communities by providing funding to First Nations to establish *"community development and service development in relation to jurisdiction. The final goal of these projects [is] to determine a process of child welfare governance and then move forward to providing that governance with the support of MCFD."*[82] The problem with this approach, the Representative observes, is that there was no clear overarching direction. There was no comprehensive policy, just a series of adhoc contracts.

Beginning in 2009, proposals were approved for 17 First Nations and/or Aboriginal organizations covering more than 100 First Nations, as well as urban and Métis communities and the First Nations Child and Family Wellness Council. Approved projects were broad in scope. Initial direction from the deputy minister at the time the initiative was launched was to be non-prescriptive and that any proposals received were to be accepted as they were submitted.[83]

Samples of funded projects include:

- Research into service-delivery and governance models, including design and development of community-based and integrated service-delivery models
- Identification and documentation of traditional child welfare practice (including accessing knowledge and learning of community elders)

[81] The Recognition and Reconciliation Protocol on First Nations Children, Youth and Families, http://www.mcf.gov.bc.ca/about_us/aboriginal/pdf/Recognition_Reconciliation_Protocol.pdf
[82] MCFD. Guidelines for Indigenous Approaches Contracts.
[83] MCFD. Guidelines for Indigenous Approaches Contracts.

- Design of governance models for taking on jurisdiction for child welfare
- Community capacity building (including gap analysis)
- Community consultation and engagement processes
- Supporting and enhancing existing community child welfare agencies, including DAAs, to take on authority and responsibility for child welfare services.

Funding was also used to support youth engagement activities to help youth learn about their culture and traditions through culture camps, conferences and gatherings with elders, for community events and feasts and for focus groups and interviews with youth and parents.

The Representative notes that there was a poor policy foundation for these projects regarding how they helped children and no clear approach or rationale for proceeding with them. Most proposals were for three-year projects. In 2009/10, individual contracts ranging from $70,000 to $800,000 were approved. In 2010/11, approved contracts ranged from $70,000 to $1.6 million, and in 2011/12 they ranged from $72,000 to $1.1 million. Between 2009/10 and 2012/13, a total of $31.02 million was expended and committed to Indigenous Approaches contracts. Table 5 provides a list of First Nations and/or Aboriginal organizations funded under the initiative and the amounts of the associated contracts.

Starting in fiscal year 2011/12, management of Indigenous Approaches contracts was aligned with provincial procurement guidelines and contractors were required to submit a logic model work plan with clear deliverables and quarterly financial and progress reports. With respect to the criteria for funding, contractors were advised that MCFD *"cannot support governance and jurisdiction research and processes with this funding, and that by spring 2013, all new contracts and work plans must be focused on community development and service delivery."*[84]

[84] MCFD. Guidelines for Indigenous Approaches Contracts.

Table 5: Indigenous Approaches – Contract Amounts – 2009/10 to 2012/13

	First Nations / Aboriginal agencies	Approved Contract 2009/10	Actual Paid 2009/10	Approved Contract 2010/11	Actual Paid 2010/11	Approved Contract 2011/12	Actual Paid 2011/12	Approved Contract 2012/13	Total Contract Amounts 2009/10 to 2012/13*
1	Aboriginal Children and Families Chiefs' Coalition	$500,000	$500,000	$500,000	$500,000	$450,000	$450,000	$500,000	$1,950,000
2	Carrier Sekani Family Services	–	–	$514,360	$514,360	$514,360	$514,360	$514,360	$1,543,080
3	Chehalis Indian Band (Sts'ailes)	$257,000	$257,000	$617,000	$617,000	$617,000	$617,000	$617,000	$2,108,000
4	Fraser Thompson Indian Services Society (Nlaka'pamux Nation)	–	–	$361,790	$361,790	$181,790	$181,790	$361,790	$905,370
5	Haida Child & Family Services	$453,000	$452,500	$395,000	$395,000	$400,000	$400,000	$49,800	$1,297,800
6	Ktunaxa Nation Council Society	$500,000	$500,000	$250,000	$250,000	$250,000	$250,000	$248,000	$1,248,000
7	Lalum'utul Smun'eem Child & Family Services (Cowichan Tribes)	$150,000	$150,000	–	–	$150,000	$150,000	–	$300,000
8	Métis Commission for Children and Families of BC	–	–	$410,176	$410,176	$386,000	$379,304	$86,000	$882,176
9	Métis Nation BC	$70,000	$70,000	$70,000	$70,000	$163,047	$163,047	$101,200	$404,247
10	Nenan Dane zaa Deh Zona Child & Family Services Society	$800,000	$800,000	$1,600,000	$1,600,000	$1,600,000	$1,055,000	$1,600,000	$5,600,000
11	Nuu-chah-nulth Tribal Council	$160,000	$160,000	$172,000	$172,000	$172,000	$72,000	$100,000	$604,000
12	Office of the Wet'suwet'en	–	–	$400,000	$400,000	$400,000	–	$400,000	$1,200,000
13	Okanagan Nation Alliance	$300,000	$150,000		$150,000	$161,975	$161,975	$161,975	$623,950
14	Sasamans (Our Children) Society	$334,000	$334,000	$632,600	$632,600	$632,600	$632,600	$632,600	$2,231,800
15	Shuswap Nation Tribal Council Society	$250,000	$250,000	$450,000	$450,000	$450,000	$415,000	$450,000	$1,600,000
16	South Island Wellness Society	$510,000	$510,000	$1,029,055	$1,094,055	$848,126	$848,126	$848,126	$3,235,307
17	Stikine Wholistic Working Group (Taku River Tlingit First Nation)	$636,000	$636,437	$1,100,000	$1,100,000	$1,100,000	$1,100,000	$1,002,000	$3,838,000
18	First Nations Child & Family Wellness Council	$619,000	$619,288	–*	–*	$1,000,000	$1,077,800	$775,000	$2,394,000
	Total	$5,539,000	$5,389,225	$8,501,981	$8,716,981	$9,476,898	$8,468,002	$8,447,851	$31,965,730

* The First Nations Child & Family Wellness Council did not receive any funding in 2010/11 due to the time taken to transition funding and operations when the Wellness Council was created as a distinct organization.
[Source: MCFD. Note: Actual Contract Paid Amount not available for 2012/13]

Findings

Overall Finding

Landmark agreements between government and Aboriginal leaders have set the foundation for a new, more positive relationship. Commitments to action include the need to address the dire state of Aboriginal child welfare and acknowledgement that Aboriginal people must be involved in the solution.

Agreements made by B.C. government and Aboriginal leaders created a climate of hope and expectations about a new approach to Aboriginal child welfare; one that would result in meaningful improvements in service for Aboriginal children, youth and their families. MCFD, the administrative body charged with the responsibility for achieving this, has, however, been unable to effectively translate this vision into practical action – action that meets the child welfare needs of Aboriginal children, youth and their families and results in improved services. There is no clear direction as to how the Aboriginal child welfare system will be improved; there is no observable logic between how the current Aboriginal governance and service structure initiatives will improve services and there is no monitoring of the impact of the various initiatives undertaken to date.

Broad statements illustrate MCFD's commitment to improving the state of Aboriginal child welfare through supporting Aboriginal families in caring for their children, and working with Aboriginal communities to build and develop their capacity and strength to care for their members. However, the various activities and initiatives undertaken by MCFD during the past decade have created only an illusion of action and progress; there has been no concrete resulting change in the Aboriginal child welfare service-delivery system or demonstrable improvements in outcomes for Aboriginal children, youth and their families.

Furthermore, attention to improving direct program delivery and services to Aboriginal children, youth and their families has been adversely impacted by the attention focused and resources expended on the various governance and service-delivery structural initiatives – initiatives that have no clear connections to the needs, rights and best interests of the children who should be the focus. Since 2002/03, beginning with the Regional Aboriginal Authorities initiative and continuing with the Indigenous Approaches initiative, more than $66 million has been expended on these change initiatives and not a single child directly served.

Regional Aboriginal Authorities	**$34.68 million**
Indigenous Approaches	**$31.96 million**
Total expenditure Aboriginal initiatives 2002/03 through 2012/13	**$66.64 million**

Aboriginal Child Welfare Program Planning, Management and Accountability

Finding: ***At present, there is no articulated, overarching and comprehensive strategy for delivering Aboriginal child welfare services throughout the province to achieve responsive, effective, accessible, equitable and culturally appropriate services that meet the needs of Aboriginal children, youth and their families and desired health, well-being and social outcomes. Nor has there been effective collaboration and coordination with other B.C. government ministries such as Health and Education to develop an integrated approach to addressing the needs of Aboriginal children, youth and their families.***

There are visionary plans containing high-level statements outlining the commitment to Aboriginal governance, the continuing transfer of responsibility for service delivery and partnering with Aboriginal communities to build capacity and develop quality, culturally appropriate services. There is, however, a disconnect between these Aboriginal governance and service-delivery initiatives and intended outcomes. There is no clear strategic framework articulating the expected outcomes, supported by specific, evidence-based actions, programs and services designed to achieve the intended outcomes. There is no management of these projects and no children receive services from them.

Although the *Operational and Strategic Directional Plan* outlines certain high-level key actions aimed at improving Aboriginal child welfare services, there is no context for how these actions fit within a framework for meeting the needs of Aboriginal children, youth and their families and improving outcomes. For example, one high-level key action is to build cultural competencies but what is meant by cultural competencies is not defined. Although the *CFCS Act* establishes unique requirements related to Aboriginal cultural identity in the delivery of services, it is not clear that culturally appropriate services are embedded in policy and practice, applied consistently throughout the Aboriginal child welfare delivery system and impacting the delivery of services.

Furthermore, although the transfer of responsibility for Aboriginal child welfare to DAAs is in theory based on the concept that delivery of services in a culturally appropriate and sensitive way will have a positive impact on Aboriginal child welfare outcomes,[85] there is no assessment of the outcome or impact of services being delivered by agencies – all that is measured is the number of Aboriginal children served by DAAs.

The same holds true for other articulated *"key actions"* such as increasing community-based initiatives and establishing effective partnership forums to ensure full engagement of Aboriginal communities, DAAs and Aboriginal community service agencies in planning for services for Aboriginal children, youth and families. It is not clear how this will be accomplished and to what end – how will it meet the needs of Aboriginal children and families and what will this do for improving services to Aboriginal children, youth and their families?

Other elements of a comprehensive program management and accountability framework are also undeveloped or insufficient. Data and information on performance is scanty. MCFD explicitly recognizes that it needs to do more in this area, including working with

[85] MCFD, *Revised 2013/14 – 2015/16 Service Plan*, Performance Measure 3.

DAAs and community social service providers to fill the data shortfalls in operational metrics information for Aboriginal service delivery. It also indicates that it needs to work with community partners to clarify outcomes and measures of success for Aboriginal children, youth and families. However, in the absence of a clear, understood and accepted overarching Aboriginal child welfare service framework, any effort to establish meaningful and connected measures will be difficult.

Although MCFD has intentions to report more fully and regularly on its operations and performance through the *Operational Performance and Strategic Management Report*, the information reported is limited in terms of measuring the impact of programs.

Quality assurance responsibilities lie with the province and this has not worked with regard to the audit process and service duty to children and youth. During the last decade, the ministry quality assurance function has suffered due to the focus on the governance and service-delivery structure initiatives as an answer to improved services. When poor results and compliance were uncovered, there was no robust system of follow-up to ensure improved services. There is also a lack of alignment and consistency in the overall quality assurance function with separate processes for ministry child welfare operations and DAAs.

The Representative notes that the Indigenous Approaches agenda was ad hoc and that securing resources for governance consisted of making a pitch to senior officials, who then recommended funding for activities. The financial accounting was too poor to permit assessment of objectives and outcomes. These projects existed outside most government financial and policy frameworks.

The continued absence of an overarching, comprehensive, integrated program planning, management and accountability framework for the delivery of Aboriginal child welfare services in the province designed to meet the needs of Aboriginal children and families will thwart any real progress to improve outcomes.

Adequate and Equitable Funding

Finding: ***The funding of the Aboriginal child welfare service is complex and uneven, hampering the effective, efficient and equitable delivery of services across the province.***

An Aboriginal child who is a Status Indian but does not reside on-reserve, or resides on a reserve that is not served by a DAA, receives the full range of child welfare services funded and delivered by MCFD. If that same child lives on a reserve served by a DAA, he or she receives a more limited range of services focused on protection rather than prevention.

The federal government has recognized and is taking steps to provide additional funding to support prevention services for Status Indian children on-reserve, but very limited progress has been made in implementing the Enhanced Prevention Focus Approach in B.C. Greater effort and attention must be directed to working with the federal government to ensure a fair and sufficient level of funding to support its responsibility

and shared commitment to improving services for First Nations children, youth and their families. MCFD has made no real investment in engaging with the federal government to address the child welfare needs of First Nations people on-reserve.

Failed Governance and Service-Delivery Initiatives

Finding: ***The Aboriginal child welfare governance and service-delivery change initiatives suffer from flaws similar to those affecting the delivery of Aboriginal child welfare service delivery. The specific goals and objectives and intended impact on the delivery of Aboriginal child welfare services were not defined at the outset of the initiatives, or during the process.***

The initiatives were guided by overarching visionary principles of transferring services to Aboriginal authorities, but the end-state goal and intended outcomes were not elaborated. The initiatives also suffered from poor pre-planning, ongoing project management challenges and limited accountability.

Although the Core Review outlined the strategic shifts underlying the transfer of authority to Regional Authorities, it did not articulate the ultimate goal or vision of the new system in terms of its impact on enhancing child welfare services, including how such a service-delivery change would positively impact services and improve outcomes for Aboriginal children, youth and families.

There did not appear to be an overarching, province-wide service-delivery model and supporting governance structure to guide the various regional efforts. The Regional Aboriginal Authorities project overall could be described as planning for implementation without a clear blueprint for the desired end-state of the change process and with the manner of planning varying throughout the project. Increasingly, stakeholders held out no expectations for the success of the initiative. The Representative can only speculate as to why funds continued to be allocated to a project that was seen to be going nowhere.

Lack of an overall vision outlining improved service delivery along with fundamental shifts and changes in direction characterized the Regional Aboriginal Authorities initiative:

- From an early focus on regional governance to one focused on capacity building.
- From a strategy of a comprehensive community-based governance and service-delivery structure through the creation of 10 Regional Authorities (five Non-Aboriginal and five Aboriginal), plus one Provincial Common Services Authority and Community Living BC, to five Aboriginal Authorities and Community Living BC, to one Authority, and then back to five Aboriginal Authorities.
- From an early focus on Regional Aboriginal Planning Committees empowered to develop community-based service-delivery and governance conceptual models, to planning focused within an integrated province-wide Joint Multi-Year Plan, supported by a Master Project work plan.
- From limited financial and planning controls and protocols to more disciplined financial management, business and budget planning and protocol agreements between the ministry and the key planning committees.

- From the target of establishing Regional Aboriginal Authorities by spring of 2004, to the target of April 2008, to not establishing them at all.

The fundamental flaw was the lack of connection to how the rights and best interests of Aboriginal children, who should have been the focus, would be served.

The Indigenous Approaches initiative appears to be following the same path. It is moving forward in the absence of a clear strategic framework outlining how it will improve services and outcomes for Aboriginal children, youth and families, with no obvious integration with other aspects of the Aboriginal child welfare service-delivery system, and with limited accountability. It had an origin in failure of the Authorities process and a position taken that First Nations partners should do what they want and be funded to reflect that.

There does not appear to have been any Cabinet-level consideration and approval of the initiative. There are no clear program funding criteria or objectives published and initially there was no requirement for contract financial reporting or ongoing written progress reports. The general parameters are that projects should support Aboriginal peoples *"developing child and family services approaches based on their unique Indigenous identity that will better serve the children and families in their communities,"* [86] including engaging with First Nations communities to design and develop their own models of care for their children.

The Representative has nothing to evaluate other than a hodgepodge of financial agreements and limited reports. Apart from this report, there has been no evaluation of what these projects have achieved and their impact. The absence of a solid policy foundation for the Indigenous Approaches initiative means that money will continue to be bled out of the ministry without any accountability for the expenditures.

The Indigenous Approaches initiative also creates a further complexity for the ministry in the delivery of Aboriginal child welfare services. This includes integration with its DAA initiative, linking the initiative with its own regional structure of service delivery, and ensuring equitable and integrated service delivery throughout the province. Federal government involvement has also been absent and no serious effort made to bring AAND to the table in the true spirit of collaboration with the best interests of the child as the focus.

MCFD does not appear to have learned from the other Aboriginal governance and service-delivery change initiatives and is again pursuing an initiative with ill-defined goals and no direct connection to meeting the needs of Aboriginal children.

[86] Presentation by Minister of Children and Family Development Mary Polak to the Standing Committee on Aboriginal Affairs and Northern Development: Feb. 8, 2011.

Recommendations

Recommendation 1

That the government of British Columbia, with the leadership of the Attorney General, develop an ***explicit*** policy for negotiation of jurisdictional transfer and exercise of governmental powers over child welfare.

Actions Required to Implement this Recommendation:

- This policy must be developed before any further action relating to Aboriginal self-governance or jurisdiction over child welfare or related services occurs.
- The policy must provide clear technical guidance regarding the capacity, scale and funding for a planned negotiation process so that children and youth will not be left uncertain about service responsibilities or accountability during such negotiations.
- The policy must identify the key triggering steps and ensure that a process of validation and approval at the cabinet level accompanies such decisions given their consequence to the lives of vulnerable children and their families.
- The policy must be consistent with existing public and constitutional law, and take into account a functional understanding of the federal-provincial dimensions of the issues, and a commitment to continue and uphold the human rights of children and youth.
- The policy must ensure that MCFD and human service ministries receive proper guidance in the fundamental requirements of public law and jurisdiction transfer to prevent the situation described in the current report from ever being repeated.

The Attorney General must take the lead responsibility to set out such a policy given that the laws, regulations and administration of services across government are on the table for discussion, and that any such initiative must be appropriate and consistent with constitutional obligations and the machinery of government, courts and public bodies such as the Public Guardian and Trustee. In preparing such a self-government child welfare negotiation policy, the Attorney General must clearly address the following:

- Identifying the parties (i.e. "nations") that enjoy self-government powers and can exercise constitutional jurisdiction, and the representational requirements to validly trigger such a formal negotiation process leading to the exercise of such powers
- Ensuring that the constitutional human rights of children and youth are upheld, including how meaningful access to justice will be maintained, and how they will be consulted or involved in such negotiation processes, and represented in any decision-making process that decides their status
- Developing a process for ratification of new arrangements, including regulation of such a process and recognition of entities to manage the process
- Recognizing scope and scale of new child welfare arrangements, including proscribing any provincial view of a minimum number of children for jurisdiction to be effectively exercised (i.e., must there be an economy of scale for this jurisdiction to be functionally effective?)
- Identifying the various steps required in the negotiation process before any jurisdiction can be recognized and powers transferred, so that technical requirements are satisfied and it will be clear to all if s. 88 of the *Indian Act* (provincial jurisdiction) would no longer apply

continued on next page

Recommendation 1, *continued*

- Identifying which powers the province views as exclusive to the First Nation or shared with the province (i.e., adoptions, child welfare safety, special needs, estate guardianship, health care, education)
- Clearly identifying the scope and scale of legislative amendments, preparation and public announcement of bills, deposit of laws and regulations to support the exercise of jurisdiction
- Identifying how conflicts of laws will be resolved, especially in relation to areas that will impact provincial law, policy and practice, such as family law (personal and estate guardianship), child welfare, child and spousal support and maintenance enforcement, domestic violence protective orders and protective intervention orders
- Identifying the provincial government capacity and commitment to funding for such a negotiation process and whether it is the policy of the province that this be shared with other governments, and the form it will take (e.g., loans and other arrangements to protect existing service budgets from being used for this purpose)
- Determining the numbers of negotiations the province will enter into in each year that the policy will be in place, with a minimum projection for the first five years of such a policy
- Developing any working formula or framework for funding services that may be exercised by the First Nations under their self-government authority at the conclusion of the process (i.e., fund only equivalent services to those provided at the provincial level, or apply another fiscal standard?)
- Defining the legal and political position of the province on the federal government's role as a participant in such negotiations and whether these can proceed to a transfer of power and authority in the absence of the participation and recognition by the federal government.

The draft policy should be prepared by April 1, 2014 and provided to Representative. A final policy should be in place by Sept. 1, 2014.

Recommendation 2

That the Ministry of Children and Family Development take immediate action to suspend open-ended initiatives in its ministry related to Aboriginal governance and organization of child welfare services, develop a clear public policy for delivery of services to Aboriginal children including the roles and operational requirements for delegated Aboriginal Agencies, and re-profile funds to support those much-needed direct services.

Actions Required to Implement this Recommendation:

- Recommendation 1 and the requirement that the Attorney General prepare an appropriate framework policy for jurisdictional negotiations must be immediately communicated within MCFD and to all partners and service providers, and the reasons that a proper policy is needed should be explained to those working in the children and youth services sectors.
- MCFD policy and service delivery must be based on strong collaborative relationships with First Nations and Aboriginal communities that occur as part of the regular process of service delivery, rather than as separately funded initiatives. The collaboration should focus on relationships important to support children, youth and their families.
- It is expected that MCFD will deliver services to Aboriginal children, youth and families across all six of its program areas, with a robust commitment to competency, accessibility, accountability and evaluation.
- MCFD must focus its immediate attention on meeting its responsibilities under the *Child, Family and Community Service Act* and *Adoption Act*, including child safety and guardianship and on resulting service delivery to improve outcomes for Aboriginal children. Specifically:
  - Work with DAAs to focus on service delivery to improve outcomes and compliance with policy, standards and practice and to ensure there is a robust integrated quality-assurance program, with measures when audits determine practice falls below standards
  - Ensure that delegation agreements are current, consistent and appropriate and are aligned with outcomes and a seamless child welfare policy in order to avoid fractured accountabilities and confusion over who is responsible for service-delivery areas and regions
  - Ensure an operational context for the work of DAAs, including clear expectations on scope and scale of the work with a strong focus on effectiveness for service to children and a clear policy on the numbers of children required before an agency can be formed or agreement can be entered into, including upfront acknowledgement of the scale of funding to be expected from MCFD and resulting service requirements
  - Phase out exceptions to the workforce requirements for staff of DAAs over a three-year period so that qualified staff is required throughout the province
  - Ensure that existing DAA staff who did not meet employment pre-qualifications and were granted an exemption are required to complete the equivalent in service training to that required of a non-exempt employee within a reasonable period of time, and that none of those currently employed be "grandfathered" into these positions on a permanent basis, or given an exemption from this requirement
  - Ensure that each Aboriginal child and youth in care has a plan to respect and preserve his or her Aboriginal identity and ties to family, community, and heritage and that each child receives the services required of that plan.

The policy framework for service should be provided to the Representative by Feb. 1, 2014, and finalized for release to service providers and partners by March 31, 2014.

Recommendation 3

That MCFD take the lead in developing a clear plan for B.C. to close the outcomes gap for Aboriginal children and youth across government ministries including Education and Health as well as other service-delivery organizations, with clear targeted outcomes and performance measures that would be applicable on- and off-reserve, and encompass all Aboriginal children and youth regardless of where they reside.

Actions Required to Implement this Recommendation:

The following participants might be involved in the plan and its on-going monitoring:

- Representatives of Aboriginal organizations, including those with a clear mandate, such as First Nations Health Authority, First Nations Education Steering Committee, Friendship Centres, First Nations Schools Association and delegated Aboriginal Agencies
- The Federal government (AAND), which should be encouraged to participate to align any programs, services and outcomes measures for its services or transfers supporting services.

This process must ensure that:

- The discussions are ***not*** a jurisdiction or governance process but are an active effort to close the gap province-wide
- Immediate steps are taken to address deficiencies in key areas (e.g., setting clear high school completion rates and strategies to improve these on- and off-reserve, especially for children in care)
- Intermediate and long-term goals are identified
- Aboriginal youth are engaged in a meaningful way in the plan's creation so that it reflects their rights, views and interests
- There is consistent alignment, funding and provision of child welfare services in B.C. – regardless of whether a child lives on- or off-reserve, is a Status Indian or is served by a delegated Aboriginal Agency or MCFD
- There is stronger accountability and quality assurance with regard to the provision of services and resolution of jurisdictional issues now preventing the equitable provision of services
- Services reflect and facilitate cultural continuity and connection to community, fulfilling the unique human rights of Aboriginal people
- There is a clear policy and resource commitment to supporting Aboriginal families through the Extended Family Program and other kinship care arrangements
- Evaluation is a component of the plan or strategies, with regular public reporting and a yearly report to the Select Standing Committee on Children and Youth.

A progress report on development of the plan to be presented to the Representative by March 1, 2014 and the plan be completed and implementation initiated by June 2014. The first public report to the Select Standing Committee on Children and Youth should be delivered by fall 2014.

Recommendation 4

That MCFD immediately undertake a review of its senior leadership team and develop an action plan to ensure that Aboriginal leaders with expertise in effective child welfare service provision are represented on that team and that an Aboriginal perspective in the ministry's decision-making process reflects the fact that a majority of the children and families the ministry serves are Aboriginal.

Actions Required to Implement this Recommendation:

- Senior leadership must be given accountabilities for identifying when issues pertain to self-government negotiations, and have the required communication expertise to direct these to the appropriate ministry and forum, while maintaining a focus on service-delivery, capacity building and outcomes for children and youth.
- At least one person on the senior executive team must be an Aboriginal person with these competencies, and a senior Aboriginal person must be directly involved in leading each of the six program lines of the ministry's work with similar competency.

A copy of the review and draft action plan to be presented to the Representative by Feb. 1, 2014.

Recommendation 5

That MCFD begin to publicly report semi-annually on the safety and well-being of Aboriginal children receiving services, especially children in care, whether those services were provided through the ministry, a contracted agency, or a delegated Aboriginal Agency.

Actions Required to Implement this Recommendation:

These reports should include:

- Progress at school, including receipt of support services geared to promoting academic achievement where needed
- Participation in early childhood education or child care
- Health status, especially comprehensive assessments of possible developmental delay and the provision of needed therapies and supports
- Special needs and/or mental health assessments and services provided to the child or youth
- Preparation of Comprehensive Plans of Care and Permanency Plans, including cultural plans
- The number of face-to-face visits by guardianship workers in the preceding six months
- The number of moves while in care
- The number and resolution of complaints about services to Aboriginal children and their families
- Efforts to find permanent families for Aboriginal children in care
- Interactions with the criminal justice system – contact with police, criminal charges, sentences and dispositions, including community resolutions such as restorative justice, warnings and findings of fitness to stand trial
- Participation in child protection mediation and family group conferencing
- Efforts to keep Aboriginal children connected with families and communities while in care
- Number of youth agreements and transition agreements
- The well-being of children placed with extended family, including those in the former Children in the Home of a Relative program and children placed through the Extended Family Program
- Efforts to promote the health status and levels of participation in sports and recreational activities by Aboriginal children
- The proportion of Aboriginal children suffering a recurrence of maltreatment, and advocacy services sought and received
- The number of open files and timeliness of work completed, including results of audits and remedial actions, if necessary
- Comparison of services received to those received by non-Aboriginal children.

A draft copy of the reporting plans to be presented to the Representative by March 1, 2014. The first such report should be prepared and released by June 2014.

Conclusion

MCFD is failing in its mandate to set out effective, responsive and culturally appropriate child welfare services to Aboriginal children, youth and their families. There is no durable program with measurable outcomes and improvements, especially in relation to the fundamental legislated requirements for child welfare, or the other MCFD service areas. This area is rife with competing ideas, episodes of activity directed without policy basis, and follows no observable logic, leaving it open to other agendas.

Aboriginal child welfare goals, strategies and intended outcomes are undefined, there is a lack of evidence-based standards and practices, there is a disparity in access and availability of services, and there is a lack of accountability to Aboriginal children whose lives have been impacted by the child welfare system.

It is not clear how ministry programs and services are culturally grounded and whether the transfer of responsibility to DAAs with the goal of maintaining the connection to their culture and tradition is improving child welfare services for Aboriginal children and youth and their families.

Many millions of dollars have been expended by MCFD during the last dozen years on Aboriginal child welfare initiatives – initiatives that have demonstrated no direct benefit in terms of services to Aboriginal children and families. This report underscores not only the failure of the these initiatives to contribute to improved outcomes for Aboriginal children, but also highlights the lost opportunity of the dollars expended on these initiatives to enhancing services to Aboriginal children. At the same time as extensive budget reductions, significant dollars were being allocated to governance and service-delivery change initiatives to the detriment of direct service provision. This has had an enduring impact on child welfare services in the province – a budget has been reallocated without the appropriate framework and without children's best interests as the focus.

It is worth noting what the funding expended on the governance and service-delivery structural initiatives might have bought in terms of direct services to support children and youth. As found by the Representative in her recent report, *Who Protected Him? How B.C.'s Child Welfare System Failed One of its Most Vulnerable Children*,[87] there is a critical deficiency in MCFD's ability to meet the needs of children with complex needs requiring out-of-home care. Money expended on failed governance initiatives could have been directed to the development and maintenance of a robust residential placement system properly staffed and supported to help children with complex needs rather than simply house them.

It is undeniably difficult, complex and challenging to deliver Aboriginal child welfare services in a responsive, effective and culturally sensitive way. There is significant cultural diversity among Aboriginal people in B.C. Aboriginal children in B.C. live in a large

[87] Representative for Children and Youth *Who Protected Him? How B.C.'s Child Welfare System Failed One of its Most Vulnerable Children* (February 2013).

number of small and isolated towns, villages and First Nations communities across the province, with the vast majority of Aboriginal children living in cities and large metropolitan centres. Added challenges include jurisdictional issues and eligibility and funding constraints between the federal and provincial governments dictated in large by the *Indian Act*.

Improving the child welfare system is not a solution in itself for improving the overall conditions for Aboriginal children and families. Other factors relating to community and family stability impact the health, safety and well-being of Aboriginal children. Historic injustices have caused systemic disadvantages leading to poverty, unemployment, substance abuse, inadequate housing, relative isolation and lack of access to social and health supports – all contributing to poor overall outcomes for Aboriginal children and families. However, the existing system is not fulfilling its responsibility with respect to meeting the child welfare needs, rights and best interests of Aboriginal children and youth and providing them with services and support.

The Representative respects the Aboriginal leadership's constitutional right to self determination. By virtue of recent treaty agreements, some First Nations in B.C. have the statutory ability to take down power to change child welfare. Yet, the discussions on governance have produced little practical results for children and youth. The ministry is currently stretched to its limit in serving children and youth and any diversion of funds to future governance initiatives would be catastrophic. As recommended by this report, MCFD should re-profile its funding into direct services for children and leave self-governance initiatives to the Attorney General, who should lead the development of explicit policy for negotiation of jurisdictional transfer and exercise of governmental powers. Such initiatives need to be led by an organization with the capacity, experience and expertise and with funding devoted to that purpose – not funding drawn from the child welfare direct service budget.

Furthermore, any initiative to delegate child welfare authority must have clear parameters – a clear understanding of the ultimate goal and how it will serve children. A devolved system must be built on the foundation that MCFD maintains the ultimate authority and responsibility for the protection of vulnerable children. It must be connected to the mainstream system and be based on common standards to ensure quality and equity of services. As recommended, the path to such a system must include consideration of scope issues and minimum criteria for devolution in terms of size of community and client group, capacity and readiness.

In May 2008, the Auditor General for British Columbia expressed concern that many of the child protection needs of Aboriginal children and their families remained unmet. The Auditor General noted that MCFD change-management practices were not in step with its delivery goals, commented that reporting on the effectiveness of child protection services was lacking and recommended establishing a set of comprehensive measures for the ministry to determine the impacts of its services on Aboriginal children.[88]

[88] *Report #3: Management of Aboriginal Child Protection Services:* Office of the Auditor General of British Columbia: May, 2008.

MCFD must put children at the centre. So, too, must partner governments and agencies. That hasn't been done and the result so far has been significant expenditures without results.

The recent approaches have not helped to allay the fear that Aboriginal families harbour about government's involvement in their lives. Instead, these approaches have caused confusion and distracted from real issues, creating a climate of expectations with no concrete improvements to actual services.

The ministry needs to re-focus, and dedicate the time and effort required to develop and articulate a plan for a cross-government overarching Aboriginal child welfare service-delivery program designed to close the outcome gaps in the lives of Aboriginal children compared to their non-Aboriginal counterparts. The program must be based on an understanding of the needs of Aboriginal children, youth and their families, be grounded in evidence-based strategies and practices and collaboration, not governance. Intended outcomes must be clearly defined and regularly monitored to determine the effectiveness of services and to inform corrective action, including the adjustment or cancellation of ineffective services and the reallocation of resources to effective services. The development of this plan must include collaboration with the ministry's key partners in Aboriginal child welfare service delivery – AAND, DAAs, other human service ministries, the First Nations Health Authority, First Nations Education Steering Committee, Friendship Centres, the First Nations Schools Association and others – to identify the design and delivery of services and the governance, service-delivery and funding responsibilities to best meet the needs of Aboriginal children, youth and families in the province.

In developing this plan, the ministry must explore and address a number of fundamental issues including:

- Why is the proportion of Aboriginal children in care continuing to increase, while the number of non-Aboriginal children in care is declining?
- Do these trends relate specifically to issues in the child welfare system or are other factors affecting these trends which must be addressed in an integrated way?
- What elements of the current Aboriginal service-delivery model are working well? What is not working well? Is it possible to determine what is working well and what is not working well? Is there any evaluative data to support these determinations?
- What outcomes or results would be expected from an ideal model in terms of improving the lives of Aboriginal children and youth? What do Aboriginal people want with respect to Aboriginal child welfare services?
- Given the desired ultimate outcomes, what does the Aboriginal child welfare service-delivery system need to provide? What needs to change?
- What can be learned from the province's own experience and the experiences in other jurisdictions to inform the development of the B.C. system of Aboriginal service delivery and governance?

Appendix 1: Documents, Information and Reports Reviewed

Legislation

British Columbia. *Adoption Act*. R.S.B.C. 1996. Ch. 5.

British Columbia. Bill 65 – 2002 *Community Services Interim Authorities Act.* 3rd Session, 37th Parliament. THIRD READING on the 29th day of October, 2002. (Cliff # 9488)

British Columbia. *Child, Family and Community Service Act*. R.S.B.C. 1996. Ch. 46 (as amended).

British Columbia. *Representative for Children and Youth Act.* S.B.C. 2006. Ch. 29 (as amended).

MCFD Documents

AGTI Consulting Services (West) Inc. Due Diligence and Preparation for Child and Family Service Delivery Governance: A Proposed Work Plan Approach for Aboriginal Interim Authorities. April 28, 2003. (Cliff # 6569)

KPMG Consulting. Authority Readiness Criteria to support the transfer of responsibilities. Prepared for the Ministry of Children and Family Development. Revised November 20, 2002. FINAL. (Cliff # 9480)

KPMG Consulting. Ministry Readiness Criteria. Prepared for the Ministry of Children and Family Development. Draft 2. October 03, 2002. (Cliff # 10299)

KPMG Consulting. Public Services. Readiness Criteria Key Lessons Learned from Other Jurisdictions. Prepared for the Ministry of Children and Family Development. August 19, 2002. (Cliff # 10299)

KPMG Consulting. Regional Authority Readiness Criteria. Prepared for the Ministry of Children and Family Development. August 19, 2002. (Cliff # 10299)

Ministry of Children and Family Development. A Guide to Establishing Interim Authorities' Readiness for Transition to Permanent Authorities. Prepared by BearingPoint for Regional Interim CEO's. March 14, 2003. (Cliff # 6560)

Ministry of Children and Family Development. 2008/09 Annual Service Plan Report.

Ministry of Children and Family Development. Board Governance. Emails and attachments related to Comparing Legislation Related to Board Development for New Authorities and Jurisdictional Review. September 23, 2005. (Cliff # 9165)

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Ministry of Children and Family Development. Briefing Note Prepared for Deputy Minister, Lesley du Toit and Acting Deputy Minister Arn van Iersel. For a meeting of the Joint Aboriginal Management Committee (JAMC) on May 5, 2006. Debra Foxcroft, Chair of the Aboriginal Chairs Caucas (ACC) asked for "Stabilized funding for Regional (Aboriginal) Planning Committees be an agenda item for the JAMC meeting." March 10, 2006. (Cliff # 10043)

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Ministry of Children and Family Development. Decision Note Prepared for Deputy Minister Alison MacPhail. With regard to Vancouver Coastal Aboriginal Planning Committee. September 01, 2004. (Cliff # 8569)

Ministry of Children and Family Development. Decision Note Prepared for ADM Lenora Angel for Executive Decision. With regard to planning and funding options for Aboriginal planning. November 23, 2004. (Cliff # 7725)

Ministry of Children and Family Development. Decision Note Prepared for Deputy Minister Alison MacPhail for Executive Decision. With regards to establishing five Regional Interim Aboriginal Authorities pending achievement of five prerequisite factors. January 18, 2005. (Cliff # 6137)

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Ministry of Children and Family Development. Framework. Proposed Devolution Project Framework. Presentation to Transition Managers and Regional Aboriginal Coordinators by MCFD. January 23, 2004. (Cliff # 6473)

Ministry of Children and Family Development. Framework. Project Management Framework Meeting in Vancouver, BC. MCFD, Regional Coordinators and Transition Managers in attendance. January 29, 2004. (Cliff # 6500). Links to Cliff # 6491: Working Group Terms of Reference.

Ministry of Children and Family Development. Framework. Child and Family Development Move to Community-based Governance Project Management Framework Summary. February 03, 2004. (Cliff # 6485)

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Ministry of Children and Family Development. Framework. Project Management Framework: Transition to Community Governance. Version 2. February 13, 2004. (Cliff # 6480)

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Ministry of Children and Family Development. Information Note Prepared for Minister (Ministry Cliff # 137692). Membership and Staffing of the Vancouver Coastal Aboriginal Planning Committee. September 28, 2004. (Cliff # 8568)

Ministry of Children and Family Development. Information Note Prepared for Special Advisor to the Premier Lesley du Toit for Information. Regarding the Aboriginal Provincial Forum scheduled for April 21, 22, 2006 plus agendas. April 07, 2006. (Cliff # 7335)

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Ministry of Children and Family Development. Information Note Prepared for Minister Tom Christensen for Information Regarding Permanent Authorities. June 21, 2007. (Cliff # 6044)

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Ministry of Children and Family Development. Information Note Prepared for Deputy Minister Lesley du Toit for Information. Regarding a briefing with Chris Trumpy, Deputy Minister of Finance to request a special arrangement to the Treasury Board Guideline 1/08. August 3, 2007. (Cliff # 5428)

Ministry of Children and Family Development. Information Sheet. Permanent Authorities legislation Overview Draft. September 06, 2007. (Cliff # 6121)

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Ministry of Children and Family Development. Issues Note (Confidential) Prepared for Minister Stan Hagen. Final Advice to Minister on Aboriginal Governance. March, 2006. (Cliff # 7682)

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Ministry of Children and Family Development. Joint Multi-Year Plan Toward Regional Aboriginal Authorities. Power Point Presentation to Aboriginal Chairs Caucus. September 27, 2004. (Cliff # 10496)

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Ministry of Children and Family Development. Aboriginal Caucus Committee/MCFD Committee Meeting. November 29, 2005 – includes Summary of Changes to the Joint Multi-Year Workplan. (Cliff # 7873)

Ministry of Children and Family Development. Joint Multi-Year Workplan Master Project Plan. September, 2006 Version – Draft pending ACC/MCFD approval. (Cliff # 6092)

Ministry of Children and Family Development. Master Project Plan – Working Group Composition, Scope and Deliverables. Draft. April 18, 2005. (Cliff # 8017). Updated version: September 21, 2007 (Cliff # 6013)

Ministry of Children and Family Development. JAMC Joint Multi-Year Workplan 2005-2006. April 01, 2005. (Cliff # 7525)

Ministry of Children and Family Development. Establishment of the Joint Multi-Year Plan. Prepared for Transition Binder May, 2005. (Cliff # 6106)

Ministry of Children and Family Development. Legislative Package related to development of new act: Regional and Aboriginal Authority Act. Prepared for Legislative Review Committee. Submitted by Honourable Gordon Hogg for Spring 2003 Legislative Session. March 11, 2003. (Cliff # 8922 – 8931). Package contains draft copy of proposed Act (Cliff # 8922), Section Notes (Cliff # 8928), Briefing Note (Cliff # 8929), Regulatory Criteria/Exemption Form (Cliff # 8930), Table of Contents for the Questions and Answers to the Regional and Aboriginal Authorities Act (Cliff # 8931), Answers to Questions outlined in Cliff # 8931 (Cliff # 8931)

Ministry of Children and Family Development and Legislative Advisory Working Group. Consultation on Proposed Content of a Bill for an Aboriginal Authorities Act for Spring 2006 Session for distribution by Legislation Advisory Working Group. February 02, 2006. (Cliff # 9030)

Ministry of Children and Family Development. Legislation. Legislation Advisory Working Group List of Issues from All Meetings and Recommended Changes to Draft Legislation. February 09, 2006. (Cliff # 10551)

Ministry of Children and Family Development. Letter from Minister Gordon Hogg to Joint Aboriginal Management Committee. Re: Provincial Interim Authority Structure. November 27, 2003. (Cliff # 9485)

Ministry of Children and Family Development. Letter from Minister Gordon Hogg to those individuals being appointed as members of the new Provincial Interim Authority for Aboriginal Child and Family Development Services. Includes MCFD Deputy Minister Chris Haynes and Chairs of Five Aboriginal Planning or Transition Councils. January 12, 2004. (Cliff # 9475)

Ministry of Children and Family Development. Letter from Minister Gordon Hogg to Debbie Abbott, Chair Interior Regional Aboriginal Transition Council. Letter of Instruction. January 14, 2004. (Cliff # 8367)

Ministry of Children and Family Development. Letters from Assistant Deputy Minister Jeremy Berland, Child and Development Services – Transformation and James Gorman, Executive Financial Officer to each Interim CEO for each Region. Re: 2004/05 Regional Budget and Accountability Memorandum. February 24, 2004. (Cliff # 13696)

Ministry of Children and Family Development. Letter from Deputy Minister Alison MacPhail to Glen Schmidt, Associate Professor and Chair of Social Work, University of Northern British Columbia. Re: Concerns about discontinuing Regional Transition Committees. August 05, 2004. (Cliff # 9045)

Ministry of Children and Family Development. Letter from Frank van Zandwijk, Director, Governance and Transition Support and Dan Ludeman, ACC Liaison Co-ordinator to Chairs, Regional Aboriginal Planning Committees, Regional Executive Directors Re: Joint Regional Aboriginal Work Plan/Business Planning. Attachments: Master Project Plan, Joint Regional Work/Business Plan Template, Service Delivery Model and Service Delivery Plan Diagram, Regional Aboriginal Planning Committee Budget Template, Regional Aboriginal Planning Committee Financial Report Template. November 17, 2004. (Cliff # 7899)

Ministry of Children and Family Development. Letter from Acting Deputy Minister Arn van Iersel to Chief Bob Pasco, Chair, Interior Political Committee. February 10, 2006. (Cliff # 8331)

Ministry of Children and Family Development. Letter from Assistant Deputy Minister Lenora Angel to former chairs of Child and Family Development Planning Committee Chairs Wayne McRann, Lynne Kent, Jim Latham, Clifford Dezell and Ann Geddes. Re: Request participation in an interim provincial advisory committee. March 22, 2006. (Cliff # 10001)

Ministry of Children and Family Development. Letter from Minister Stan Hagen to Joint Aboriginal Management Committee members. Regarding delaying enabling Regional Aboriginal Authorities Legislation. March 28, 2006. (Cliff# 4061)

Ministry of Children and Family Development. Form Letter from Minister Tom Christensen to Chairs of Aboriginal Planning Committees. Re-affirms ministry support of transition to Aboriginal governance of child & family services. May 14, 2007. (Cliff # 6031)

Ministry of Children and Family Development. Letter from Deputy Minister Leslie du Toit to all Delegated Agencies. Re: Authorities Legislation, Authorities and Regionalization. September 28, 2007. (Cliff # 4426)

Ministry of Children and Family Development. Letter from Minister Tom Christensen to Bruce Parisian, Executive Director, Victoria Native Friendship Centre. June 22, 2008. Response to letter to Minister from Bruce Parisian on May 14, 2008 Re: Regional Aboriginal Authority Legislation. (Cliff # 6008)

Ministry of Children and Family Development. Memorandum to Lenora Angel ADM, Aboriginal and Transition Service Division from Arn van Iersal, Acting Deputy Minister. Re: 2006/07 Initial Budget and Accountability Memorandum. March 24, 2006. (Cliff # 8057)

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Ministry of Children and Family Development. Opening Address Northern Caucus. March 15, 2005. Power Point presented by Frank van Zandsijk, Director, Governance Transition and Support Branch, Aboriginal and Transition Services Division. (Cliff # 8503)

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Ministry of Children and Family Development. Plan. Vancouver Coastal Child and Family Development Business Plan 2003/2004. Prepared by Vancouver Coastal Integrated Planning Committee. March, 2003. (Cliff # 6634)

Ministry of Children and Family Development. Plan. Community Challenge: Planning for Today's Children, Tomorrow's Adults. Business Plan of Vancouver Island Regional Planning Committee. Prepared by Vancouver Island Regional Planning Committee – Not for Distribution. April 22, 2003. (Cliff # 7805)

Ministry of Children and Family Development. Plan. Memo from Elaine Murray Senior Government Executive Officer to MCFD senior executives regarding instructions for writing the plan and evaluation criteria. May 01, 2003. (Cliff # 6639)

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Ministry of Children and Family Development. Plan. Human Resource Management Plan 2006/07 – 2007/08 Workforce Planning. November 25, 2005. (Cliff # 7676)

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Ministry of Children and Family Development. Project Map. What is the Purpose of this Project Map/Plan? Draft. October 23, 2007. (Cliff # 6009)

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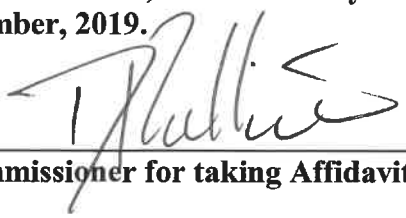
REPRESENTATIVE FOR
CHILDREN AND YOUTH

This is Exhibit "E" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, 2019.



A commissioner for taking Affidavits

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Too Many Victims
Sexualized Violence in the Lives of Children and Youth in Care

An Aggregate Review

October 2016

Oct. 4, 2016

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C., V8V 1X4

Dear Ms. Speaker,

I have the honour of submitting the report *Too Many Victims: Sexualized Violence in the Lives of Children and Youth in Care* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act,* which enables the Representative to aggregate and analyze the information received from the reviews and investigations conducted under Sections 11 and 12 and produce a report of the aggregated and analyzed information that does not contain information in individually identifiable form.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

Ms. Jane Thornthwaite, MLA
Chair, Select Standing Committee on Children and Youth

Contents

Executive Summary

During the past 10 years, the Representative for Children and Youth has repeatedly raised deep concerns about the treatment of young people who are in the care of the British Columbia government and, in particular, the treatment of Aboriginal children and youth, who continue to be over-represented in the province's care system.

Those concerns are reflected on the pages of this report, which examines the prevalence and nature of sexualized violence committed against children and youth in the government's care during a three-year period. This document is the result of a Representative's review of 145 reports of sexualized violence against 121 children and youth in the care of the Ministry of Children and Family Development (MCFD) and the province's 23 delegated Aboriginal Agencies (DAAs) between 2011 and 2014. While this review is the first of its kind in Canada, the Representative believes much more careful attention is needed by government to both prevention and response to sexualized violence.

No child or youth should ever experience sexual abuse, but such assaults are more egregious when they happen to already-vulnerable young people who, for reasons beyond their control, cannot live with their families and whose protection is the responsibility of the government.

The numbers from this review alone – 145 incidents of sexualized violence against 121 children and youth in care – should be troubling to every British Columbian. And the true total of such incidents committed against children in care during that time period is likely far higher as reporting is often delayed by these young, traumatized victims or never completed at all.

One number produced by this review is particularly staggering to the Representative. Of the 121 youth who reported being the victim of sexualized violence while in government care, a total of 74 – or 61 per cent – were Aboriginal girls, despite the fact that Aboriginal girls comprised, on average, only 25 per cent of the total children in care in B.C. during the time period covered by this review.

Female victims in this review who were age 12 or younger at the time of the incident of sexualized violence were four times more likely to be Aboriginal than non-Aboriginal, while girls between the ages of 13 and 18 were twice as likely to be Aboriginal.

And, while this review looks at sexualized violence against children and youth in care over a three-year period ending in 2014, recent statistics are just as troubling. Of the victims of reported sexualized violence in 2015/16, nearly twice as many were Aboriginal girls than non-Aboriginal.

The Representative hopes that these findings, which demonstrate just how vulnerable Aboriginal girls can be to sexualized violence, will prompt a more concerted effort by government to change the trajectory of this cohort in B.C., to better protect them and to ensure they are given the tools and services to be as resilient as possible. Nothing less should be expected. These cases need careful examination and learning and this aggregate review is an opening, far from a satisfactory treatment of the issue.

Overall, the findings of this review can only be described as disturbing. Children and youth in government care are more vulnerable to incidents of sexualized violence than their peers who are not in care. In fact, 2015/16 statistics show that sexualized violence is the most common type of critical injury involving children and youth in care, at 21 per cent. And yet, this report finds that not one specific policy or set of practice standards exists to guide social workers in their role as the guardian of a child or youth in care who is sexually assaulted while in care. Consequently, actions of social workers in the cases of the 121 youth in this review are, not surprisingly, varied and inconsistent, leaving children and youth potentially at risk for further abuse and long-lasting harm.

This review finds that the underlying systems and supports required to prevent sexual victimization and to support victims are underdeveloped, underfunded and uncoordinated. It concludes that B.C.'s most vulnerable children and youth remain at high risk for such abuse.

This is not the first report from the Representative on sexualized violence and change has been very slow in this area. Other reports that have dealt with this issue include:

- *Approach with Caution: Why the Story of One Vulnerable B.C. Youth Can't be Told* (May 2016)
- *Paige's Story: Abuse, Indifference and a Young Life Discarded* (May 2015)
- *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl* (February 2014)
- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (November 2012)
- *The Impact of Criminal Justice Funding Decisions on Children in B.C.* (March 2012).

Social workers and justice system personnel too often fail to adequately respond to the needs of children and youth who are victims of sexualized violence while in care, and knowledge of protective factors and prevention strategies is missing from social workers' training – a glaring gap in the education of those who are responsible for the safety of children and youth who are already vulnerable when they come into care. Social workers are not part of a seamless system of care for prevention, detection, response and therapeutic care for victims of this violence.

Compounding this problem is that the required and appropriate service options for children and youth in care who have been subjected to sexualized violence, especially those with complex needs, are too often non-existent, inaccessible, under-resourced or not delivered in any culturally appropriate, safe way.

Other findings from this review include:

- Of the 121 children and youth who were victims of sexualized violence, the vast majority (109) were girls. Girls were at an increased risk of being subjected to sexualized violence in their teenage years.
- A quarter of the reported incidents of sexualized violence that occurred in care placements were perpetrated by the child or youth's foster parent. More than one-third were perpetrated by another child or youth in the same placement.
- Nearly 20 per cent of the children and youth in this review harmed themselves or attempted suicide, usually within a year of disclosing the sexualized violence.
- Half had problematic substance use issues.

- More than 70 per cent had at least one diagnosed or suspected mental health issue, with two-thirds having one or more neurodevelopmental disabilities.
- Half of the 121 children and youth were dealing with both a mental health concern and a neurodevelopmental disability.
- Forty per cent had experienced some level of placement disruption during their time in care. The average number of moves per child or youth was eight, although some moved placements up to 30 times.

As required under the *Representative for Children and Youth Act (RCY Act),* public bodies such as MCFD and DAAs must file reports of such critical injuries to the Representative's Office. However, it is important to emphasize that the number of reports in this review likely represents only a small proportion of actual incidents of sexualized violence committed against children and youth in care during this time period, as many children and youth do not disclose sexualized violence until they reach adulthood. Once youth in care have "aged out" of the child welfare system at 19, they are no longer within RCY's mandate, and cannot be tracked by the Representative. There is no current way of determining the number of former youth in care who disclose as adults that they were victimized while in the care of MCFD or DAAs. Nor is there a way to track the number who may be re-victimized once they leave care.

Clearly, there is an urgent need to prevent and respond to sexualized violence against children and youth in care. To that end, the first recommendation of this review calls for MCFD to support social workers and other front-line workers with adequate policy, standards and training for the prevention and treatment of children and youth in care victimized by sexualized violence, with a particular focus on Aboriginal girls.

The Representative also recommends that the Ministry of Public Safety and Solicitor General lead the development and implementation of a network of Child and Youth Advocacy Centres (CYACs) in B.C. This network of community-based services should be phased in, with the first phase establishing several CYACs serving Aboriginal children and youth and their communities.

Finally, the Representative calls for the Premier to identify a lead minister responsible for creating and implementing a strategy to prevent and respond to sexualized violence against all children and youth in B.C. This strategy must be evidence-based and have a strong Aboriginal lens.

The government of B.C. is the legal "parent" of children and youth who, through no fault of their own, have been removed from their families and placed in care. It is past time for government to take steps to prevent and respond to sexualized violence against children and youth in B.C. Only through strong and supported collaborative action on this issue can we do right by our vulnerable children and youth, giving them the chance to become self-sufficient adults. This kind of careful prudence is no less than we would expect of any parent in B.C.

Methodology

MCFD is required to notify RCY of all critical injuries and deaths of children or youth who have received a reviewable service during the past year.[i] Critical injuries may include incidents of sexualized violence. This review includes 145 critical injuries involving sexualized violence affecting 121 children or youth who were in the care of MCFD or DAAs at the time of the reporting. Although these reports were received by RCY between March 2011 and February 2014, the actual critical injuries that were reported took place between December 2004 and February 2014. Pseudonyms have been used for case examples in this review in order to protect the identities of the child and youth victims.

Terms Used

The term "**sexualized violence**" is used in this review as an umbrella term that includes sexual assault, sexual abuse and sexual exploitation. Sexual assault is often understood as referring to sexualized violence perpetrated by one adult against another, and can include peer-to-peer sexualized violence among children and youth, while sexual abuse often refers to sexualized violence by an adult against a child. Sexual exploitation of a minor refers to the sexual abuse of children and youth through exploitive images or sexually explicit websites or the exchange of sexual acts for drugs, food, shelter, protection or money.

Violence is described as "sexualized" rather than "sexual" because, while "sexual assault," "sexual abuse" and "sexual exploitation" all make it clear that the victim is unwilling and free of blame, the term "sexual violence" could be taken to suggest that a victim is somehow a consenting participant in violence rather than a true victim of a perpetrator of sexualized violence.

This review incorporates data from those completed reports, combined with the voices of social workers who were the legal guardians of those children and youth as well as knowledge gained from an exploration of best practices around child and youth sexualized violence. It also includes an overview of current MCFD and DAA policies and guidelines that make reference to the issue of sexualized violence and how social workers should address the issue. Taken together, these sources of information allow RCY to highlight the systemic issues that create heightened vulnerability for sexualized violence against children and youth, and explore what can be done to address these vulnerabilities.

This review presents a range of data to describe the children and youth who were assaulted, including their age, gender and any mental health concerns or neurodevelopmental disabilities. It also examines the identities of the perpetrators, their associations with the victims and the settings in which the incidents took place. Finally, it compiles information on responses to the sexualized violence by the criminal justice system, social workers, anti-violence experts and other service providers.

[i] As prescribed by the *Representative for Children and Youth Act*, SBC 2006 c. 29, s.11. A reviewable service includes any of the following designated services: a) services or programs under the *CFCS Act* and the *Youth Justice Act*; b) mental health services for children; b.1) addiction services for children; c) additional designated services that are prescribed under section 29(2)(b). For a definition of critical injury, please see the Glossary.

Much of this information was gathered from the critical injury reports that were submitted to RCY, as well as from police and court records. While the 145 reports of sexualized violence is a relatively small sample size, the results are an indicator that this issue requires more study. This information was supplemented by interviews with the social workers who were the guardians of the children and youth involved in the sexual victimization reports. RCY investigators conducted the interviews between December 2014 and June 2015.

While some of the data contained within this review are objective and easily confirmed (such as the age and gender of the victims of sexualized violence), other information relating to the incidents themselves and subsequent responses by the social and justice systems is subjective. A number of observations in the children and youths' case files were based on the judgments of social workers and may not have been confirmed by third parties. For instance, child or youth mental health concerns that were noted by social workers may have resulted from official clinical diagnoses, or simply from the social worker's suspicions that the child or youth was experiencing mental health difficulties. Similarly, some aspects of the justice and health care responses to the incidents, such as whether interviews were conducted in a child-friendly manner or whether physical evidence was taken at the hospital, were not known by all social workers and were not evident from the child or youth's files.

Background

Sexualized violence against children and youth

It is important to understand the issue of sexualized violence against children and youth in care in a wider context. Despite significant legislative changes in Canada in the last 30 years, increased public understanding of sexualized violence and encouragement for victims to come forward, the majority of sexual offences are not reported to authorities.[1] This makes it difficult to determine the prevalence of sexualized violence perpetrated against children and youth. Definitions of child sexualized violence also vary, leading to prevalence and incidence rates that are certainly underestimating the extent of this violence.[2, 3] However, despite these limitations, police-reported sexual offences have been found to occur about five times more often among children and youth than among adults over the age of 18.[1]

Child and youth sexual abuse in B.C.

The most recent BC Adolescent Health Survey estimated that 13 per cent of female youth in B.C., or one in seven, reported ever being sexually abused, including being forced into sexual activity against their will. The rate of reported sexual abuse was five per cent for male children and youth.

For Aboriginal children and youth, rates of reported sexual abuse were 23 per cent for females and seven per cent for males.[7]

The majority of incidents of sexualized violence are not disclosed by children and youth often until years afterwards.[4, 5] Children and youth may not disclose sexualized violence for a variety of reasons, including: fear of getting a family member in trouble; feeling guilty or blaming themselves for the violence; being embarrassed or afraid of what others will think; facing threats of harm against themselves or others with whom they are close; or, viewing the sexualized violence as "normal" if they have been subjected to the violence for an extended period of time.[6] In addition, children or youth who are young at the time of the sexualized violence may not understand what is happening to them or may feel that they have nobody to confide in, especially if the perpetrator is a caregiver or adult in a position of trust. The climate of silence and pressure not to discuss "unpleasant" matters, and the vulnerability of young persons to stay quiet under the influence of more powerful adults and peers, are key concerns.

The pressure on young people to not disclose can be enormous and the isolation experienced after disclosure can frequently cause additional harm. For some children and youth, it is simply less painful not to disclose than to deal with the consequences of telling. Delays in reporting sexual victimization can have significant consequences, including diminishing the possibility of successful prosecution of the offenders and, as a result, there is the possibility of harm to other children and youth by the unreported perpetrators. It may also increase the likelihood of long-term negative outcomes for the victims. Children and youth who delay disclosures are more likely to experience more serious and long-lasting psychological damage.[8]

Many children and youth do not disclose sexualized violence until they reach adulthood, with males being less likely to disclose than females.[5] Disclosure is a complicated process and children and youth who have been victims of other forms of maltreatment in the home, as is the case for many in care, are also less likely to disclose.[6] Whether children and youth disclose often depends upon how supportive

they perceive their environment to be. If they have a supportive and trusted family member or adult in the community, they will be more likely to report their victimization in a timely manner. Having supportive and accessible services in their communities increases the likelihood of disclosure, as does having professionals who have the specialized training and skills to assist children and youth who have been victimized.

Impacts of sexualized violence

The psychological impacts of sexualized violence on children and youth can be far-reaching, life-long and devastating. Child and youth victims of sexualized violence are approximately four times more likely than the general child and youth population to suffer from depression or an internalizing disorder, or report suicidal ideation and attempts at suicide.[9] When adults respond negatively to a child or youth's disclosure of sexualized violence, these psychosocial effects can be further worsened and the child or youth's sense of safety and security can be undermined.[10] Because most perpetrators of sexualized violence are known to their victims, children and youth may feel a strong sense of betrayal from the abuse, accompanied by feelings of being powerless to stop the victimization from happening.[11] Once an incident of sexualized violence has occurred, children and youth are increasingly likely to be victims of future abuses, a situation that is termed re-victimization.[2, 10]

Perpetrators of sexual crimes against children (birth to 17 years of age)

Data on police reported sexual offences against children and youth in Canada in 2012 show that the majority of persons accused of a sexual offence against a child or youth were known to the victim. The accused was most commonly an acquaintance (44 per cent) or a family member (38 per cent). Only one in 10 sexual offences against children and youth were committed by a stranger. The vast majority of individuals accused of sexual offences were male (97 per cent).

Very young children were more frequently victimized by a family member, while older children were most often victimized by an acquaintance or stranger. In fact, for youth who were 16 and 17 years of age, an acquaintance was most often the accused (53 per cent).

One-third of all sexual offences against children or youth were committed by another youth under the age of 18, although this was higher for children under 12 where the accused was most commonly between the ages of 12 and 17 (39 per cent).[15]

Peer-to-peer abuse

Although much of the sexualized violence against children is perpetrated by adults, cases of peer-to-peer sexualized violence – sexualized violence where both the perpetrator and the victim are children or youth – account for a considerable number of incidents.[12] The sexualized violence may take a number of forms and may involve perpetrators who are similar in age to their victims, older, or younger.[13] Often, children and youth who perpetrate peer-to-peer sexualized violence have themselves been the victim of sexual abuse or have a number of non-sexual issues that contribute to their sexualized behaviour. There is an increased awareness that peer-to-peer abuse may be more prevalent in out-of-home care settings than had been previously thought.[14] Determining how to keep children and youth safe in out-of-home placements is considered a critical responsibility of child protection services and other social service agencies. Unfortunately, these issues of safety for children and youth in care do not always receive the required attention.

Vulnerability to sexualized violence

Sexual victimization does not occur because of anything done by a child or youth, but because of the actions of perpetrators as well as a lack of sustained effort to prevent sexualized violence. Some victims may be more accessible to perpetrators and have less societal protection because of their circumstances. Particular groups of children and youth can be more vulnerable to abuses by other youth or adults. Sexualized violence perpetrated against children and youth results from the interaction of a number of risk factors, such as larger societal attitudes to this type of violence and policies and practices that make some groups less safe and more vulnerable to victimization.[16, 17]

Although all children and youth have some level of vulnerability to sexual victimization, groups that have been found to be more vulnerable to abuse include:

- **Gender**: There is a wide variation in which groups of children and youth are vulnerable to victimization. The likelihood of abuse is dependent upon the age and circumstances of the children and youth although females are significantly more likely to be victims of sexualized violence. Generally, perpetrators go after children and youth who are the most vulnerable and the least likely to be able to defend themselves. Children and youth with multiple vulnerabilities are the most commonly targeted. Aboriginal girls and young women experience especially high rates of sexualized violence because of issues related to poverty, intergenerational trauma, isolation and devaluing attitudes towards them within society.[11, 18, 19]

- **Children and youth in care**: Children and youth in government care are particularly likely to have experienced multiple types of mistreatment.[20] They are generally members of families where there are disproportionately high levels of substance use, domestic violence, untreated mental health issues and multiple stresses related to poverty. Many families lack the necessary supports and services needed for them to be able to provide the necessary protection for their children. Children and youth in care also suffer disproportionately from neurodevelopmental disabilities, mental health concerns and behaviour issues related to past victimization and neglect.[20, 21] All of this means that they are significantly vulnerable to victimization while in care. These individual risk factors can be compounded by frequent placement changes or school moves while in care, which may increase a child or youth's social isolation and disconnection. There is also a widely recognized lack of appropriate transitional supports for most youth as they leave care.[22] This leaves them vulnerable to victimization immediately prior to and during the transition because they often are simply cut loose from the system that has been meant to support them. Young women who have been sexually victimized are at increased risk for future exploitation as they leave care.[23]

- **Indigenous children and youth**: Years of government policies – including the forced removal of Indigenous children to residential schools, the experience of neglect and physical and sexual abuse for many of the children in these institutional settings and the resulting intergenerational trauma, the loss of control over land and the high levels of poverty as a result of the systemic exclusion from economic opportunities – have created the conditions where some Indigenous children and youth are at heightened risk for sexual abuse.[24] Perpetrators of this violence may also believe that they will not risk detection or prosecution since society is less concerned with the welfare of Indigenous than that of non-Indigenous children and youth.[17, 25]

- **Children and youth with physical and neurodevelopmental disabilities**: Children and youth who have disabilities may be more socially and physically isolated than their peers because of their circumstances, may be unable to defend themselves against sexualized violence or may be perceived as easier to victimize by perpetrators.[26, 27] Some children and youth with neurodevelopmental disabilities may be further at risk because they may not fully understand or be able to communicate what has happened to them.[28]

- **LGBT2Q+ Youth:**[ii] These children and youth may be particularly vulnerable as a result of their experiences of stigmatization, marginalization and oppression as well as isolation due to having fewer family, school and community supports.[29, 30, 31]

- **Children and youth who live in poverty**: Children and youth who experience poverty may be at an increased risk of harm from sexualized violence. The poverty experienced by many youth leaving care due to a lack of adequate government support and appropriate transitional supports also increases the likelihood of young people engaging in survival sex work.[23] Young women transitioning out of care are particularly vulnerable in this regard.

Sexual assault is a criminal offence

It is important to remember that sexualized violence against children and youth is a serious criminal act that can result in a variety of criminal charges with consequences including a custodial sentence for the perpetrator. In B.C., the responsibility for investigating sexualized violence rests with municipal police forces or the RCMP, depending upon the geographic location of the incident.

In 2012 and 2013, approximately 14,000 sexual offences[iii] against children and youth ages 17 and younger were reported to police across Canada.[1, 15] Nearly 30 per cent of alleged perpetrators were younger than 18, and most were family members or acquaintances of the child or youth victim.[15] Just over a quarter of sexual offences involved a delay of at least 12 months between the actual offence and a report being made to police, highlighting the problem of delayed disclosures or non-disclosures for child and youth victims of sexualized violence. The actual number of sexual offences that occurred across Canada in 2012 but were not reported to authorities is thought to be much higher than 14,000, as sexual offences against children and youth are more likely than any other type of offence against the person to involve delayed disclosure.[15]

In B.C., it is estimated that 1,615 sexual offences against children and youth ages 17 and younger were reported to police during 2012, or 11.5 per cent of the Canadian total.[15] In terms of the child and youth population of the province, this equates to a rate of 192 sexual offences per 100,000 children and youth in B.C. The greatest numbers of sexual offences were committed against 12- to 15-year-olds, equating to a rate of 264 offences per 100,000 children and youth in this age group.

[ii] Lesbian, Gay, Bisexual, Transsexual, Transgender, Queer, Two Spirit. The plus sign acknowledges the evolving aspects of sexual identities.

[iii] These offences included aggravated sexual assault (level 3), sexual assault with a weapon or causing bodily harm (level 2), sexual assault (level 1), sexual interference, invitation to sexual touching, sexual exploitation, sexual exploitation of a person with a disability, incest, corrupting children, making sexually explicit material available to children, luring a child via a computer and voyeurism.

Police can recommend charges to Crown Counsel for a number of violations of the *Criminal Code of Canada*, including:

- **Sexual Assault** – This covers sexual assault (level 1), sexual assault with a weapon or sexual assault causing bodily harm (level 2) and aggravated sexual assault (level 3). If the victim is under the age of 16, a mandatory minimum penalty of one year applies for level 1 sexual assault. These penalties increase to a five-year mandatory minimum for level 2 and level 3 sexual assaults.
- **Sexual Interference** – Criminalizes the touching of a person under the age of 16 for a sexual purpose, and carries a maximum sentence of 14 years in prison.
- **Invitation to Sexual Touching** – Includes inviting, counselling or inciting a person under the age of 16 to touch the body of any person for a sexual purpose. Carries a maximum sentence of 14 years in prison.
- **Sexual Exploitation** – Criminalizes touching a person who is 16- or 17-years-old for a sexual purpose, or inviting, counselling or inciting that person to touch the body of any person for a sexual purpose, where the person who commits the offence is in a position of trust or authority. Carries a maximum sentence of 14 years in prison.

Of the sexual offences against children and youth that were reported in Canada in 2012, it is estimated that only about 15 per cent of cases were eventually tried in provincial and territorial adult criminal and youth courts.[iv] In cases where the outcome of the cases was known, nearly 75 per cent of perpetrators were found guilty of at least one sexual offence against a child or youth. Of these perpetrators, 16 per cent were youth offenders and 84 per cent were adults.[15] For incidents where data is available provincially, percentages were almost identical in B.C., where 15 per cent of perpetrators charged with a sexual offence against a child or youth were youth themselves and 84 per cent were adults.[v]

For adult perpetrators across Canada, custody was the most frequent sentence that resulted from a guilty finding (81 per cent of sentences) in conjunction with probation (75 per cent). In contrast, youth offenders were more likely to receive a sentence of probation (67 per cent), with less than nine per cent of youth perpetrators sentenced to custody.[15] It is important to reiterate that these statistics reflect only those cases of sexualized violence against children and youth that were disclosed by victims, reported to police and progressed fully through the court system. In Canada and elsewhere, the successful prosecution of perpetrators of sexualized violence against children and youth is the exception, rather than the rule. The Representative is also aware of the reluctance of victims in the cohort examined to participate in the criminal justice system due to poor supports, having to face intense adversarial questioning and the trauma of re-living the event in a courtroom of strangers. In cases where criminal proceedings have been engaged leading to a successful prosecution and conviction, the time frame alone may span four to five years. This may mean that an entire secondary school period of development occurs with the proceeding looming, causing deep stress and anxiety for a victim in care. Support services are episodic and relate to points in the criminal trial – they are not encompassing of the lived development experience of a youth.

[iv] 1,775 cases (12.6 per cent) were eventually completed in courts in 10 provinces and three territories. However, information from superior courts in Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan, as well as municipal courts in Quebec, was unavailable. Because some of the most serious cases are processed in the superior courts, it is therefore likely that the number of completed cases in 2012 is higher than 12.6 per cent.

[v] Data from Statistics Canada CANSIM table #252-0081, using only the Incident-Based Crime Reporting Survey (UCR2).

Overview of Sexualized Violence Against 121 Children and Youth in Care

As part of this review, individual reports of sexualized violence against children and youth in government care were examined together. Each of these reports was submitted to RCY by MCFD and DAA social workers, as required by the *RCY Act*.

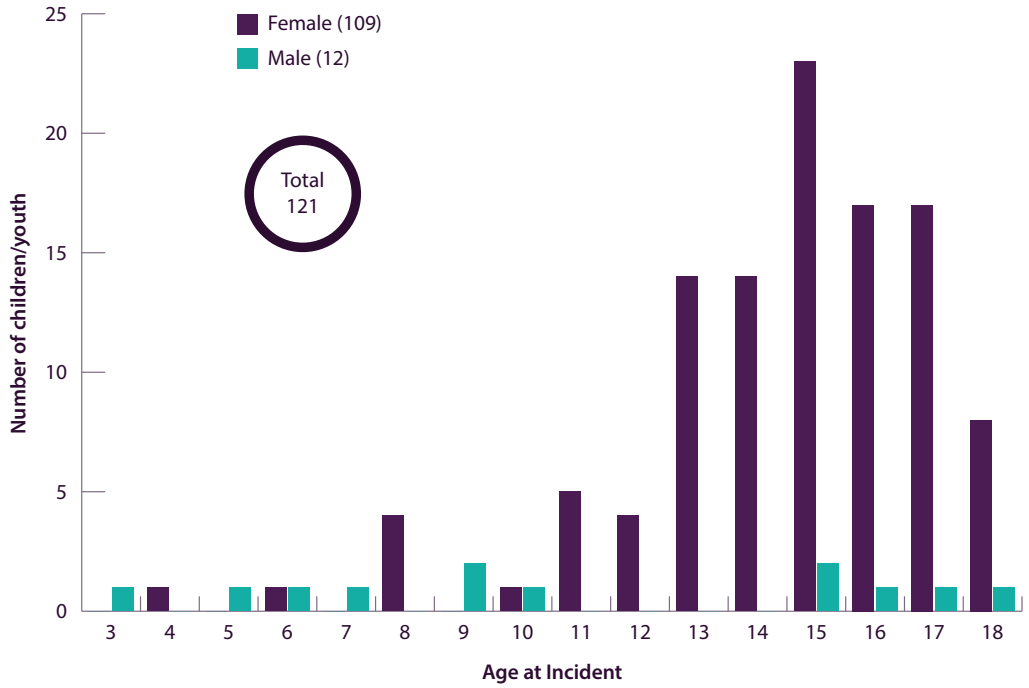
This data reflects the experiences of a group of children and youth in government care, and some issues specific to being in care. It also offers insight into vulnerabilities of other children and youth, and looks at the availability of supports and services for children and youth who are victims of sexualized violence in B.C.

Who were the victims?

Age and gender

Of the 121 children and youth in our review who disclosed sexualized violence over the three-year reporting period, 109 were girls and 12 were boys. The age at which the sexualized violence was reported to have first occurred ranged from three to 18.[vi] Twenty-three of the children were 12-years-old or younger at the time of the first reported incident, with 98 of the children and youth between 13 and 18 when the sexualized violence occurred (see Figure 1 below).

Figure 1: Age and gender at first reported incident



[vi] Some of the children and youth in our data set may have been the victims of sexualized violence prior to RCY receiving a critical injury report. In addition, some children and youth experienced more than one incident of sexualized violence during our reporting period. However, for the purposes of this review, we will consider the age of the child or youth as stated on their first incident report as the "age at first reported incident."

The risk of boys experiencing sexualized violence appeared to be similar across all ages, while girls were at increased risk of being subjected to sexualized violence as they entered their teenage years.

Aboriginal status

Nearly two-thirds of the victims in our review were Aboriginal (79 of 121 children and youth).[vii] However, only five of the 79 Aboriginal children and youth were boys, with slightly more non-Aboriginal boys than Aboriginal boys being subjected to sexualized violence (see Figures 2 and 3 below).

Figure 2: Aboriginal children: birth to age 12

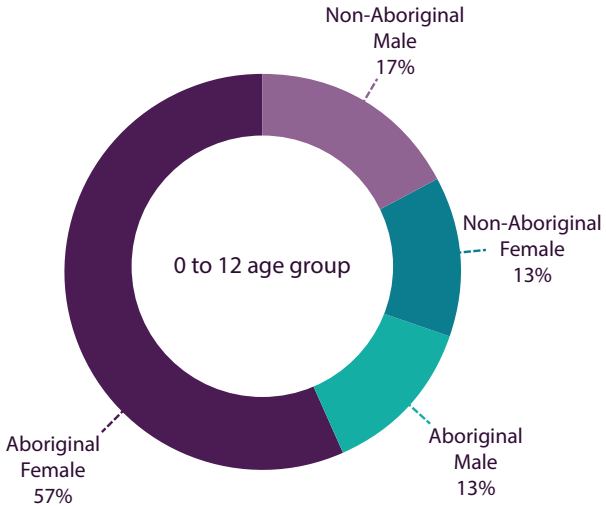


Figure 3: Aboriginal youth: ages 13 to 18

Female victims of sexualized violence who were ages 12 and younger at the time of the incident were four times more likely to be Aboriginal, and 13- to 18-year-olds were twice as likely to be Aboriginal as non-Aboriginal.

[vii] During the review period (March 2011 to February 2014), an average of 53 per cent of children and youth in care were Aboriginal.

Mental health and neurodevelopmental disability

More than 70 per cent of the children and youth in RCY's review had at least one diagnosed or suspected[viii] mental health issue, with two-thirds having one or more neurodevelopmental disability. This was the case across all ages of children and youth. The most widely reported issues amongst children and youth in RCY's sample were anxiety, depression, trauma-related disorders including post-traumatic stress disorder, self-harm or suicidal ideation, attention deficit hyperactivity disorder, attachment disorders and fetal alcohol syndrome disorder. Half of the 121 children and youth in this review were dealing with both a mental health concern and a neurodevelopmental disability. Only 14 of the children and youth had neither a neurodevelopmental disability nor a mental health issue. Because of lack of information, it was not possible to determine if these diagnoses were received before or after the sexualized violence occurred.

EVA'S STORY

Eva was born with a hearing impairment and neurodevelopmental disabilities. She came into care at seven-years-old after the death of her mother, when the ministry concluded that her father lacked the capacity to properly care for her. She had lived in the same foster home since coming into care. When she was 15-years-old, Eva reported to her foster parent that the relief caregiver brought in to support the foster parent had repeatedly touched her inappropriately and exposed himself to her. Although Eva was able to identify that the sexualized abuse made her unhappy, she was not able to articulate that it was wrong. The police investigated her complaint and charges were forwarded to Crown Counsel, but it was concluded that Eva's cognitive deficits meant her evidence would not be enough to support a conviction. Eva remains in foster care and is receiving counselling through victim services.

RCY received a report of self-harm or attempted suicide for 23 of the 121 children and youth in this review (19 per cent) after they had been sexually assaulted. The rate of attempted suicide or self-harm was similar in both the age 12 and younger and 13- to 18-year-old groups. The majority of self-harm or suicide attempts involved cuts to arms and/or wrists, ingesting medication or over-the-counter painkillers, or drinking household cleaning products, and took place within a year of the sexualized violence.

Although the *RCY Act* requires that any critical injuries involving children or youth who are receiving mandated services be reported to the Office, it is likely that the number of children and youth in this review who self-harmed or attempted suicide after an incident of sexualized violence is higher than 19 per cent. Critical injuries involving youth who have "aged out" of the child welfare system[ix] are not within RCY's mandate and cannot be tracked. Similarly, only those instances of self-harm or attempted suicide that came to the attention of the children or youths' social workers are represented in this data. Instances of self-harm or attempted suicide that were not disclosed to social workers, or that were disclosed but not logged as a critical injury, are not reflected in this review.

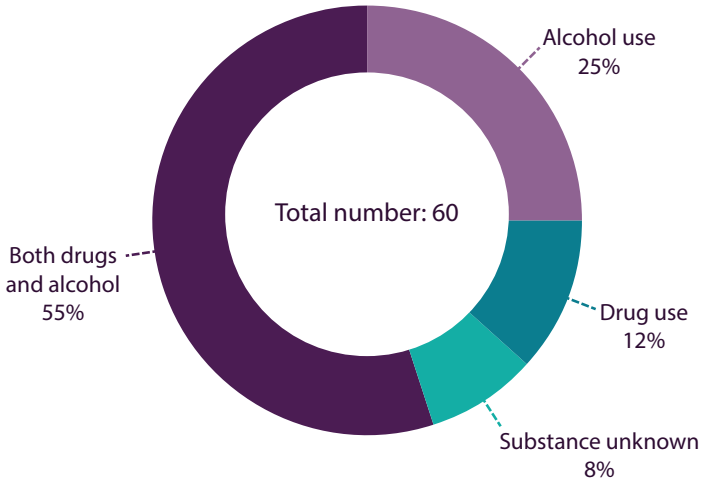
[viii] Often, mental health concerns or disabilities were suspected by social workers who worked with the children or youth but no official diagnoses had been made. Reasons for this were diverse and included long wait lists for screening, resistance to assessment on the part of the child or youth and ineligibility for specific services.

[ix] Once a youth in B.C. reaches his or her 19th birthday, he or she is no longer eligible to receive government services within the formal child welfare system. The process of being released by the system at age 19 is commonly termed "aging out."

Substance use

Half of the 121 children and youth in this review were identified as having problematic substance use issues. Alcohol was the most widely used substance, either alone or in conjunction with illicit drugs. In a number of cases, the perpetrator of the sexualized violence used drugs or alcohol to facilitate the assault on the child or youth, either to hinder the child or youth's efforts to resist or to lure the child or youth into a situation where the perpetrator could engage in the assault.

Figure 4: Problematic substance use by children or youth



Absenteeism from placements

Almost half of the children and youth in care who were the victims of sexualized violence were frequently absent from their placements, including leaving placements without notice or permission, staying away from placements later than agreed and remaining absent from placements overnight. In the older age category, more than half of the 98 youth ages 13 to 18 were frequently absent from their placements.

Placement instability

Many of the children and youth in care who formed part of this review had a history of being in placements that did not meet their needs and, as a result, experienced a high level of instability. Forty-eight of the 121 children and youth (40 per cent) experienced some level of placement disruption during their time in care. Some had moved placements up to 30 times, with the average number of moves per child or youth being eight.

Long-term placement disruption was defined as a breakdown in a long-term foster home (at least five years in the same home) that resulted in the youth having to leave. Twenty-nine of the 121 children and youth experienced a long-term placement disruption as an adolescent. This type

CALLIE'S STORY

Callie was placed in care at 12-years-old after her parents decided they were unable to continue caring for her. After her first foster home placement broke down, she was placed in a group home setting. Staff in this home recognized that her desire for peer acceptance and approval had the potential to put her at risk. They were also concerned with possible sexual exploitation.

On one occasion, Callie was driven to an abandoned building by a man who had previously sold her illicit drugs. He demanded sex, exposed himself, burned her arm and threatened to burn her hair before she was able to escape. Callie refused to provide a statement to police, but she was able to connect with a youth worker specializing in supporting youth who are at risk of sexual exploitation. She also attended the Maples Adolescent Treatment Centre, where she was diagnosed with reactive attachment disorder and depressed mood. The assessment recognized that her fear of rejection would make it difficult for her to make choices that would keep her safe from further abuse.

of disruption can have an enormous effect on well-being due to feelings of loss, abandonment and rejection. Placement breakdowns occurred as a result of a combination of the youth's behaviours (often stemming from complex trauma, mental health or developmental issues) and caregivers who were ill-equipped or not adequately supported to care for the needs of the youth. Placement breakdowns disrupt attachment and stability and may create conditions for easy victimization. Group home settings tend to be the final stop on this trajectory and occurrences may be more common in this setting, including peer-on-peer abuse.

Who were the perpetrators?

Although this review consists of 121 children and youth in care who were the victims of sexualized violence, the RCY received critical injury reports for 145 cases pertaining to these children and youth, as several of them (15 per cent) had been the victims of sexualized violence on multiple occasions during their time in care (see Table 1).

Table 1: Number of Reports and Number of Children and Youth

Number of reports of sexual assault[xi]	Number of children or youth
1	103
2	13
3	4
4	1

The reports in Table 1 are based only on disclosures that were reported to RCY during the three-year period between March 2011 and February 2014. Not only will many child and youth victims not disclose incidents of sexualized violence, but some incidents may not subsequently be communicated to RCY once they are disclosed by the child or youth. In addition, in a quarter of cases, there were indications that single perpetrators had committed multiple acts of sexualized violence over time, even though only one incident report had been made by the child or youth. In some cases, the sexualized violence spanned months or years before it was finally disclosed. Therefore, the actual percentage of children and youth in this review who had experienced multiple incidents of sexualized violence during their childhood is likely to be much higher than 15 per cent.

More than 93 per cent of the perpetrators in this review were known to the child or youth victims, with just nine of the 127 identified perpetrators being strangers. The majority of assaults were carried out by casual acquaintances of the children or youth (see Table 2). In 17 cases, more than one assailant was involved in the sexualized violence.

Table 2: Perpetrator Type

Perpetrator type (where known)	Total	%
Acquaintance	41	32.3
Child or youth in care, in foster home or group home	10	7.9
Family member or member of extended family	9	7.1
Boyfriend/girlfriend	9	7.1
Friend	9	7.1
Stranger	9	7.1
Just met	8	6.3
Foster father	7	5.5
Met online	7	5.5
Sibling	6	4.7
Other	12	9.4
Total	**127**	**100**

[x] These reports are single critical injury reports that were made to RCY by social workers and pertained to a child or youth currently in MCFD or DAA care. One incident report may contain details of multiple occasions of sexualized violence.

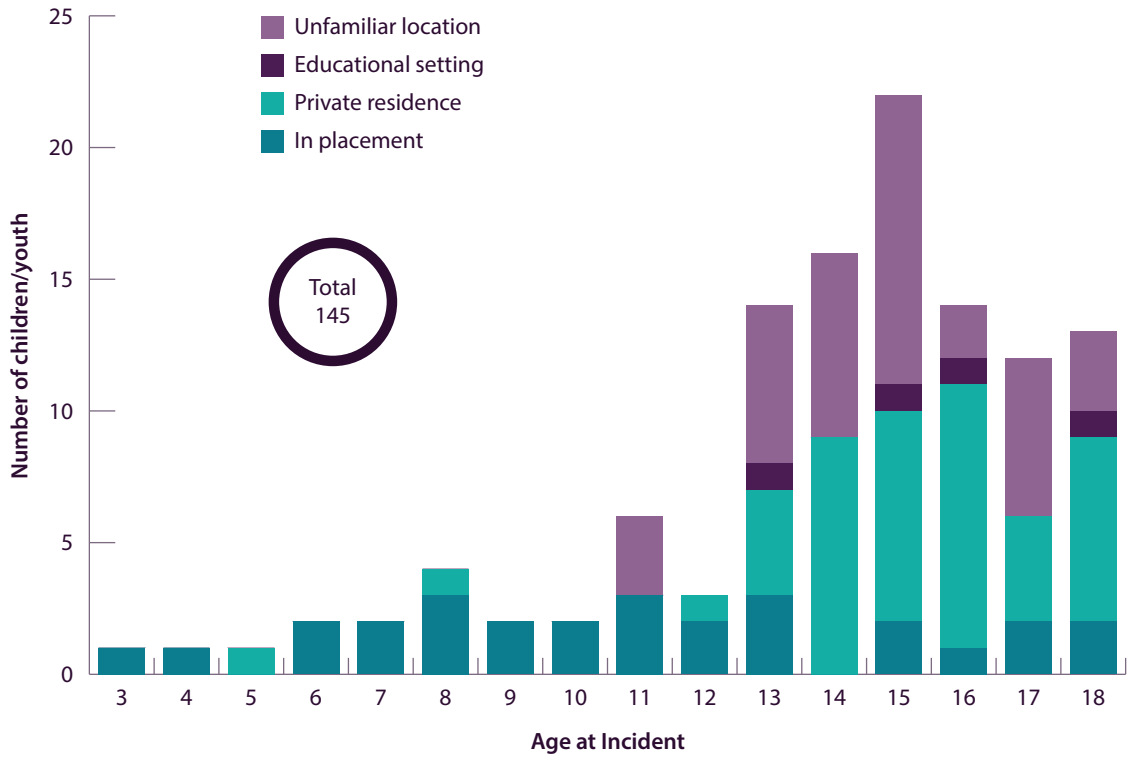
Fifteen cases involved intimate partner violence where perpetrators were boyfriends, girlfriends, friends or acquaintances. A female perpetrator was implicated in only four of the 135 cases in which the gender of the offender was known.

What were the circumstances?

For the 23 children who were under 12-years-old when they were assaulted, 25 incidents of sexualized violence were reviewed for this report. For the 98 youth who were ages 13 to 18 at the time of the first reported assault, 120 incidents were reviewed. The majority of reported incidents of sexualized violence that involved younger victims occurred in a care placement (75 per cent), while the majority of reported incidents involving older victims occurred in residences other than their care placement (46 per cent) and unfamiliar or public locations (38 per cent) (see Figure 5).

As youth age, they are more likely to be away from their caregivers. This gradual increase in freedom is reflected in the settings where the sexualized violence occurred. Youth in their teenage years were more likely to be sexually assaulted at events such as house parties and at the homes of strangers, or in public locations such as parks, streets, or wooded areas. In some cases, youth reported being assaulted at the home of a boyfriend, friend or relative. The sexualized violence in this review occurred throughout B.C. in both rural and urban areas, although more incidents were reported in larger urban centres such as Vancouver, Surrey, Prince George and Burnaby.

Figure 5: Location of sexualized violence, where known, by age



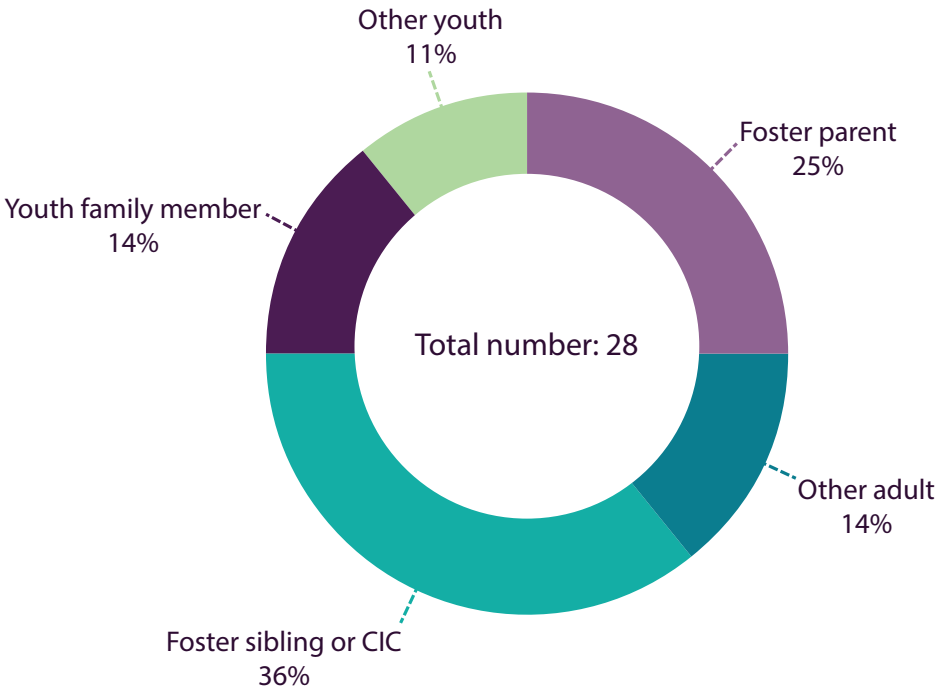
Incidents occurring in care placements

Of the 145 reported incidents of sexualized violence included in this review, 28 occurred in the child or youth's care placement setting. Eighteen of these 28 assaults involved victims under 12-years-old, with the remaining 10 involving youth between 13- and 18-years-old.

ROWAN'S STORY

Rowan was brought into care at age six because his mother's substance use resulted in him being neglected. His mother also struggled to manage the behaviours that were believed to be a result of his diagnosed attention deficit hyperactivity disorder and oppositional defiant disorder. When he was 11-years-old, he disclosed to his relief caregiver that he had been sexually assaulted by a 17-year-old boy who was also in government care and previously lived in the foster home with Rowan. Rowan disclosed this incident only after the offender had moved out of the foster home one year after the assault. The offender was convicted of sexual assault and sentenced to six months in custody and 18 months probation.

In a shocking breach of trust, a quarter of the reported incidents of sexualized violence that occurred in care placements were perpetrated by the child or youth's foster parent. A further 14 per cent of the reported assaults were perpetrated in the care placement by another adult such as an extended family member, respite caregiver or another adult member of the household. Just over one-third of reported care placement incidents of sexualized violence were perpetrated by another child or youth in care in the same placement as their victim (see Figure 6).



Other concerns

Of the 79 Aboriginal children and youth in this review, 24 did not have a cultural plan on file as part of their Comprehensive Plan of Care[xi] and the status of cultural plans for a further 14 children and youth was unknown. MCFD policy recognizes that meaningful cultural and community engagement is critical to the short- and long-term well-being of Aboriginal children and youth, and all children and youth in care are expected to have a cultural component to their plan of care.

For those children or youth who did have a cultural plan on file, there was great variety in the depth and detail of the plan. Cultural practices and dimensions to respond to abuse and comfort victims, as well as to hold perpetrators accountable, may be important and necessary for the well-being of Aboriginal children and youth in care.

The absence of a plan is an indicator of dislocation from an Aboriginal family and community. This suggests less support for these children and youth and this factor may be correlated to increased exposure to possible abuse in care settings.

Another concern is that these critical injury reports deal only with a snapshot in time, and usually lack background information on the child or youth's life prior to the reported assault. This is especially problematic for the 11 cases of sexualized violence that were not reported to RCY until more than six months after the assault. In the most extreme case, more than eight years passed between the sexualized violence and the critical injury report to RCY. In these cases, the Representative is unable to determine whether some issues, such as mental health concerns, substance use problems and self-harm behaviour, were present prior to the sexualized violence (thus making the child or youth more vulnerable to future harm), or whether these issues were a direct consequence of trauma resulting from the assault.

BRIANNA AND AVERY'S STORIES

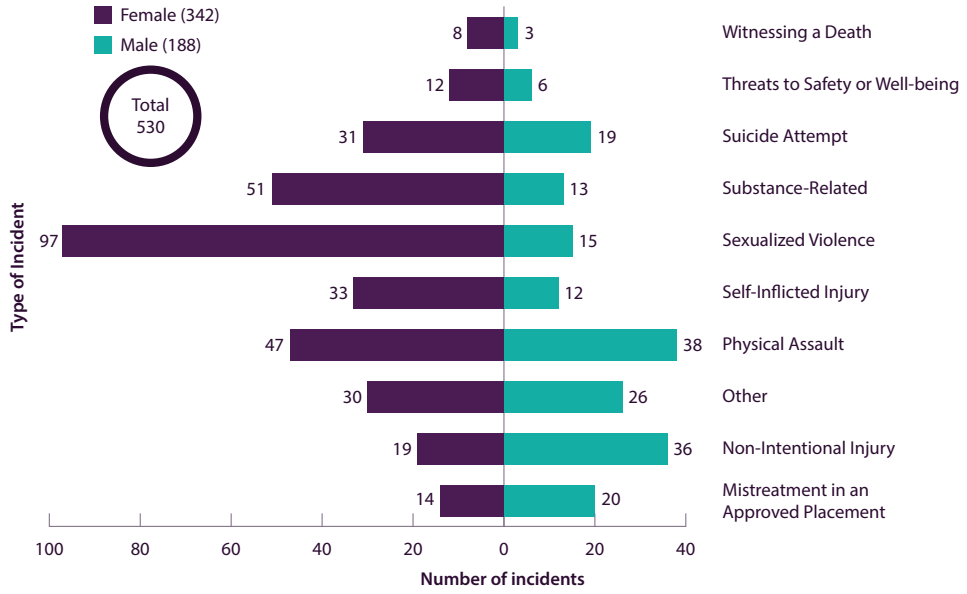
Brianna, eight, and her brother Avery, three, were placed in a foster home with extended family members. In the years following their placement, concerns were raised about the quality of care provided by the foster home, particularly the management of the aggressive behaviour of a boy in care who was also living in the home. When Brianna was almost 11, she brought her brother Avery, who was then six-years-old, to their foster father and urged her brother to disclose abuse by their 13-year-old foster brother. Avery told his foster father that the foster brother had hurt him by repeated sexual assaults. Brianna then disclosed that the foster brother had also been sexually abusing her, and had threatened to continue abusing her brother if she told anyone. MCFD and police were notified immediately and the foster sibling was moved to another group home. Brianna contracted chlamydia as a result of the abuse and was diagnosed with post-traumatic stress disorder. She was provided with trauma counselling and a spiritual healing worker from her First Nation, while the First Nation provided Avery with a play therapist to begin addressing the emotional harm.

[xi] A Comprehensive Plan of Care is an action-based planning tool for children and youth in care that is used to identify specific developmental objectives based on continuous assessments of the child/youth's evolving needs and the outcomes of previous decisions and actions. Since data for this report was collected, the term "Comprehensive Plan of Care" has been replaced by "Care Plan."

Urgent and current concern

While this review looks at sexualized violence against children and youth in care over a three-year period ending in 2014, more recent statistics for this group are chilling and confirm the urgent need to prevent and respond to sexualized violence against children and youth in care. Data from critical injuries reported by MCFD to RCY in the 2015/16 fiscal year[1] confirm that sexualized violence against children and youth in care remains all too common. In fact, sexualized violence is the most common type of critical injury involving children and youth in care. Twenty-one per cent of all critical injuries involving children and youth in care in 2015/16 involved sexualized violence – more than any other category (physical assault: 16 per cent; substance-related injuries: 12 per cent). Among these critical injuries, reports of sexualized violence were more than six times more prevalent for girls than for boys, and almost twice as common for Aboriginal girls as non-Aboriginal girls.

Figure 7: Categories of 530 critical injuries involving children and youth in care received by RCY in 2015/16[2]



[1] MCFD submits both serious incident and critical injury reports to the RCY. RCY considers both types of MCFD reports and determines which ones meet the RCY criteria for a critical injury. RCY then categorizes all critical injuries that meet its criteria according to the incident types listed in Figure 7.

[2] Figure 7 does not include four critical injuries reported to RCY by MCFD for which the gender of the child or youth in care in question was indicated as "other/unknown."

Preventing and Responding to the Sexualized Victimization of Children and Youth in Care

Prevention

Although it is generally accepted that there is a great deal still unknown about the effectiveness of prevention strategies, there is general agreement that efforts should be concentrated on a number of key areas. These strategies focus upon changing societal attitudes and improving the individual, family and community conditions that put children and youth at risk. Broader multisystem approaches that target not just individuals and families but also communities and societal factors that contribute to the conditions that create vulnerability hold the most promise for preventing sexual victimization. A key strategy is also developing accessible and appropriate services to respond to children and youth who have been victimized in order to help them deal with their trauma and decrease the likelihood of future re-victimization. These prevention efforts need to be targeted at all children and youth. In addition, given their particular vulnerability, additional strategies need to be in place for children and youth in care. Prevention efforts need to be rooted in a strong understanding of how exploitation and powerful strategies impact children and youth and result in very strong emotional trauma bonds with perpetrators. These bonds can make prevention and recovery very challenging, so specialized training is needed to do effective prevention.

Prevention – what does B.C. do?

When children and youth are taken into government care, the expectation is that their lives will be safer than if they had stayed where they were. Preventing sexualized violence against children and youth in care is a critical element of keeping them safe. This review considered MCFD and DAA policies, standards and guidelines to identify where and to what extent preventing sexualized violence of children and youth in care is addressed. A brief overview is provided here.

Screening of caregivers

MCFD standards require screening and training of potential caregivers. The *Caregiver Support Service Standards* is a mandatory framework for service provision for caregivers, including contracted service providers.[32] MCFD also has a specific policy for the assessment and approval of caregivers by contracted agencies,[33] as well as requirements for contracted agencies conducting criminal record checks on individuals who provide residential services under the *CFCS Act*.[34] These documents include standards and policy on recruitment, retention, screening, assessment and approval of caregivers. All caregivers must undergo intensive screening assessments via a series of questionnaires, interviews, home studies, visits, criminal record checks and reviews, as well as three reference checks. Prior contact checks and criminal record checks must be completed for everyone over age 18 who spends significant and unsupervised time with a child placed in the home. Caregivers must also complete a mandatory approved ministry caregiver education program.[xii] The *Caregiver Support Service Standards* require annual reviews of family care homes and also describe the circumstances under which caregivers must report abuse to the ministry.[32]

[xii] The B.C. Foster Care Education program was developed by MCFD and the B.C. Federation of Foster Parent Associations. The program includes 53 hours of classroom instruction in 14 modules, covering topics such as communication, child and youth development and cultural responsiveness.

While it is beyond the scope of this review to evaluate the effectiveness of these screening procedures, it appears that MCFD has a well-articulated set of procedures for screening prospective caregivers in foster homes.

Guardianship of children and youth in care

The standards of practice for B.C. social workers recognize that stability and planning are keys to ongoing child well-being and safety.[35] Plans of care are required to ensure that each child or youth is appropriately assessed and cared for while in government care. These same standards require social workers to build meaningful relationships with these children by *"maintaining frequent contact and celebrating milestones and achievements with the child."*[35]

Interviews with social workers confirmed that the responsibility for providing stable relationships with the children and youth in their care rests on the shoulders of workers providing guardianship services, who are generally overburdened with high caseloads. A number of social workers interviewed for this review commented on the problem of high caseloads and the resulting impact on their ability to monitor the ongoing well-being of children and youth and to build trusting relationships. Several front-line workers made a direct link between inadequate staffing levels and the failure to appropriately supervise the care being provided to children in group or foster home settings. As one worker said:

> *"The workload is too much. We used to dictate our notes and have admin enter the info; now we are always behind on documentation and we are less connected with children and families. All we do is enter data. You have to let trained social workers do what they need to do . . . we need better service to kids."*

These views were also echoed in RCY's 2015 report on staffing at the ministry, *The Thin Front Line: MCFD staffing crunch leaves social workers over-burdened, B.C. children under-protected.*[36] Workers interviewed for that report who provided both protection and guardianship services repeatedly told the Representative's investigators that, because immediate safety concerns took precedence, they had too little time to spend with the children and youth who were already in the care of the ministry.[36] While the Representative has no doubt that many guardianship social workers form loving bonds with the children and youth they are responsible for, these comments suggest that there are clearly situations in which children are not sufficiently supported and monitored in their residential placements and those with more complex needs often fail to receive care planning and engagement commensurate to their circumstances.

Children and youth at risk of sexual exploitation

The Representative regularly receives critical injury reports involving children and youth in the care of MCFD or DAAs who are subject to sexual exploitation (e.g. through child pornography, sexually explicit websites, or via the exchange of sexual acts for drugs, food, shelter, protection or money). MCFD has special guidelines for social workers on preventing sexual exploitation that stem from government-wide concern in the early 2000s about commercial sexual exploitation of youth.[37] These guidelines encourage workers to take an active role in preventing children or youth in their care from being sexually exploited.[37] The guidelines recommend certain practices but are not audited for compliance:

- maintaining regular communication with children and youth
- being supportive and making children and youth feel valued

- keeping track of a child or youth's friends, preferred meeting places and phone numbers
- setting appropriate expectations for children and youth
- maintaining regular contact with a child or youth's teachers
- ensuring that children and youth know where to go to get help or support, and
- ensuring that children and youth realize the potential dangers that are associated with use of the Internet.

For some youth experiencing vulnerability, not being able to access food or shelter, or coping with a parent who is in active addiction or poverty, this leads to sexualized violence and survival sex in exchange for money.

The value of stable homes

As the aggregate data included in this review suggests, many children and youth in care who are victims of sexualized violence experience multiple placement changes. Several social workers reported that stable residential placements are important for reducing the vulnerability of some children and youth to sexualized violence. This is echoed in the prevention literature, which notes the importance of both stable living arrangements and stable relationships with adults for the well-being of children and youth.[22, 38]

Workers interviewed for this review repeatedly described a lack of residential options for children and youth. Because of this, workers described being forced to place children and youth in whatever living arrangements were available, rather than in homes that would meet the specific needs of a child, such as addressing their drug and alcohol issues or history of abuse and neglect. These issues are echoed in MCFD's 2012 report on residential services that noted the *"importance of matching a child's needs within a residential care context to an appropriate residential setting"* [39] and were also confirmed in a recent joint RCY and MCFD review of hotel placements that found a lack of available residential care to meet the specialized needs of the children or youth.[40] The pattern of multiple moves is also reflected in other reports issued by the Representative (*Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*, 2012; *Who Protected Him: How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children*, 2013).[41, 42]

Responding

Given the high potential for psychological trauma from sexualized violence, children and youth can benefit from services provided by skilled and experienced practitioners with specialized training in child sexualized violence and abuse. It is also important that service providers have a strong understanding of the dynamics of sexualized violence in institutional and other care settings.[43] Because of the heightened potential for re-victimization after a child or youth has been sexually assaulted for the first time,[8] the need to respond immediately to incidents of sexualized violence against children and youth is especially important. Families and communities also play an important role for children and youth who are victims of sexualized violence and need support to be able to do so. There may be a cascading impact of multiple abusers and patterning of children and youth being vulnerable to further abuse and exploitation having never received support for earlier victimization.

It is also important to make services more accessible and seamless so as to proactively increase engagement of children and youth with the needed services. Unfortunately, data show that the rate of participation in post-incident services by children and youth who have been subjected to sexualized

violence is only moderate. Some children and youth, based on the quality of previous services received, may have a negative view of health and social service professionals that influences their engagement with these services.[5] It is therefore important to increase the accessibility and tailored nature of these services, employing strategies such as the use of child- and youth-friendly service locations, eliminating financial barriers to supports, increasing the provision of services in rural or remote areas, or ensuring that care is provided in a consistent manner with minimal change in service providers so that trusting relationships can be formed.[44] Services also need to be culturally appropriate. Other strategies, such as increasing the range of available services to include crisis services, outreach, family therapy, support groups or telephone helplines, or using flexible service models with frequent appointment reminders, may address low service participation rates on the part of children and youth.[43] Creating low-barrier and effective services may require championing by more powerful adults so that the abuse can be safely discussed.

Services that are coordinated between multiple agencies, are co-located in easily accessible settings, or follow the "wrap-around" model of service provision, may also increase participation in post-assault services. Child Advocacy Centres (CACs) appear to be particularly helpful at reducing the number of times that children or youth have to discuss the incident of sexualized violence, as they allow professionals from relevant fields (police, social services, mental health, physical health) to respond to the incident in a holistic, coordinated and collaborative manner.[8, 45]

Responding – what does B.C. do?

The *CFCS Act* and MCFD's child protection policies clearly state that sexual abuse is grounds for a child protection investigation when a child or youth lives with his or her family (e.g. parents, other relatives). Once a child comes into government care, either on a temporary or permanent basis, it becomes considerably less clear what actions social workers are required to take when they receive reports of sexualized violence against the children and youth in their care – this despite the fact that the government is now the child's legal parent.

Child protection responses

Part 3, s. 13 of the *CFCS Act* details the circumstances under which a child or youth needs protection, including harm caused to the child or youth by sexual abuse or sexual exploitation. Specifically, a child or youth is considered to be in need of protection if they have been (or are likely to be) sexually abused or exploited by a parent, or sexually abused or exploited by a person other than a parent where the parent is unable to protect them. For the purpose of the *CFCS Act*, sexual exploitation involves encouragement or coercion to engage in sex work.

MCFD standards require that once a report of sexual abuse or sexualized violence is made about a child living in a family home, social workers initially screen the report and determine the priority of the response.[46] Social workers are advised that any reports of sexual abuse should be responded to within 24 hours if the child requires medical attention because of sexualized violence, and/or the alleged perpetrator will have access to the child or youth in the next five days. Otherwise, social workers can decide to respond within five days.[46] From there, the required safety assessments are conducted to assess the report. In addition, social workers must *"immediately inform the police if information is received that indicates that . . . the child/youth has been sexually abused or sexually exploited"* (p. 6).[46]

PROMISING PRACTICES

Child Advocacy Centres

One of the promising practices to address child sexual abuse is the emergence in North America of Child Advocacy Centres (CAC). Conventional responses to child sexual abuse can be fragmented among multiple service providers, police, Crown and courts. CACs seek to reduce the potential for additional trauma that can occur when child victims and their families are required to tell their stories multiple times and in multiple settings. CACs bring together multidisciplinary teams of professionals in a coordinated and child-friendly manner to support the needs of young victims and their families. This collaborative method of providing services ensures that a child-focused, trauma-informed practice can begin as soon as possible.

One such centre is the Victoria CAC, a program of the Victoria Child Abuse Prevention and Counselling Centre, housed in the Victoria Community Response Centre. The Victoria CAC model is based on the principle that the needs of children and youth should come first when cases of child abuse are investigated and prosecuted. The Victoria CAC ensures that services are available through the Victim Assistance Program for child and youth victims of crime from the time of police interviews and throughout the justice process for those who are required to be a witness in court. The Victoria CAC has two rooms for police forensic interviews and a child- and youth-friendly waiting area for children, youth and their parents to meet with a victim assistance program worker. The goal is to reduce the number of interviews by criminal justice professionals and the risk of re-traumatization.

The Representative fully supports the development of a network of CACs around the province but cautions that programming and services will only be successful with appropriate, stable, multi-year funding. During the past decade, there have been major fluctuations in this funding and service disruption at times.

Turtle Talk Program

Turtle Talk was originally a three-year initiative between Victoria's Mary Manning Centre and the Tsawout First Nation's Health Centre that continues today at the Tsawout First Nation. Funded by the federal government, the program used the metaphor of a turtle to teach safety and prevention skills to children. Like the turtle, the children are taught that they always have a natural boundary around their body that is to be respected by all others, no matter what. The turtle is also an appropriate symbol for teaching the Turtle Talk program within Indigenous communities because turtles always travel with their clan and go back to their roots, just like the salmon.

The primary focus of Turtle Talk is on teaching children safety and prevention skills. The children learn concepts such as appropriate boundaries for themselves and others, the importance of honouring their feelings, being assertive about their boundaries, and that it is always important to seek help when they experience something that does not feel right to them. In addition, the Turtle Talk program focuses on bullying prevention work and integrating the virtues of respect, cooperation, compassion, honour, generosity and love into their choices and behaviours.

The Federal Department of Justice is the program's main funder.

Sexual Abuse Intervention Program (SAIP)

The SAIP program is a community-based program, funded by MCFD, that provides specialized assessment and treatment services to children and youth under age 19 who have been sexually abused, and to their families. See text box on page 27.

Although the *CFCS Act* includes detailed descriptions of the circumstances under which a child or youth can be taken into care, the Act is clear that the legislation only pertains to child protection responses when a child is not in government care. In other words, a child or youth is in need of protection if they have been (or are likely to be) sexually abused or exploited while in the care of a parent or other adult, and are not yet in the care of the ministry. In such a case, the child or youth would likely be removed from the unsafe situation (living with the parent) and MCFD or a DAA would assume guardianship.

Deeply concerning is the lack of a provision in the Act for a child or youth who may be in need of protection if they are sexually abused or exploited by another person while under the care of MCFD, even though this circumstance would require an equal (or greater) response on the part of the ministry in its role as the "prudent parent" of the child or youth.

It should also be noted that the ministry has a set of standards that apply to B.C.'s 23 DAAs. These standards are organized by delegation responsibility (voluntary, guardianship, child protection) and offer a more culturally-based approach to service. The *Aboriginal Operational and Practice Standards and Indicators* (AOPSI), similar to MCFD's practice standards, do not provide social workers with any guidance on how to address sexualized violence, other than referring to s.3 of the *CFCS Act* as detailed above.[47]

Screening of residential placements by MCFD

MCFD has standards that govern the screening of potential foster parents, as well as protocols for addressing how reports of sexual abuse against children or youth will be handled if they occur in a foster home setting.

In the case of children and youth who were included in this review, they were already in the care of MCFD or a DAA when the sexualized violence was reported. Children and youth in care may live in one of a range of residential options, which include: foster homes, most of which are recruited, assessed and approved by MCFD staff; staffed residential care, which can include group homes and contracted family-based care models; and kinship care, which includes placements in "restricted foster care" where a child or youth who is in the ministry's care is placed with extended family or other adults. It is also possible that children and youth who are not in the care of the ministry may be placed with family and other adults through either the Extended Family Program or court orders under the *CFCS Act*. Youth may also reside in a "tertiary care" facility such as a hospital designated under the *Mental Health Act*, youth custody centres and youth justice substance use treatment programs.[39]

MCFD's *Standards for Foster Homes* (1998) requires foster caregivers to be responsible for a child's personal safety, although no guidelines are provided on how to respond to disclosures of sexual abuse.[48] Another MCFD document, *The Pre-Service Orientation – Family Care Home Program*, a publication aimed at potential foster parents, defines and discusses sexual abuse and provides information on possible indicators of sexual abuse.[49] This guide also advises foster parents on how to best respond if a child discloses sexual abuse. The guidelines emphasize staying calm, reassuring the child that they have not done anything wrong, talking with the child about what will happen next and reporting the disclosures to the child's social worker. They underline the fact that foster parents have a duty to report abuse and neglect of the children and youth in their care to the children's social worker, but do not specifically mention sexualized violence.[49]

While a child or youth is in care

The document *Protocols for Foster Home Framework* (2002) covers how reports of abuse in foster homes will be handled.[50] The document states that *"Protocol investigations are conducted following the requirements laid out in the Practice Standards for Child Protection and the Standards for Foster Homes."* A protocol investigation should be undertaken if *"a child in care has been, or is likely to be, sexually abused or exploited by the child's caregiver . . . sexually abused or sexually exploited by another person and if the child's caregiver is unwilling or unable to protect the child."*[50] Depending upon the outcome of an investigation, a foster home can be deemed to be unsafe. A new residential placement is then sought for the child or youth and the new caregiver must be provided with information about the sexualized violence allegations, whether they were investigated, and the outcome if known.[50]

While the ministry's *Child and Family Development Service Standards* (2003) referred to previously in this report provide a mandatory framework for guardianship workers, these standards do not specifically outline what actions a worker should take and what supports should be provided to children and youth when an incident of sexualized violence occurs.[32] Reports of sexualized violence will prompt a protocol investigation of a foster home, but it is unclear what is required of social workers in terms of connecting children and youth to services and supports.

Similarly, there is a lack of clarity in MCFD documents about how workers should respond if a child or youth is subjected to sexualized violence in a staffed resource operated by a contracted agency. The *Standards for Staffed Children's Residential Services* (1998) require that staff members take action to prevent harmful situations but provide little in the way of guidance on mandatory requirements for how these same workers should respond to reports of sexualized violence.[51] Nor are there clear policies and standards around how reports of sexualized violence should be addressed or investigated in staffed residential services. This lack of clarity in policy and standards is likely to result in differences in practice between social workers and thus differences in the supports provided to children and youth by workers. MCFD is currently developing a policy that will guide investigations of contracted resources.

Both child protection and guardianship workers lack specific guidelines on how to respond to and manage disclosures of sexualized violence, on to how to empower youth, on who the community experts on sexualized violence are, and on where to refer children and youth for specialized sexual assault supports. MCFD also lacks guidelines that can help workers understand the different power dynamics that distinguish sexualized violence by peers (e.g. boyfriends) from child and youth sexual abuse by adults in positions of power. Ideally, workers should be able to engage in an informed discussion with children and youth when they first come into care regarding the potential risks of violence, particularly sexualized violence. Children and youth in government care should be assured that if they are ever a victim of sexualized violence, they should feel comfortable coming forward, as they will be listened to and responded to appropriately.[xiii]

[xiii] Ending Violence Association of B.C. recently released *Responding to a Sexual Assault Disclosure: Practice tips for child protection workers*. Available at: http://endingviolence.org/wp-content/uploads/2016/05/EVA_PracticeTips_ChildProtection_vF.pdf

Services for children and youth

The province of B.C., through various ministries, provides a number of funded service options for children and youth who have been subjected to sexualized violence, including:

- **SAIP – Sexual Abuse Intervention program:** a community-based program, funded by MCFD, that provides specialized assessment and treatment services to children and youth under age 19 who have been sexually abused, and to their families.[52]
- **Victim Services:** Two kinds of victim services are publicly funded in B.C. – police-based and community-based. Police-based victim services operate out of police departments and provide services to victims of all crimes. Community-based victim services usually operate out of community agencies and have a specialization in supporting survivors of sexual assault and domestic violence. Both police-based and community-based victim services are funded through the Ministry of Public Safety and Solicitor General. These services can help with any aspect of sexualized violence, from emotional support and accompaniment to hospitals and police stations, to advocacy with MCFD and helping to speak to caregivers.
- **Stopping the Violence Counselling:** These services provide more in-depth counselling for survivors of sexualized violence and relationship violence and, while mostly focused on adult women, all have provisions to provide services to youth who are *"living an adult lifestyle."* Clients do not have to report incidents to the police in order to access these services.[xiv]
- **Outreach and Multicultural Outreach:** Outreach programs have a large degree of flexibility to support survivors of violence. While they usually focus on relationship violence, they can provide practical assistance and advocacy, transportation and counselling.
- **Specialized emergency response teams:** Some hospitals in B.C. have specialized sexual assault teams that can provide a range of services including assessment and treatment of injuries, forensic sample collection, medical reports for police and referrals to health, legal and community-based supports.

Sexual Abuse Intervention Program

In 2010, the Representative released a report that reviewed implementation of recommendations contained in an independent contractor's review of the provincial Sexual Abuse Intervention Program (SAIP). This program was established by government in the 1990s to provide a range of treatments and support services to children and youth who have been sexually abused, and to children under the age of 12 with sexual behaviour disorders. Dr. Kimberly McEwan reviewed SAIP in 2005, looking at the mandate, contracting processes and management, service capacity, quality control and how the program works with Child and Youth Mental Health services. RCY's review of McEwan's 15 recommendations five years later noted progress, highlighted ongoing issues and recommended five actions to ensure full implementation of the recommendations. As of 2014, RCY's recommended actions – addressing consistency in data collection, staff training, the need to ensure evidence-based clinical and policy direction, funding for training and curriculum development and evaluation of program performance – have all been implemented.

[xiv] See B.C. (2016). *Victim Services*. Available at: http://www2.gov.bc.ca/gov/content/justice/criminal-justice/bcs-criminal-justice-system/understanding-criminal-justice/key-parts/victim-services

With the exception of specialized emergency response teams in hospitals, the services described above are offered through contracted agencies located throughout B.C. A recent analysis of working conditions for the anti-violence staff in these programs found that, while the complexity of the work has increased significantly in the last 20 years, B.C. government funding has not kept pace and in some cases has decreased.[53] Before 2000, B.C. was a leader in Canada in developing progressive and innovative approaches to addressing violence against children and women. But over the last 15 years, funding and program cuts, failure to keep up with increased demand and policy decisions have meant that B.C. has fallen behind in responding to sexualized violence. In 2004, for example, core funding for sexual assault centres in B.C. was cut.[53]

Workers in the anti-violence fields have reported increased job pressures in terms of larger caseloads, longer wait lists and increasingly complex legal, policy and reporting requirements. They also share concerns that the child and youth focus is distinct and should not be included with adult services. In addition, workers are faced with addressing the needs of clients with increasingly complex issues, declining public resources for legal aid, low wages, limited to no benefits and low retention of trained and experienced workers. While these workers have specialized knowledge about how to prevent and respond to sexualized violence, they have little time to do the necessary community-level prevention work that could help prevent sexualized and other forms of violence.[53] The implications of these pressures for children, youth and families seeking services could be significant. Increasing wait times for services mean that children, youth and their families in the midst of a crisis may not be able to find and receive immediate services when they reach out for support.

There is also a lack of culturally appropriate, community-level services, particularly in rural and remote communities. Where services are available in urban areas, they tend to be fragmented among various providers and across ministry responsibilities. Services for Aboriginal people are further jeopardized by a complex and multijurisdictional funding environment that lacks collaboration between federal, provincial and local governments.[54] Given that a large number of the victims of sexualized violence identified in this report are Aboriginal, the lack of culturally based services in many areas of the province is of deep concern.

Services to the children and youth in this review

The aggregate data included in this review suggests that post-sexual assault services were offered to the child and youth victims in almost three-quarters of the cases, usually in the form of counselling, although specific sexualized violence services were rarely offered. In half of the 33 cases in which post-assault services were not offered, the child or youth was already receiving some type of service (usually mental health counselling, drug or alcohol counselling, or working with a psychologist or youth worker), and the social worker did not see further referrals as necessary. In 13 of the 145 cases, there was no mention of any supports being offered by social workers or healthcare workers after a report of sexualized violence had been made.

Where services were offered to the child or youth post-sexual assault, only about half of the children or youth participated. Often a child or youth declined the services that were offered because they did not want to further discuss details of the incident. In other cases, the child or youth preferred to continue with the workers they were already engaged with rather than developing new relationships with other service providers. Unfortunately, there is little consistent information on whether or not children and youth were offered culturally appropriate services.

In many cases, guardianship social workers expressed frustration with their inability to respond adequately to a child or youth's complex needs. One worker described the feeling of helplessly *"watching a train wreck"* as vulnerable youth were continually exposed to high-risk situations and refused services or were not adequately supported to engage with services that were offered. Some caregivers, social workers and other professionals involved with these youth were at a loss as to how to help, beyond managing the current crisis, although early intervention services were suggested as a possible tool to support children and youth who have been traumatized by adverse childhood experiences, including sexualized violence. Often, children and youth who are in care have been let down by adults in the past. Their resistance to services may be the result of a well-founded mistrust of systems and a history of experiencing ineffective social responses that did not address their needs.

AMBER'S STORY

Amber, an Aboriginal female youth with special needs, was sexually assaulted by another youth she knew from school. An MCFD social worker and the RCMP were notified of the youth's disclosure. The RCMP officer interviewed Amber alone, in a small padded room between two jail cells. This small room in the local RCMP detachment is normally used to interrogate people who have been accused of crimes. The RCMP officer had no training in interviewing young people who have experienced sexualized violence, let alone a youth with special needs (FASD).

Best practices would have been for the investigation to be completed jointly with the RCMP officer and social worker, with ongoing collaboration and communication as it progressed. The interview should have been conducted in a "soft" interview room – a quiet, comfortable room designed to ease the investigative interview process for victims of sexualized violence. A "soft" room is usually soundproof, has comfortable and inviting décor and digital cameras. The digital cameras and microphone usually connect to an adjacent room where a social worker can view and hear the interview to avoid having to conduct two interviews – which can be re-traumatizing to the child.

More than one worker noted that office-based appointments were highly unlikely to be successful for difficult-to-engage youth and stressed the need for more outreach services rather than expecting youth to come to appointments during regular business hours. However, office-based appointments were often the only therapeutic service available for these youth, and sometimes entailed lengthy wait times. For the few youth who had access to other services, outreach mental health was noted to be somewhat more successful. However, workers were also concerned that services were inadequate, wait-listed or not sufficiently specialized. As one worker said:

> *"There's a lack of culturally appropriate counselling, lack of funding, lack of qualified staff, and the wait list for treatment for substance use is long."*

Interaction with Justice and Health Care Systems – the Children and Youth in this Review

As this review has noted, sexualized violence against children and youth is a crime and perpetrators are subject to penalties set out in Canada's *Criminal Code*. However, the justice system's response to sexualized violence against children and youth remains an area of concern. Successful prosecution of offenders is dependent on a variety of factors, not all of them connected to the strength of the evidence.

Child-Friendly Justice System

Child-friendly processes recognize that disclosing sexualized violence, being interviewed by police and court proceedings can be uniquely stressful for children and youth. Adult survivors of sexualized violence often find court proceedings to be stressful, painful and re-traumatizing; this can be even more so for children who are disclosing and/or testifying against adults who may have been in positions of trust in these children's lives. Some ways that the justice system can be made friendlier for children include:

- Conducting initial interviews with specially trained social workers and police in a neutral place that takes into consideration the child's needs and best interests (e.g. where does the child feel safe, availability of qualified interpreters if needed) and using recording equipment so that children do not have to tell their story multiple times.
- Assigning Crown attorneys who know how to work with children to build rapport and be sensitive to their needs.
- Improving access to court resources that protect child witnesses. Provisions in the *Criminal Code of Canada* recognize that special provisions must be made for children when they provide evidence in court to make testifying less stressful (e.g. use of closed circuit television allowing a child to testify outside the courtroom; a screen that blocks a child's view of the accused to avoid seeing the offender; excluding the public from the courtroom during the proceedings; a ban on publication of the child's name; allowing a support person to sit with or stand next to the child in the witness box). However, the availability of these techniques can be dependent on court resources. Circuit courts, for example, which make use of local community facilities for court proceedings, may lack the technology required to support child witnesses. [55, 56]

Most MCFD and DAA guardianship workers and After Hours[xv] staff made attempts to preserve evidence, initiate reports to police as soon as possible, and respond to the child or youth's needs for support. However, these actions were not consistently applied. In some cases, the social worker was either unaware of, or did not record the full extent of, treatment and services received at the hospital, the details of the incident, or the result of the police report.

In most files examined in this review, few details exist regarding whether crisis-response services were offered at the hospital where the child or youth was examined. Information was also missing regarding whether all victims were interviewed in a child-friendly, trauma-informed manner – for example, by conducting interviews with police and social workers at the same time so as to minimize the trauma of making multiple statements, using child-friendly language, or offering support services immediately after the child or youth's disclosure.

[xv] Social workers respond to after-hours calls involving child protection, services to children in care, services to youth and families, Community Living BC and other MCFD programs.

However, in 27 of the 145 incidents of sexualized violence, social workers did indicate that child-friendly interview methods had been used.

Of the children and youth included in this review, 12 did not want to report their experiences of sexualized violence to police. There is no indication that social workers in these cases made reports on the child or youth's behalf.

There were also significant delays in reporting. While three-quarters of the 121 children and youth in this review reported an incident of sexualized violence within one month of it happening, 17 children and youth waited between one and six months to make a report, and 11 children or youth did not report the assault until more than six months had passed. In the most extreme case, eight years passed between the sexualized violence and the disclosure, which was not made to a social worker until six months after the victim revealed the assault to a family member.

In addition to the 12 cases in which no police report was filed, a further 14 cases resulted in a report being filed with police but the child or youth declining to provide physical or written evidence to corroborate the sexualized violence. Reasons for this reluctance to disclose to police included not wanting to repeat details of the incident and being fearful of repercussions resulting from an official investigation. In one case, a youth was willing to make a report to a particular police officer, but that person was not immediately available. By the time the officer became available to hear the youth's statement, the youth no longer wished to discuss the assault.

Of the 133 incidents of sexualized violence that were reported to the police, more than half (71) resulted in no charges being recommended to the Crown. In many cases, there was not enough evidence for a charge, often because the child or youth was reluctant to disclose the identity of the perpetrator or discuss the sexualized violence in detail.

Details on 58 of the sexualized violence incidents were forwarded from police to the Crown for consideration of charges. In 21 of these cases, the Crown did not proceed with prosecution, and in eight cases, trials remain pending as of June 2016. However, in 22 cases, the perpetrators were successfully prosecuted. Six cases did not result in conviction and one case followed a restorative justice process.[xvi]

Prosecution of an Offence

Before a perpetrator can be successfully prosecuted for a sexual offence, the crime must be reported to the police. It is not required that the offence be reported by the victim, as police detachments accept "third-party reports" (reports from family members or service providers). Once the police have a report of a criminal offence, a file is opened and an investigation commences. The investigation involves gathering all available evidence of the alleged crime. Once complete, the police will determine whether there is sufficient evidence for a report to Crown Counsel to be filed.

If there is sufficient evidence, the file is forwarded to Crown Counsel for consideration of whether the evidence is sufficient for a successful prosecution. This generally requires that the evidence demonstrates a substantial likelihood that the alleged perpetrator's guilt can be proven beyond a reasonable doubt. Crown Counsel must also determine whether it is in the public interest to proceed with a prosecution. If there is a decision to prosecute, and a finding of guilt is made, a judge will then determine a suitable sentence.

[xvi] Restorative justice is a process to repair the harm caused by crime. It emphasizes accountability, making amends, and can facilitate meetings between victims, offenders and others.

Some of the guardianship social workers who were interviewed for this review expressed concern that police, and occasionally hospitals, did not respond appropriately to reports of sexualized violence. Some workers reported that children or youth were not believed when divulging their stories, or were deemed to be lacking in credibility because of mental health concerns or disabilities. One social worker commented:

> *"Communication between RCMP and Crown Counsel needs to improve. A lot of times, RCMP and the Crown don't take sexual assault seriously, saying it's consent issues."*

A number of social workers also expressed concern about the perceived lack of willingness on the part of the Crown to lay charges against offenders and pursue convictions. Some social workers recommended that incidents of sexualized violence should be investigated by specialized teams in order to promote collaboration between agencies and hold perpetrators to account for their actions.

A further concern raised in interviews was the failure by police to inform social workers about the outcome of criminal investigations. At times, workers were able to acquire this information by initiating contact with the police themselves. Occasionally, however, workers reported that police refused to provide any information to them despite their status as the child or youth's legal guardian.

A number of social workers expressed a desire for more comprehensive training on how to respond to incidents of sexualized violence to better support children and youth on their caseload. One worker commented that, *"The unit needs to have proper protocols, proper training and supervision."* Although specialized teams were proposed as one option, social workers also suggested that all staff receive more training on how the criminal justice system works and how to best work with the police and Crown on sexualized violence cases.

Discrimination against Aboriginal children and youth

While there are many disturbing discoveries in this review, one of the most egregious is that several of the Aboriginal children and youth included in this aggregate review were identified by their MCFD or DAA social workers as facing barriers consistent with discrimination from justice and health care professionals. One worker noted that a youth on her caseload who was both Aboriginal and female, and who was also frequently away from her placement and involved with the youth justice system, was treated differently by police and by service providers. The worker noted that, *"There is almost an assumption in the community that [this youth] will be sexually victimized and that it is only a question of when."* Despite frequently being the victim of physical and sexualized violence, this youth was *"described in such a way that one would believe these incidents are her fault."* By treating this youth differently and describing her as if she were a participant in the violence rather than a victim, police and service providers minimized the violent intent of potential perpetrators and, instead, blamed the youth for her situation. Not surprisingly, this social worker was concerned that such discrimination would cause further emotional harm to the youth. "Normalizing" sexualized violence against Aboriginal girls can lead to professional indifference on the part of some service providers who expect it to occur.

Results from research studies and consultations with Aboriginal people in Canada have found that the low trust Aboriginal people have in systems including justice, education and child welfare is due to systemic racism (see for example:[17, 24]). Additionally, numerous reports have highlighted the fact that sexualized violence directed at Aboriginal women and girls is common.[xvii] Many of these reports support culturally based responses that value the traditions and world views of Aboriginal children, youth and families. These reports highlight the importance of ensuring that Aboriginal communities play a role in defining their own service needs and designing appropriate services for Aboriginal children and youth. Many of these same works point to the need for social service and criminal justice professionals to work toward lessening the distrust that has become normal for many Aboriginal children and youth, by strengthening relationships between service providers and victims and their communities, and by addressing systemic racism within the justice system itself.[17, 57, 58]

A DAA PERSPECTIVE

"The need to support victims of sexual violence who are in care is a major concern to me. In our community, I've seen some very difficult situations in which young victims struggle with overwhelming shame and a trauma that makes disclosure and recovery very challenging. Our agency has no support to address this, yet we face it every week. So much change is needed and safety for our kids must include building on our cultural practices of supporting those who come forward instead of isolating them and simply moving them through this difficult time. Healing is a meaningless word if we don't have our culture and resources to blanket our children and youth. We need to wrap them in love and care and walk with them to see that the violence is exposed and that it stops."

– Leader of a B.C. delegated Aboriginal Agency

Other studies confirm that there is a lack of culturally appropriate, community-level services, particularly in rural and remote communities. Where services are available in urban areas, they tend to be fragmented among various providers and across ministry responsibilities. Services for Aboriginal people are further jeopardized by a complex and multijurisdictional funding environment that lacks collaboration between federal, provincial and local governments.[54] Given that a large number of victims of sexualized violence identified in this report are Aboriginal children and youth, the lack of culturally appropriate services in many areas of the province is of concern to the Representative.

[xvii] There are many reports and studies that document the issue of sexual, physical violence and trafficking of Indigenous women in Canada. Summary reports of these studies include: Native Women's Association of Canada, 2014; Byrne et al., 2011; EVA-BC, 2005.

Government "Vision" without Sustained Action

In terms of both preventive action and responses to sexualized violence against children and youth, B.C. falls well short. The promising results of social-ecological approaches to preventing sexualized violence described earlier in this report suggest that efforts to prevent sexualized violence against children and youth in care must reach beyond MCFD and other service systems to address the broader social issues, such as sexism and racism, that increase the risk of sexualized violence. Similarly, child- and youth-centred responses to victims of sexualized violence need to take place within a well-designed and appropriately resourced system of services.

In 2015, the B.C. government released a framework entitled *A Vision for a Violence Free BC: Addressing violence against women in British Columbia*.[59] This framework promises a set of actions to reduce violence against women that focus on prevention and enhanced responses, along with addressing violence against Aboriginal women. The framework acknowledges that young women (ages 15 to 24) are at greater risk of being subjected to violence than older women, but does not provide any context for violence against girls.[59]

The framework focuses mainly on domestic violence and suggests a number of actions that build on already existing programs to prevent violence, including school-based prevention programs that decrease social aggression in young children, programs to address bullying, programs to work with perpetrators and efforts to challenge attitudes and behaviours that perpetuate violence.[59] It promises to enhance school-based programs *"as funding becomes available"* (p. 11) and to continue to support mostly already existing prevention initiatives.[59]

An additional response to violence includes existing violence response and counselling programs noted in the previous section of this review.[59] The 2015 framework promises a provincial sexual assault policy, which to-date has not been released by government, leaving B.C. without direction to guide a comprehensive and coordinated response to sexualized violence across a number of ministries and service providers. This framework also commits government to *"target new investments, as funding becomes available, to support enhancement and development of responses to address sexual assault."* While these investments are crucial for an effective response to sexualized violence, the framework does not make it clear what the scope and scale of these investments will be and when they will occur, and nor does the framework commit government to specific actions in this regard for children and youth.

The province has also made one-time-only grant funding available through its criminal and civil forfeiture program that is then directed toward initiatives under the Violence Free B.C. framework mentioned earlier in this review. Some of the projects funded by this grant money focus on coordinated sexual assault responses for girls and young women, initiatives for at-risk youth and culturally based sexualized violence programs.[xviii] However, there are significant limitations to funding provided on a time-limited, project-by-project basis or through crime source forfeiture when these revenues are not stable. There is no guarantee that these initiatives will receive on-going funding, making it difficult for anti-violence workers and organizations to plan future staffing and programs.

[xviii] See: B.C. Government. (2016). *News Release: Over $7 million to combat gangs, youth crime and violence against women.* March 23, 2016. https://news.gov.bc.ca/releases/2016PSSG0075-000446. See also: *Civil Forfeiture & Criminal Forfeiture Grants, 2015-16.* Available at: http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/crime-prevention/community-crime-prevention/grants/cfo-2015-16-grant-recipients.pdf

In general, the B.C. government's framework focuses on existing initiatives and promises little in the way of new resources to prevent and respond to sexualized violence, especially violence directed toward children and youth. When considered together with cuts to anti-violence programs such as sexual assault centres mentioned earlier, it is clear that B.C., despite a laudable pledge to be "violence-free," is a laggard rather than a leader in preventing and responding to sexualized violence.

Given the high level of sexualized violence directed at children and youth in care, and the knowledge that much of this violence goes unreported, it is disappointing to see that government has not made a sustained effort to include this in its anti-violence framework. This must change if it is to adequately prevent and respond to violence against children and youth, particularly those in its own care.

Analysis and Findings

An analysis of the aggregate data included in this review shows that sexualized violence is not a rare occurrence for children and youth in government care, and that children and youth are more vulnerable to sexualized violence if they are female, Aboriginal, or have complex needs such as mental health concerns, problematic substance use issues or disabilities. For younger children in RCY's sample, sexualized violence was most likely to occur in a placement setting. For older youth, public places and private residences were the most high-risk settings for sexualized violence, especially when perpetrators were casual acquaintances. Almost all of the identified perpetrators in this review were male and were known in some way to the children and youth they victimized.

Finding: A disproportionate number of children and youth who are subjected to sexualized violence while in government care are Aboriginal girls.

Seventy-four of the 121 children and youth in this review were both Aboriginal and female – a number that clearly demands further attention. Aboriginal girls in RCY's review were four times more likely than non-Aboriginal girls to be the victims of sexualized violence if they were under the age of 12.

When asking why this is the case, the findings of Canada's Truth and Reconciliation Commission demonstrate that violence against Aboriginal children and youth must be understood not simply as individual incidents, but as one of the many negative remnants of Canada's historical and current discriminatory policies and practices.[24]

In addition, there is an urgent need to acknowledge and address the racism that prevents Aboriginal victims from asking for and receiving support.[58] Consistent cultural planning was absent for children and youth in this review, with some social workers noting that funding for cultural programming was inadequate. It is important that the supports and services that are offered to Aboriginal children and youth who have been subjected to sexualized violence focus on their cultural identities and use values and norms from their Indigenous cultures for healthy boundaries and personal safety. Although some Aboriginal children and youth in this review did receive traditional supports alongside more mainstream counselling services, the lack of consistency in the cultural planning portion of their formal plan, and the restricted funding of cultural support opportunities, resulted in some Aboriginal children and youth missing out on significant post-assault services.

Finding: There is a lower standard for MCFD investigations of alleged sexualized violence when children and youth are in care than when they are not in care, and no policies or guidelines exist for guardianship social workers specifically for preventing and responding to sexualized violence once children and youth are in government care.

While child protection processes are clear regarding alleged abuse of children and youth who are not in care, the policy guiding protocol investigations of foster homes lacks specifics, and MCFD does not yet have a policy to guide investigations for contracted residential resources. This lower standard exists despite the fact that the government of B.C. has legal and moral responsibility for children in care, many of whom have vulnerabilities that place them at higher risk of sexualized violence.

A review of policies and standards at MCFD and DAAs finds an adequate level of screening for foster parents, but little in the way of specialized training to prevent and respond to sexualized violence against

children and youth in their care. Training of caregivers and foster parents is therefore important to ensure that caregivers know how children and youth might respond to sexualized violence, can recognize behaviours that indicate a child or youth is struggling with post-incident trauma, and will avoid blaming the child or youth if sexualized violence occurs. Group homes and staffed residential resources that are run by contracted agencies lack clear lines of responsibility regarding how to report an incident of sexualized violence against a child or youth in their care to MCFD or DAA staff or to justice agencies. This lack of guidance can result in inconsistent responses to sexualized violence that vary depending on the resource itself, the staff employed there, and the relationships between contracted staff and MCFD/DAA social workers. The idea that a child or youth who is subjected to sexualized violence while in care may receive an inadequate service response from caregivers based simply on where the ministry has placed them is alarming.

Although MCFD and DAA policies stipulate that social workers must report any incident of child or youth sexual abuse to the police when it pertains to a child protection matter, there is no corresponding policy or guideline when the child or youth is already in government care. Some social workers in this review did not provide a third-party report of incidents of sexualized violence to police, meaning that some incidents were never investigated beyond the critical injury report stage. However, a number of guardianship social workers expressed their desire for more specific policies that would clearly spell out their responsibilities for responding to sexualized violence. These policies should lay out the steps to take when children or youth in care disclose an incident of sexualized violence to social workers, and would encourage standardized responses across all offices and regions. Supplementing these policies with more information about the appropriate services and supports available to child and youth victims of sexualized violence would also assist guardianship social workers in responding to incidents when they occur.

Finding: The child welfare and justice systems most often fail to respond to children and youth who are victims of sexualized violence while in care in a direct or sustained way to support these young people and to address the root causes with appropriate partners in the system.

Delays in reporting sexualized violence are common and may be related to a number of factors, including: fear of reprisals; fear of not being believed; lack of understanding around the issue of consent; believing that the sexualized violence is "normal," or not wishing to get the perpetrator in trouble with authorities. However, children and youth in government care may have a number of added reasons for delayed disclosure of abuse. For children and youth who are already involved with the child welfare and/or criminal justice systems, the fear of not being believed is likely high, especially when alcohol or drugs have been consumed or when the child or youth is absent from their placement without permission.

Some children and youth may have negative views of child welfare and criminal justice professionals, based on past experiences with workers in these systems. These views can influence their decision to tell someone about being a victim of sexualized violence or their cooperation with criminal investigations once disclosure has occurred. A number of social workers interviewed for this review raised concerns about the high number of children and youth in care who were discriminated against when they reported an incident of sexualized violence to the police. These concerns were amplified by the reported lack of tailored support services that are available to help children and youth who disclose sexualized violence.

While the majority of child welfare social workers expressed concern that police and the courts did not take child and youth sexualized violence seriously, it was shocking that some workers seem to blame the youth for this violence. One worker said that it was *"hard to keep this youth safe as she puts herself in dangerous situations."* This lack of support on the part of responsible adults can lead to poor outcomes for children and youth in care who have been affected by sexualized violence. Clearly, there is a need to address myths about sexualized violence among professionals in the criminal justice and social services systems to ensure that children and youth feel safe to come forward and tell their stories. One of these myths is that children can keep themselves safe in an unsafe environment where known exploitation is prevalent.

MCFD reports that there is information for new employees in its child welfare training on completing joint investigations with police, including joint interviews. The ministry also offers a four-day course on investigative interviewing. However, there are no guidelines or provincial protocols that would assist social workers to work with police and courts when sexualized violence occurs, as there are with other services in B.C. Nor is there guidance for social workers around how to work with communities as a whole, and local resources in particular, in order to ensure that standardized services are offered.

Finding: Service options for children and youth in care who have been subjected to sexualized violence, especially those with complex needs, are not low-barrier, youth-friendly, culturally appropriate or widely accessible.

Coordinated and cooperative services are essential to support vulnerable children and youth, especially when they are reluctant to engage in services. However, similar to other reports released by the Representative (e.g. *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.,* 2013),[60] collaboration among service providers continues to be challenging. Other RCY reports have also demonstrated that, similar to some of the children and youth in this review, many other children and youth experience well-founded resistance to accessing services due to negative experiences in their past. Youth who have been subjected to sexualized violence are particularly likely to avoid services if they perceive them to be unhelpful or judgmental. For this reason, services must be child- and youth-friendly, available and easy to access and financially viable.[44]

Too many children and youth in this review experienced multiple placement changes, often necessitating changes in community, school, friends and professional supports. Child welfare workers also reported that there were too few emergency and long-term placements available with skilled and well-supported caregivers. Several highlighted the lack of group homes for high-needs children and youth, noting that these children and youth were either frequently discharged from placements or that placement staff failed to intervene to prevent them from being subjected to high-risk situations. Some workers also noted that there were few placements that could provide a holistic response to mental health, trauma or substance-related problems.

In addition, social workers stressed the need for prevention and response initiatives that would support children and youth with complex needs, including multiple mental health and neurodevelopmental disability concerns – a cohort of children and youth that is known to be more vulnerable to sexualized violence than young people who do not experience such issues. Children and youth who are already dealing with mental health concerns may find that these issues are compounded by an experience of sexualized violence.

Almost 15 per cent of the child and youth victims in this review had been subjected to sexualized violence on more than one occasion, with one youth being subjected to four separate incidents of sexualized violence over the course of a two-year period, each involving a different perpetrator and high-risk setting. Being subjected to sexualized violence as a child or youth is itself a risk factor for later re-victimization,[2] therefore it is imperative that specialized services are provided to all child and youth victims of sexualized violence immediately after an incident is disclosed.

This review found that specialized services appropriate to sexualized violence are often not available in a timely manner, if at all, for children and youth in B.C. Although CACs are a proven model for coordinated, child-friendly responses to the sexual abuse of children, B.C. has only a few such centres and they are not fully resourced and able to provide an integrated, long-term service model. These centres were sparked by federal government "seed" money and need more stable funding to function with the proper scope and scale of services. While B.C. needs more and better services for younger children, teenagers who are victims of sexualized violence in B.C. face a particularly dire gap in age-appropriate supports available to them. This service gap must be remedied immediately, which will require new funding and an about-face of the austerity of the past 15 years that has seriously limited the capacity of anti-violence services. These changes are urgently needed to meet the needs of all children and youth in B.C., including children and youth in care, who are victims of sexualized violence. B.C. has a limited network of only six functioning CACs, none of which currently has secure on-going funding.

Finding: Sexualized violence of children and youth in government care occurs across multiple settings.

This review has shown that sexualized violence of children and youth in care is not isolated to one particular setting or type of perpetrator. Perpetrators can be peers, family members and other adults. The findings of this report show that the majority of reported assaults that involved younger victims occurred in a care placement (75 per cent), while the majority of reported incidents involving older victims occurred in residences other than their care placement (46 per cent) and unfamiliar or public locations (38 per cent). This finding suggests that, while age matters in terms of where sexualized violence is most likely to occur, it also occurs across a range of sites and locations.

Recommendations

Recommendation 1

That the Ministry of Children and Family Development create and implement a broad strategy with adequate policy, standards, resources and training to address sexualized violence against children and youth in care, with a particular focus on sexualized violence against Aboriginal girls. Strategies directed at Aboriginal children and youth should be developed in consultation with delegated Aboriginal Agencies and First Nations organizations.

Details:

This strategy should address the following:

- Prevention of sexualized violence against children and youth in care, and mandated short and long-term responses to all allegations of sexualized violence.
- Child protection standards for children and youth in the care of the government, including responses to allegations of sexualized violence, must be equal to or greater than those provided for children and youth not in government care.
- Children and youth who are the victims of sexualized violence must receive appropriate therapeutic supports.
- The provision of a B.C.-wide education and training program for social workers, educators, police-based community and victim service workers, police and others on how to detect the signs of sexualized violence, its potential impacts on children and youth and the importance of communication and coordination across service types when a child or youth in care is a victim of sexualized violence.
- Sufficient and appropriate residential placements should be available so that children and youth are not kept in situations where they are at risk of sexualized violence or their vulnerability to sexualized violence is increased.
- Creation of policy to mandate protocol investigations whenever there is an allegation of sexualized violence connected to a child or youth's residential placement.
- This strategy must address the workload issues that prevent social workers from having the time with the children and youth in their care that is needed to assesses and support their well-being in general, and to respond appropriately when children and/or youth in their care are victims of sexualized violence.
- Annual reporting on rates of sexualized violence against children and youth in care in B.C. and the actions taken to prevent and respond to sexualized violence against children and youth in care.
- This strategy should be developed in parallel with the strategy described in Recommendation 2, but must not be delayed due to this coordination.

MCFD to provide a draft of this strategy to the Representative by Feb. 1, 2017.

Recommendation 2

That the Ministry of Public Safety and Solicitor General (PSSG) lead the development and implementation of a network of Child and Youth Advocacy Centres (CYACs) in B.C. This should be done in consultation with MCFD, DAAs, the Ministry of Justice, Aboriginal organizations and anti-violence organizations. This network of community-based services should be phased in, with the first phase establishing at least five culturally based CYACs serving Aboriginal children and youth and their communities. Subsequent phases should strengthen and expand existing CYACs and establish additional community-based CYAC services that meet the needs of all child and youth victims of sexualized violence in B.C., with particular attention to the needs of Aboriginal children and youth.

Details:

This strategy should include:

- CYAC services must be supported with adequate, long-term funding.
- CYAC services must include evidence-based prevention of sexualized violence against children and youth, and integrated, child- and youth-centred therapeutic and justice supports for victims of sexualized violence.
- Services must address sexual abuse perpetrated by adults and peer-to-peer sexualized violence, and respond to the distinct needs of children and youth, and girls and boys. Particular attention must be given to closing the gap in services for teenage girls, especially Aboriginal girls, who are victims of sexualized violence.

PSSG to provide a draft development and implementation plan to the Representative by Feb. 1, 2017.

Recommendation 3

That the Premier of B.C. identify a lead minister responsible for creating and implementing a five-year strategy for preventing and responding to sexualized violence against children and youth in B.C. This strategy should be created in partnership with relevant ministries, Aboriginal organizations and anti-violence organizations, must be evidence-based and should include a strong culturally based Aboriginal focus from inception.

Details:

This strategy should include:

- The network of CYACs described in Recommendation 2.
- Meaningful action to address systemic racism and sexism that make Aboriginal girls more vulnerable to sexualized violence.
- Support for police and Crown Counsel in the investigation and prosecution of perpetrators of sexualized violence against children and youth province-wide.
- Support for victim services and consideration of legal counsel for victims to assure them strong protection from cross-examination that could be abusive and re-traumatizing.

Draft strategy to be presented to the Representative by April 1, 2017.

Conclusion

This review highlights a disturbingly high level of sexualized violence directed toward children and youth in government care. While a recently developed government policy framework acknowledges that sexualized violence is a problem, neither MCFD nor the provincial government as a whole acknowledges the prevalence of this violence. Without this acknowledgment, it is challenging to develop and implement a framework for prevention and response that would meet the needs of these children and youth.

Where programs and services do exist, there is evidence that caseloads are high and wait lists are long. The Province has committed funding to some sexual assault initiatives through its civil and criminal forfeiture program, but these are still time-limited, one-time-only grants without continued funding.

The elimination of sexualized violence will require sustained and concentrated efforts that must span multiple years, service providers and regions. For children and youth in government care, this means that a focused effort is needed to address the social, economic, community, family and individual causes of sexualized violence. In addition, the government must ensure that services and supports are available, not only to these children and youth, but to families, caregivers and the child welfare workers and anti-violence workers who are charged with their safety and security.

Special attention must be paid to Aboriginal children and youth, who were found in this review to be at increased vulnerability to sexualized violence in comparison to their peers. A network of Child and Youth Advocacy Centres serving Aboriginal children and youth and their communities will go a long way to closing the gap in services for Aboriginal teenage girls who are victims of sexualized violence.

Much as was found with the Representative's reviews of youth mental health services in B.C. (*Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*, April 2013) and youth substance use services (*A Review of Youth Substance Use Services in B.C.*, May 2016), our society is often not good at serving youth. It can be difficult to engage them in services, taking time and effort. This review found that guardianship social workers do not feel well trained to respond appropriately when a child or youth in their care has been subjected to sexualized violence. The response from adults to the sexualized violence against a child or youth can either be supportive and beneficial, or it can result in greater struggles and greater needs for support in the long run. Social workers need training on prevention and treatment, and the ministry needs policies and standards that address sexualized violence and guide its workers on the job.

When it comes to preventing and responding to the sexualized violence of children and youth, this province will benefit from the creation and implementation of a province-wide strategy that is evidence-based and includes a strong culturally based Aboriginal focus. With the participation of Aboriginal and anti-violence organizations, this strategy must focus on coordinating sexualized violence programs and services, including those specifically focused on prevention.

Immediate steps can be taken to change this significant unmet need for consistent safety and support in order for children and youth to be free from the sexualized violence that has become normed by poor response. If anything is to change for past and future child and youth victims of sexualized violence, leadership is necessary to address the inadequacies identified in this review. While it is important to continue to talk about these issues, it is time to take collaborative action to prevent and respond to sexualized violence against children and youth in B.C. The full extent of sexual victimization is likely much more than this aggregate of cases would suggest. With more than 20 per cent of critical injuries categorized as sexualized violence, clearly a far more focussed and sustained effort is going to be required to stop sexualized violence against children and youth in the care of government.

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Appendix 1 – Glossary

Aboriginal: A broad term that, according to the *Constitution Act of 1982*, includes the Indian, Inuit and Métis people of Canada. However, the term "Aboriginal" is generally more broadly interpreted as including people who identify as First Nations, Inuit or Métis.

Caregiver: A family member or paid helper who regularly looks after a child or youth; may include the legal guardian of a child or youth or their social worker.

Child in care: Any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act*.

Child protection services: Services delivered under the *Child, Family and Community Service Act* (CFCSA) in response to reports of child abuse or neglect. Child protection services can include investigation, providing or arranging for support services to families, supervising the care of children in their homes, and protecting children through removal from their families and placement with relatives, foster families or specialized residential resources.

Critical Injury: As defined in section 1 of the *Representative for Children and Youth Act*, any injury to a child that may:

a) Result in the child's death, or
b) Cause serious or long-term impairment of the child's health

Delegated Aboriginal Agency: through delegation agreements, the First Nations Director (the Director) gives authority to Aboriginal Agencies, and their employees, to undertake administration of all or parts of the CFCSA. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency and the level of delegation provided by the Director.

Fetal Alcohol Spectrum Disorder (FASD): a range of disabilities that result from exposure to alcohol during pregnancy. The medical diagnoses of FASD include: Fetal Alcohol Syndrome, Partial FASD and Alcohol-Related Neurodevelopmental Disorder. Individual effects include alcohol-related birth defects that vary from mild to severe and may include a range of physical, brain and central nervous system disabilities, as well as cognitive, behavioural and emotional issues.

Foster Home: a home with a family or persons approved by and funded by the Director, to care for children who are in the care, custody and guardianship of the Director. Family care services are provided from private homes lived in and maintained by the foster parents. Foster care includes Restricted, Regular, Level 1, Level 2, and Level 3 Family Care Homes. Persons who provide family care services are referred to as family care parents, foster parents or as a foster family.

Group Home: A private residence for children and/or young people who are in government care, usually not housing more than six children or youth, and where trained caregivers or house parents are available 24/7. Children and youth often reside in group homes while waiting for foster families to be found.

Guardianship Social Worker: services provided by MCFD or delegated Aboriginal Agency Social Workers to children and youth who are in long-term or continuing care as a result of a child custody order granted under the *Child, Family and Community Service Act*, or an order under the *Family Relations Act* when a child has no parent or guardian. Guardianship Social Workers have parental duties and responsibilities towards children and youth and are responsible for their care, custody and guardianship.

Hughes Review (*BC Children and Youth Review*): the 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. This review recommended the appointment of an independent Representative for Children and Youth.

Neurodevelopmental Disability: A disability that is considered to impair the growth or development of the brain or central nervous system; affecting emotion, learning, self-control or memory. This impairment may be minor or may have significant implications for the disabled individuals and their families.

Parent: a parent is the mother of a child, the father of a child, a person to whom custody of a child has been granted by a court or by an agreement, or a person with whom a child resides and who stands in the place of a child's parent. This includes a child's guardian, but does not include a social worker working with a child in care through a voluntary agreement or court order.

Restorative Justice: Restorative justice is an approach to justice that focuses on the needs of the victims and the offenders, as well as the process, while offenders are encouraged to take responsibility for their actions.

Reviewable service: any of the following designated services:

(a) Services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*;

(b) Mental health services for children;

(c) Addiction services for children;

(d) Additional designated services that are prescribed under s. 29(2)(b)

Trauma: The emotional impact of adverse experiences which can have a detrimental impact on future behaviour and coping ability. The effect of early childhood experiences has been studied extensively and is recognized as a primary contributor to adolescent maladjustment, negative health outcomes and difficulties with social relationships. These adverse experiences include, but are not limited to, physical and sexual abuse, extreme neglect, exposure to violence and traumatic separations.

Trauma-Informed: Approaches which ready a system or service for any individual or group with trauma experience by increasing awareness of the effects of trauma and integrating this knowledge into policies, practices and procedures.

Youth justice services: services for youth who have been accused or found guilty of a criminal offence and were aged 12 to 17 at the time of the offence. A youth may be subject to community-based services (such as probation), youth custody or a combination of both.

Appendix 2 – Criminal Justice outcomes flowchart

Before an offender can be successfully prosecuted for a sexual offence, the crime must be reported to the police. It is not required that the offence be reported by the victim as police detachments accept what are called third-party reports (reports from family members or service providers).

Of 145 reports of sexualized violence against children and youth in care received by the RCY, 133 were reported to the police.

Once the police have a report of a criminal offence, a file is opened and an investigation commences. The investigation involves gathering all available evidence of the alleged crime. Once complete, the police will determine whether there is sufficient evidence for a charge to be laid. If there is sufficient evidence, the file is forwarded to Crown Counsel for prosecution.

Of 133 reports received by police, 58 were forwarded to Crown Counsel and 2 were still under investigation by police at the time of data collection.

Crown Counsel will then make its own determination of whether the evidence is sufficient for a successful prosecution. This requires that the evidence demonstrate the alleged offender's guilt beyond a reasonable doubt.

Of 58 files received by Crown Counsel, 37 were prosecuted.

If Crown Counsel chooses to prosecute the alleged offender, a conviction occurs if the alleged offender pleads guilty or a court finds the offender guilty after a trial. Once a finding of guilt is made, a judge will determine the sentence.

Of 37 prosecuted files, 22 led to conviction, six resulted in no conviction, one file resulted in a Restorative Justice process and eight trials were pending at the time of this review.

Appendix 3 – Canadian Criminal Code sexual offences against children and youth

In the following definitions, sexual offences against children and youth include any sexual offence where the victim is between 0 and 17 years of age.

Sexual interference (section 151) criminalizes touching a person under the age of 16 years for a sexual purpose. The maximum penalties are 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of one year apply if prosecuted by indictment and 90 days if prosecuted by summary conviction.

Invitation to sexual touching (section 152) criminalizes inviting, counseling or inciting a person under the age of 16 to touch the body of any person for a sexual purpose. The maximum penalties are 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of one year apply if prosecuted by indictment and 90 days if prosecuted by summary conviction.

Sexual exploitation (section 153) criminalizes touching a person who is 16 or 17 years old for a sexual purpose or inviting, counseling or inciting that person to touch the body of any person for a sexual purpose, if the person who commits the offence is in a position of trust or authority toward the young person or if the young person is in an exploitative relationship or in a relationship of dependency with the person who commits the offence. The maximum penalties are 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of one year apply if prosecuted by indictment and 90 days if prosecuted by summary conviction.

Incest (section 155) is an indictable offence that criminalizes engaging in sexual intercourse with a blood relation, including parents, children, siblings and grandparents. A mandatory minimum penalty of five years applies where the victim is under 16 years of age.

Bestiality in the Presence of or by a Child (subsection 160(3)) criminalizes committing bestiality in the presence of a person under the age of 16 years and inciting a person under the age of 16 years to commit bestiality. The maximum penalties are 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted summarily. Mandatory minimum penalties of one year apply if prosecuted by indictment and six months if prosecuted by summary conviction.

Voyeurism (section 162) is an offence that criminalizes surreptitiously observing or making a visual recording of a person in circumstances that give rise to a reasonable expectation of privacy. Printing, copying, publishing, distributing, circulating, selling, advertising or making available such a visual recording also constitute an offence. The maximum penalty is five years' imprisonment.

Publication of an intimate image without consent (section 162.1) includes knowingly publishing, distributing, transmitting, selling, making available or advertising an intimate image of a person, knowing that the person depicted in the image did not give their consent to that conduct, or being reckless as to whether or not that person gave their consent to that conduct. The maximum penalty is five years' imprisonment.

Child pornography (**section 163.1**) creates four offences that criminalize making, distributing, possessing and accessing child pornography. The maximum penalty for making or distributing child pornography is 14 years if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of one year apply if prosecuted by indictment and six months if prosecuted by summary conviction. The penalties for possessing or accessing child pornography are the same with the exception of the maximum sentence when prosecuted by indictment, which is ten years.

Parent or guardian procuring sexual activity (**section 170**) is an indictable offence that criminalizes parents and guardians of persons under the age of 18 years who procure that young person for the purposes of engaging in illegal sexual activity. The maximum penalty is 14 years' imprisonment and the mandatory minimum penalty is one year.

Householder permitting sexual activity (**section 171**) is an indictable offence that criminalizes owners, occupiers or managers of premises who permit a person under the age of 18 years to be on their premises for the purposes of engaging in illegal sexual activity. The maximum penalty is 14 years' imprisonment and the mandatory minimum penalty is one year.

Making sexually explicit material available to children (**section 171.1**) is an offence that criminalizes transmitting, making available, distributing or selling sexually explicit material to a child to facilitate the commission of a sexual offence against a child. The maximum penalties are 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of six months apply if prosecuted by indictment and 90 days if prosecuted by summary conviction.

Corrupting children (**section 172**) is an indictable offence which can result in a maximum of two years of imprisonment in cases where an individual under 18 is endangered or living in an unfit home due to the actions or behaviour of an adult. Charges may be laid under this section of the Criminal Code only if instituted by a recognized society for the protection of children or an officer of a juvenile court.

Luring a child via a computer (**section 172.1**) and Agreement or arrangement – sexual offence against child (section 172.2). Luring a child via a computer is an offence that criminalizes communicating with a child by any means of telecommunication to facilitate the commission of a sexual offence against the child. Agreement or arrangement is a hybrid offence that criminalizes agreeing or making an arrangement with a person by means of telecommunication to commit a sexual offence against a child. For each of these offences, the maximum penalty is 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of one year apply if prosecuted by indictment and six months if prosecuted by summary conviction.

Exposure (**section 173.2**) involves exposure of the genital organs to a person who is under the age of 16 years, in any place, for a sexual purpose. Mandatory minimum penalties of 90 days apply if prosecuted by indictment and 30 days if prosecuted by summary conviction; maximum penalties are two years for indictable offences and six months for summary offences.

Sexual assault (level 1) (section 271) criminalizes assault of a sexual nature that involves a violation of the sexual integrity of the complainant. If the victim is under the age of 16 years, the maximum penalties are 14 years' imprisonment if prosecuted by indictment and two years less a day if prosecuted by summary conviction. Mandatory minimum penalties of one year apply if prosecuted by indictment and six months if prosecuted by summary conviction.

Sexual assault with a weapon or causing bodily harm (level 2) (section 272) is an indictable offence that criminalizes sexual assault involving a weapon, bodily harm or threats to cause bodily harm to a third party. The maximum penalty is life imprisonment where the victim is under 16 years of age; the mandatory minimum penalty is five years.

Aggravated sexual assault (level 3) (section 273) is an indictable offence that criminalizes sexual assault involving wounding, maiming, disfiguring or endangering the life of the complainant. The maximum penalty is life imprisonment where the victim is under 16 years of age; the mandatory minimum penalty is five years.

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REPRESENTATIVE FOR
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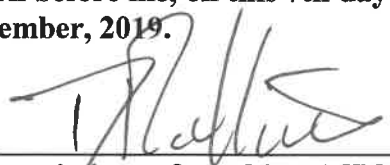
This is Exhibit "F" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, 2019.



A commissioner for taking Affidavits

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Trauma, Turmoil and Tragedy:
Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm

An Aggregate Review

November 2012

November 15, 2012

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm, An Aggregate Review* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

Ms. Joan McIntyre
Chair, Select Standing Committee on Children and Youth

Contents

Executive Summary

This is an aggregate review and analysis of the 89 suicide and self-harm incidents reported to the Representative for Children and Youth between June 1, 2007 and May 31, 2010. Included are 15 youth who died as a result of suicide and 74 youth who engaged in self-injury. Each of these youth had received services from the Ministry of Children and Family Development (MCFD).

An aggregate review is a review of a group of cases that share some common features. The intention of an aggregate review is to identify and analyze trends that will inform improvements to the child-serving system as well as broader public policy. Such reviews are part of the Representative's mandate as laid out by the *Representative for Children and Youth (RCY) Act*.

This type of review is based on data from files, as well as other administrative data, that provides an overview of the larger group, rather than specific information about individual youth. Although what we can learn from this type of review is limited by the kind of information that is consistently available in these files, it enables us to develop an understanding of the circumstances of these youths' lives and how the system of supports and services responded to them.

The report identifies a number of common circumstances in the lives of many of these children and youth, including:

- Lack of stable living arrangements – most notably, children in care being subject to multiple moves.
- Domestic violence – a significant feature in the lives of more than half the youth.
- Mental health issues – identified in nearly 70 per cent of the youth and compounded by a lack of clarity of services to address these issues.
- Substance abuse – by family members as well as the youth themselves.
- Learning disabilities and lack of attachment to school.
- Significant romantic conflict in the 24-hour period leading to these incidents.

Two other disturbing findings of the report are a significant over-representation of Aboriginal children and youth, and what is best described as varying degrees of compliance with MCFD practice standards in these cases.

The Representative acknowledges the front-line workers throughout British Columbia who daily take on the challenging role of working with vulnerable youth to try to help them cope with their circumstances and move toward a brighter future. It is difficult work, and not all suicides or serious injuries are preventable.

Although this report does not deal with each youth's individual situation, it is important to remember that each of these deaths represents a valuable loss of potential to our society, as well as a devastating event for families, friends and loved ones. The impact is very significant in Aboriginal and First Nations communities, where suicide rates among youth are five to six times higher than those of non-Aboriginal youth.

Every child has a right to succeed – some require more help than others. This report raises important questions. Did we do enough to help these youth? Can we do more? It is only through reviewing the information, through asking these questions that we can hope to improve on our outcomes.

Most of the 89 youth in the review experienced very difficult family situations characterized by major changes and instability. Of their parents, 24 had themselves been in the care of the ministry as children or youth. The majority of the youth lived in families in which the parents did not remain together, and one-quarter of the youth had a friend or family member who attempted suicide or died as a result of suicide.

At the time these incidents were reported to the Representative, the youth were either in MCFD care, living with their parents or extended family but receiving services from MCFD, or in an agreement with MCFD to receive support services while making the transition to independent living. All of the 89 youth in this review had received services from MCFD, and 58 were in the care of the ministry at the time of the suicide or self-harm incident.

Generally, the youth first came into contact with the MCFD service system at an early age – 19 per cent of them in their first year of life and more than half of them within their first five years. At one time or another, 78 per cent of the youth were taken into the care of the ministry.

These children and their families first came to the attention of the ministry in one of two ways. In 78 per cent of the files, the behaviour of the parents was assessed as a threat to the safety and well-being of their children. In the other 22 per cent of the files, the parents were overwhelmed by the behaviour of the youth or themselves raised concerns that the youth were at risk and needed help.

Some common behavioural patterns noted in the lives of the 89 youth include:

- Repeated self-injury by 72 of the youth.
- Substance abuse – self-identified or identified by social workers – by 50 of the youth.
- Running away, associating with risky people, becoming street involved and other high-risk behaviours, by 64 of the youth.
- More aggressive behavioural issues, such as breaking the law and assaulting or threatening others, by 48 of the youth.

A disturbingly high number of the youth (52, or 58 per cent) in the review were Aboriginal. The Aboriginal youth in this study were most commonly receiving ministry

services as a result of safety and well-being concerns, such as neglect, exposure to violence in the home, or physical or sexual abuse.

Of the 15 youth who died as a result of suicide, eight were Aboriginal. Of the 74 youth who sustained self-harm injuries, 44 were Aboriginal. The Representative acknowledges the tremendous challenges faced by some Aboriginal communities, and believes that much more must be done to support them as they work to improve the well-being of their children and youth.

Another concern raised by this report – and also noted in prior reports – is the frequency of moves experienced by youth in care. On average, the youth in care in this review had been in care for roughly half of their lives (49 per cent) and had experienced an average of 12 moves while in care. Five of the youth were moved more than 30 times while in care.

Although it is not possible based on information in the files to determine why each move happened, this level of instability in the lives of these vulnerable youth undoubtedly undermined their ability to form positive social attachments and the meaningful connections and relationships necessary to thrive.

Domestic violence was a significant feature in the lives of more than half the youth in this report. As with disruption and multiple moves, domestic violence can leave a child with emotional pain, deep stress and sometimes physical trauma. Children who live in fear of triggering an explosion of violence do not develop normal abilities to express themselves and seek help. The experience of having problems and being able to solve those problems, a cornerstone of developing effective coping skills, is often foreign to them.

Another factor in the lives of most of these youth was substance use in their families. Seventy-five per cent of the mothers of the youth had substance use issues. Less information about substance use was available about the fathers because they were often absent from the family or did not play a consistent role in their children's lives.

Less than half of the youth whose files were reviewed for this report were attending school on a regular basis. When vulnerable youth are struggling and acting out, the system needs more effective ways of keeping them engaged in positive activities and learning.

Approximately one-third of the youth had a romantic conflict in the 24 hours preceding their suicide or self-injury. In 10 per cent of these incidents, the use of substances (primarily alcohol) was implicated as well.

It is noteworthy that 50 per cent of the youth with no prior known history of self-injury had a significant conflict with a romantic partner within the day leading up to the incident. This included one of the three youth in care who died as a result of suicide. It was also noted that in almost all of the instances of suicide, a friend or family member had attempted suicide or died as a result of suicide.

Compliance with MCFD practice standards varied from file to file, and often within files. Specific practices were examined for all 58 youth in care at the time of the reported

incident. This examination does not constitute a formal practice audit, but it helps provide a broad picture of some aspects of ministry services. Among the practice findings:

- Comprehensive Plans of Care (CPOC) were current in only 69 per cent of the files at the time the incident was reported to the Representative.
- For the youth in care, 88 per cent had one or more CPOC on file. These varied in quality and completeness.
- 32 per cent of the youth in care had more than one Reportable Circumstance, ranging from two to seven Reportable Circumstances.
- Less than half of the Aboriginal youth in this review were in an Aboriginal placement.
- Delegated Aboriginal Agencies provided service in only 38 per cent of the files involving Aboriginal youth.
- 89 per cent of youth were meeting regularly with their social worker (e.g. at least once a month and for significant life events).

From this review it does not appear that issues such as grief, loss or recovery from domestic violence are a primary consideration when children first come into the care of the system or are receiving support services while remaining in their homes. We know that adverse and traumatic childhood experiences, such as the ones experienced by the youth in this study, can lead to significant health consequences as children grow up.

Given the high number of youth in the review with identified mental health issues, the lack of clarity of systems and services for youth in the province is also of concern. It is not always clear which youth are eligible for which services and under what conditions they will be admitted.

The Representative is conducting a broad review of Child and Youth Mental Health (CYMH) services, and will make recommendations based on the findings of that review. However, because of the clear and urgent nature of the needs of children and youth in care, the Representative recommends immediate action to address the trauma many of them experience, as evident in the current report.

Most of us cannot imagine the challenging life situations of these 89 youth. This report is a first step at increasing our awareness and understanding of the complex issues these youth faced and learning from their experiences and outcomes, with the goal of improving services for all vulnerable youth in British Columbia.

Introduction

This report examines the life circumstances of 15 youth who died as a result of suicide and 74 youth who engaged in self-injury behaviours. All of these youth had received services from the Ministry of Children and Family Development (MCFD), and many of the youth who injured themselves are still receiving services from the ministry. This review explores how these 89 youth came into the provincial system of services and supports. While that focus helps inform us about their lives and our systems of services, we must not lose another focus – the vulnerability and pain that led these youth to take their own lives or to harm themselves, and the challenges faced by the families and caregivers concerned for their safety.

Many of these youth were disconnected from their families, and many of their families, for one reason or another, were unable to offer the stability and support that children need in order to flourish. These life circumstances do not lessen the grief or distress of families when their children are injured or die.

The desperate and final act of suicide means that at least in one moment, all hope was lost. Each of these deaths represents a loss of potential to our communities, and a devastating and life-changing event for families and loved ones.

This report also contains information about a group of youth who intentionally injured themselves. Were they expressing a cry for help? Was the self-harming symptomatic of a loss of hope? Without dependable connections to systems of services and supports, it is possible that some of the children and youth in this review may have progressed to more damaging self-injury or even suicide.

Did caregivers, community, and public services do all they could do to promote resiliency in these youth? The nature of this review does not allow us to fully answer these questions, but leads us in the direction of learning and improving service.

This report is based on aggregate data from files and other administrative records. This is high-level information that provides us with an overview of this group of youth, rather than specific information about an individual youth. This information allows us to develop a general understanding about the circumstances of these youth, and a limited understanding of the supports and services they received. It does not give us a full picture of their day-to-day lives in the way that an individual investigation report would.

The research behind this report is best characterized as exploratory. It is a first attempt to understand and assess how services were delivered to these youth using the aggregate review approach referred to in the *RCY Act*. It does not directly explore suicide or self-harm from a clinical or epidemiological perspective. Rather, it uses available information from files and other documents to attempt to paint a picture of youth who came to the attention of the Representative through critical injury and death reports received from MCFD.

This report is not about assigning blame for the outcomes observed in this group of youth. Not all suicides and serious injuries are preventable. But the more we understand about the lives of children and youth, the better we will be able to understand how we can improve outcomes. The Representative supports and encourages the child-serving system to do the best work it can to ensure the most positive outcomes possible, with the goal that resilience for youth is reinforced in all areas of their lives.

On a daily basis, front-line workers throughout our province take on the difficult role of engaging with vulnerable youth, and working to help them move away from despair and discouragement. The Representative honours the dynamic work of those who serve children and youth struggling to maintain their mental health.

The Representative also pays tribute to the strength and resilience of youth struggling against odds that most of us truly cannot fathom. The life experiences of the children and youth in this report were grim, to say the least. Some of their stories are shared to promote understanding.

What can we learn? This report is a first step in increasing our awareness and understanding of these complex issues. The Representative will continue to examine and seek to provide more clarity to these issues in future reports, based on the learning from this report, and promote more integrated and effective practice at MCFD and other social serving ministries and agencies.

Terminology

The research literature is rife with different approaches to terminology. In this report, suicidality is used to describe self-harming behaviour with a lethal intent, and non-suicidal self-injury, shortened to simply self-injury, to describe self-inflicted injury that causes physical, bodily damage (both temporary and long term) intended to be non-lethal. The difference between suicidality and self-injury is often subtle and unclear, and some cases contain instances of both.

RCY Aggregate Reviews

The Honourable Ted Hughes QC, in his 2006 *BC Children and Youth Review*, introduced the idea of aggregate analysis in his discussion on reviewing child injuries and deaths:

> "The primary method of reviewing child injury and deaths will be to examine aggregated information, and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives" (p. 36).

Hughes used the term "aggregate" in reference to analyzing numerous examples of similar phenomena, as opposed to the practice of analyzing one case instance. He stated that an aggregate review "may be a matter of collecting and reviewing information on a number of deaths with similar characteristics (for example, youth suicides by hanging), to identify trends or patterns that will inform and educate the child welfare system and the public" (p. 37).

The *RCY Act*, sections 11 and 12, provides the mandate for the Representative to conduct aggregate reviews.

Rationale for Conducting this Aggregate Review

The Representative has a sustained interest in the well-being of youth who struggle with suicidality and self-injury. In October 2010, the Representative and the Provincial Health Officer released *Growing up in B.C.*, reporting on six aspects of child well-being, including dimensions of mental health. One finding in that report was that youth who have been in care are nearly three times more likely to consider suicide – and nearly six times more likely to have attempted suicide at least once – than youth who have never been in care.

Initial review of self-injuries and suicide deaths reported to the Representative showed apparent similarities in the backgrounds and service histories of the youth. A better understanding of who these youth are – and how they interact with our system of services and supports in B.C. – is an important first step in ensuring that those systems achieve the best possible outcomes.

This aggregate review was guided by the following questions:

- What brought the youth and/or family to the attention of the ministry?
- What were their pathways into and through the service system?
- Did services meet established standards?
- Were cultural continuity and involvement of family and community addressed for Aboriginal children and youth?

Methodology

The Representative receives regular reports from MCFD, including delegated Aboriginal Agencies (DAA), of critical injuries and deaths of children and youth who have received reviewable services within the year prior. The Select Standing Committee for Children and Youth (SSCCY) can also refer cases for review.

Reviewable Services

Any designated services, including services and programs under the *Child, Family and Community Service Act* and *Youth Justice Act*; mental health services for children; addiction services for children; and additional services prescribed under the *Representative for Children and Youth Act*.

Reports of critical injuries or deaths are screened by the Representative to determine if they meet the criteria for further review.

The sample for this report consists of all suicide and self-inflicted injuries reported to the Representative between June 1, 2007 and May 31, 2010. Four of the suicide deaths were referred by the SSCCY and occurred between May 1, 2003 and May 31, 2007.

The Representative notes that issues with routine reporting of critical injuries have been identified. These were described in a Special Report of December 2010, *Reporting of Critical Injuries and Deaths to the Representative for Children and Youth*. While the issues identified in the Special Report have since been addressed, the period covered in the current report pre-dates improvements in reporting. Due to under-reporting prior to March 2011, the number of critical injuries profiled in this report is certainly lower than the number that actually occurred during the time period.

This selection criterion produced a sample of 89 cases – 15 deaths as a result of suicide, and 74 self-inflicted critical injuries. While 89 is a large number, these youth represent an extremely small number of the overall population of children who were receiving services. The number of youth in this review who were in care at the time of the reported incident (58) represents much less than one-half of one per cent of the overall population of youth in care.

Similar to aggregate analyses in other fields such as economics, this review relies on secondary data collected for purposes other than research. Because this was a review under the *RCY Act* rather than an investigation, family members and service providers were not interviewed individually. Instead, data was gathered from records relating to each youth and his or her family and examined by three analysts. File documentation was requested and received from MCFD (which also provided relevant records from delegated Aboriginal Agencies), the Ministry of Health, and the BC Vital Statistics Agency.

In addition, basic demographic characteristics and features of each child and family were collected across a number of psycho-social domains, similar to those used in the 2008 report on youth suicide produced by the Child Death Review Unit of the BC Coroners Service (CDRU, 2008). The CDRU review identified which types of social services the children and youth had received. However, that review did not explore each individual youth's movement through the system of supports and services, and the degree to which selected standards were met.

In summary, this aggregate method provides a range of descriptive data about the youth in this sample, their families, and the services they received. This review is limited in that it is based solely on available files and documents. Therefore, while it tracks pathways into and through the system, it cannot address effectiveness of services or the youths' experience. For example, although we can record that a Plan of Care is in the file, we can't conclude based on those file materials alone whether it was adequate or effective in meeting the needs of a child or youth.

Another limitation is that the quality and completeness of files varies. That means that what we can learn about is limited by the kind of information that can be consistently found in all of the files under review.

This report does not identify the youth and their families by name, and care has been taken to present the information in a way that does not otherwise identify them.[1] Embedded in this report are the life experiences of youth, many of whom are still engaged with the ministry. We seek to learn from their history while respecting their privacy.

[1] Section 16(1) of the *Representative for Children and Youth Act* specifies that reports based on aggregated information not contain information in an individually identifiable form.

Background and Descriptive Data

Suicide Deaths

The Representative reviewed documents related to personal and service histories of the 15 youth who died by suicide and who had received MCFD services in the year prior to the incident. One of the youth was 12-years-old while the others ranged in age from 15 to 18. The suicide deaths occurred in all regions of the province. Table 1 shows a further breakdown of their gender and whether or not they were Aboriginal.

Table 1

	Non-Aboriginal	Aboriginal	Total
Female	3	6	9
Male	4	2	6
Total	7	8	15

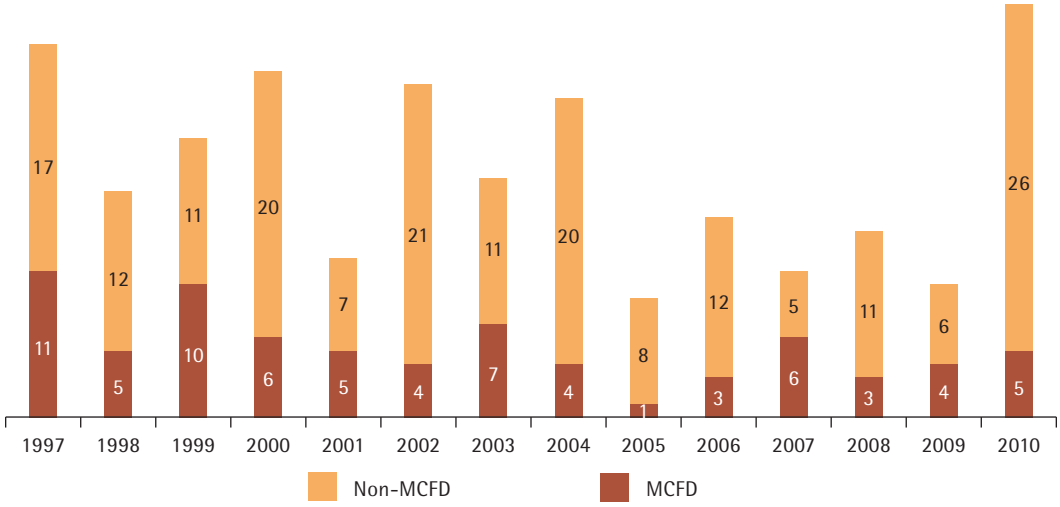
These youth were involved in four main MCFD service streams during their lives. All but two of the 15 had a history of involvement with child protection and CYMH services at some time (one of them had a history of involvement with child protection but not CYMH services, while another one had a history of involvement with CYMH services but not with child protection). Of the 15, three of the youth were in continuing care of MCFD and the other 12 were in the legal custody of their parents but involved with ministry services.

Four of the youth had previous involvement with the youth justice system, and one youth had received special needs services from MCFD.

The BC Vital Statistics Agency tracks and reports on a wide variety of data relating to significant life cycle events, including deaths. Between 1997 and 2010, the number of youth suicide deaths (12 to 18 years) in B.C. ranged from a high of 8.6 per 100,000 to a low of 2.4 per 100,000 youth, and the rate fluctuated from year to year. It is important to understand that, because absolute numbers of youth suicides are low, variations from one year to the next can seem to fluctuate more than if they are tracked over time. For example, in the 14-year period noted above, actual numbers of suicide deaths among all youth in B.C. ranged from nine to 31 per year. Over the same time period, the number of youth involved in the MCFD system of supports and services who died as a result of suicide ranged from one to 11 per year (see Table 2 following). Of all youth suicides in B.C. during those 14 years, between 38 and 42 per cent were involved with MCFD.[2]

[2] MCFD's statistics only include children and youth who received services under the *CFCS Act* in the year prior to their death.

Table 2: Youth Suicides and MCFD Service Involvement



Self-Harm Injuries

The Representative reviewed the personal and service histories of 74 youth who had self-harm injuries that were reported as critical injuries and who had received MCFD services in the year prior. As is noted later in this report, most of them had histories of more than one self-harm incident.

Two of the youth were under the age of 12, and the rest ranged in age from 12 to 18, with most of the youth being 15 or older. The youth lived in all regions of the province. Table 3 shows a further breakdown of their gender and whether or not they are Aboriginal.

Table 3

	Non-Aboriginal	Aboriginal	Total
Female	21	34	55
Male	9	10	19
Total	30	44	74

These youth were involved in four main MCFD service streams at some time during their lives: all of the 74 youth had been involved with child protection; 43 had also received services through CYMH; 22 also had involvement with the youth justice system; and three of the youth had received special needs services.

At the time of injury, 55 of the 74 youth were in care of MCFD, 34 of them in continuing care. Ten youth had been placed in care voluntarily by their parents. The remaining 11 youth were in temporary forms of care or on Special Needs Agreements.

Unlike youth suicide in B.C., self-injuries are not tracked in the general child and youth population. Consequently, there is no comparable data that can be used to establish a baseline for these types of injuries, or provide context for this review.

Life Circumstances of the Families

The families of origin of most of the 89 youth included in this aggregate review faced very difficult life circumstances, including many factors that were beyond their control and undermined their ability to parent. The daily challenges in their lives are foreign to most British Columbians. The repeated heartbreak they dealt with requires a compassionate response, and calls out for supportive and effective services.

These were families that lived with significant instability. Twenty-four of the parents had themselves been in the care of the ministry as children or youth. In 78 of the files reviewed, the parents separated, typically early in the youths' lives.

A significant proportion of the parents struggled with substance use. This was noted for 67 of the mothers. The fathers also had issues with substance use, but files contained less information on them because most of the fathers were absent from the family or did not play a constant role in their children's lives. A few prominent patterns were noted: fathers being present early in the child's life and then leaving the home; new partners and father figures; and domestic violence. More than half the families contended with physical abuse committed by fathers or male partners and witnessed by the children, often at an early age.

Life Circumstances of the Youth

The youth had many challenges in their own personal lives. For example, one-quarter of the 89 youth had a friend or family member who had attempted suicide or died as a result of suicide. This was true of seven of the 15 youth who died as a result of suicide.

At the time of the reported incident, whether it was self-injury or suicide, about one-third of the youth had experienced a romantic conflict in the preceding 24 hours and, in about one-quarter of the cases, substances (primarily alcohol) were implicated in the incident. In 10 per cent of all cases, both romantic conflict and substance use were present.

Most of the youth experienced significant risks to their health, well-being and safety. High-risk behaviours such as running away from placements, getting into dangerous situations and relationships, and living on the streets were identified by social workers for 64 of the youth. These behaviours often occurred within a context of limited options, or attempts to escape from unbearable circumstances.

Other high-risk behaviours were also noted. Repeated self-injury was reported for 72 of the youth. Substance use, beyond casual use, was identified by social workers or self-identified by 50 of the youth. Mental health issues were identified in 64 of the youth. More than half of the youth (48) were involved in serious problem behaviours, such as breaking the law, physical violence, or threatening other people. Learning challenges were also common – they were identified in 45 of the youth.

Table 4

Characteristic	Total (Out of 89)	Per cent Aboriginal of Total
Repeated self-injury	72	55
Substance use, beyond casual use	67	63
High-risk behaviours	50	62
Mental health issues	64	53
Behavioural issues	48	58
Learning challenges	45	53

Case Example

When she was a young girl, this youth suffered a traumatic brain injury as a result of a motor vehicle incident. This left her with nerve damage and significant cognitive and behavioural impairment.

Both of her parents had been in care themselves when they were growing up. Later, when they became parents, they had a long history with the ministry as a result of substance use, domestic violence in the home, and reports that the children were neglected.

The father left while the children were very young. The single mother then voluntarily placed her children into care when she was unable to find suitable housing and again when she later went to drug and alcohol treatment. As she continued to struggle with addiction, the children were permanently removed from her care.

At the time she was taken into care, this girl was eight-years-old. She was in the same foster home until she was 15-years-old, when she and her foster parent came into conflict. She was moved to another foster home.

The incident that brought this youth to the attention of the Representative came after she had an emotional break-up with a romantic partner and slashed her wrist. Before the break-up there was no known history of self-injury. She was admitted to hospital, where she continued slashing herself, and also attacked staff members and damaged her surroundings.

After stabilizing and receiving medical treatment, she was released into the care of her foster parent. She continued to be seen by her CYMH worker and youth outreach worker. However, after awhile, her foster parent was no longer willing or able to manage the youth's violent and threatening behaviour.

The latest available information is that she is eligible for services to address her cognitive impairments and acquired brain injury, and efforts, so far unsuccessful, are being made to find a place for her to live. She remains highly vulnerable.

Diagnosis and Treatment in the Health Care System

As part of this review, the Representative obtained the medical and pharmaceutical billing information for each of the 89 youth. In B.C., when physicians treat a patient, they are reimbursed for their services by submitting a claim to Health Insurance BC. These claims include information about the reason for the visit, in the form of a diagnostic code. Coding information allows the claim to be verified by Health Insurance BC and is a reasonable proxy for generating statistics about causes of illness and death.[3]

For the youth reviewed for this report, the data showed a steady increase in the total number of medical diagnoses (and by proxy, medical visits), mental disorder diagnoses, and drug prescriptions as these youth moved into adolescence.

Just seven of the 89 youth accounted for 32 per cent of the medical visits and 57 per cent of the drug prescriptions. All seven of these youth had a history of serious mental health issues and received multiple mental health diagnoses for which medication was prescribed. In addition, two of them had serious physical ailments, which also necessitated frequent doctor's visits and medication.

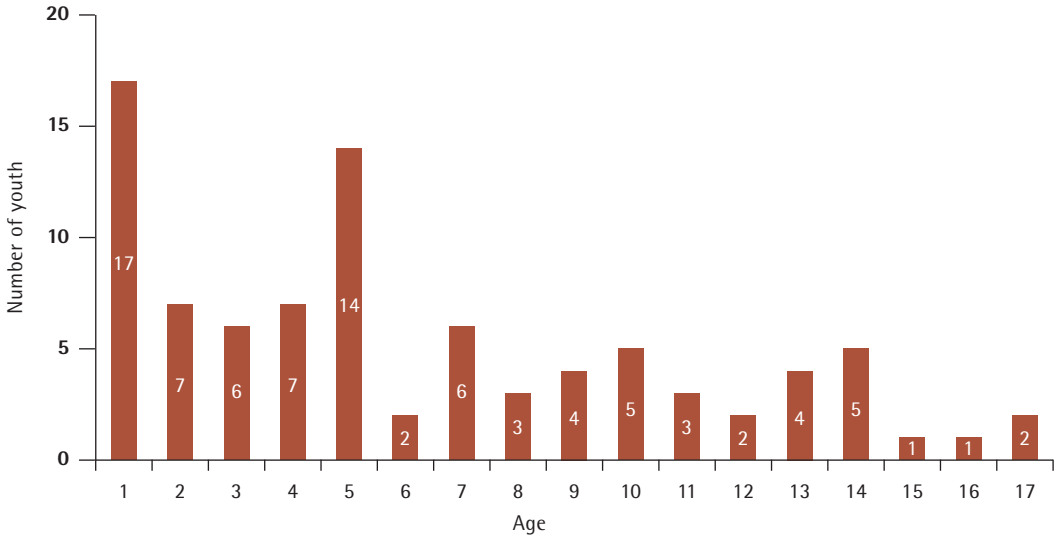
During the teen years of the youth in this report, diagnosis of mental disorders accounted for roughly one-quarter of the total number of medical diagnoses.

[3] The diagnostic codes used are based on the ninth revision of the *International Classification of Diseases* developed by the World Health Organization, commonly referred to as ICD9. Within the ICD9 coding framework, associated diseases are grouped together (for example, diseases affecting the nervous system, or diseases affecting the respiratory system).

Entry into the Service System

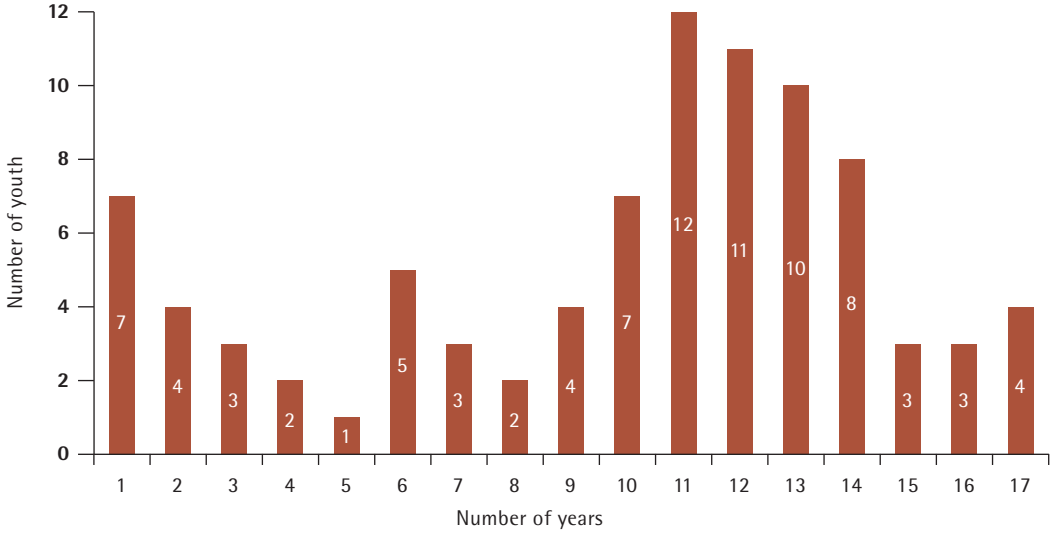
Many of the youth in this review first came into contact with the MCFD service system at an early age – 19 per cent of them in their first year of life and more than half of them within the first five years of life.

Table 5: Age at first system involvement



In most cases, they were receiving services or were known to MCFD long before the incident that resulted in a report to the Representative. For example, 58 of the youth had been involved with the ministry for 10 or more years. Only seven were involved with the ministry for one year or less prior to the incident reported to the Representative.

Table 6: Years between first involvement with MCFD and incident



Pathways through the Service System

There were two entry points by which these children and their families came to the attention of the ministry, regardless of whether they were youth who injured themselves or youth who died as a result of suicide.

In 78 per cent of the cases, the initial contact resulted in the ministry identifying concerns that the behaviour of the parents was a threat to the safety and well-being of their children.

In the remaining cases, the parents were overwhelmed by the behaviour of the youth, or the parents raised concerns that their child was at risk and needed help. These youth received support services or CYMH interventions.

At one time or another, 78 per cent of the youth were taken into care of the ministry. As would be expected, this outcome was more than three times as likely when the initial concerns were about safety and well-being than when the initial concerns were about behaviour.

One way of getting a fuller understanding of these youths' histories is to trace what happened once they became involved with the ministry. These pathways differ depending on the legal status of the children and youth at the time of the incident that was reported to the Representative. The types of services provided depended on the primary issues identified during early contact with the ministry, and whether the youth were in care of the ministry or remained with their parents or in another non-care arrangement.

Youth in Care

The average age of first contact with MCFD for the 58 youth who were in care at the time of the reported incident was 5.7 years. The youth who came into the system as a result of behavioural concerns such as aggressive behaviour and substance use that could not be managed by their parents – rather than safety and well-being concerns – were slightly older at first contact.

Initial interventions by MCFD were usually focused on supporting the child in his or her home. This did not generally succeed. Most often, the children were subsequently brought into care. Whether the problems in the family were so serious that safety could not be established, or whether the interventions themselves were not particularly effective or responsive is beyond what this review captures, but warrants a closer analysis by MCFD.

In each case, there were one or more instances in which the parents and/or the youth were not fully engaged with the services that were offered. A common notation in the records was that there was incomplete follow-through with services (for example, a parent's inability to finish drug and alcohol treatment or complete anger management programs, or a youth being assessed by a CYMH clinician and subsequently not attending the recommended counseling program).

The time span from first MCFD contact, to coming into care was typically short. More than 50 per cent came into care within a year, as shown in Table 7.

Table 7: Years from first MCFD contact to entry into care

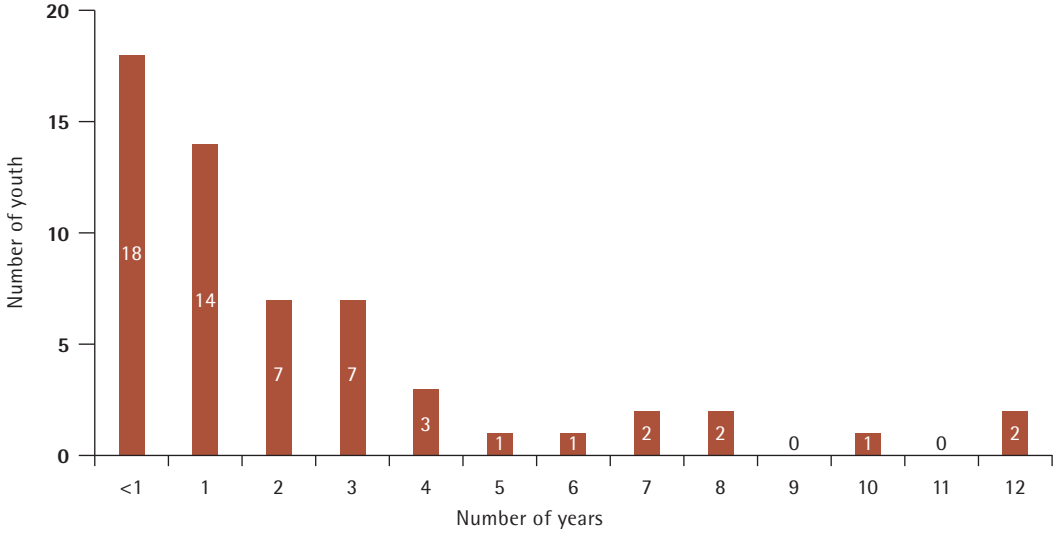
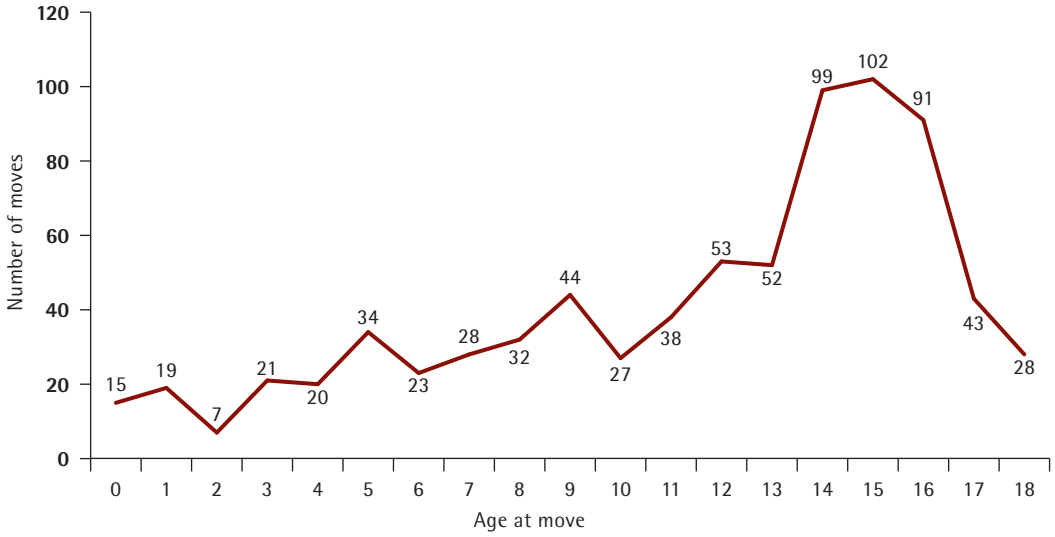


Table 8 displays the number of moves experienced by youth who were in care at the time of the reported incident. Each youth is grouped by the total number of home moves they experienced while in care.[4] This measure gives primacy to stability rather than continuity. It is not uncommon for youth to move frequently between a few placements. For example, if a youth moved from placement A to placement B, back to A and then back to B that would be three moves as opposed to two placements.

[4] The number of moves in care is different from the total number of placements (for example, some of the youth moved many times between a small number of placements).

Table 8 illustrates that the 58 youth in care experienced a combined total of 776 moves while in care.

Table 8: Number of moves in care



Just over half the youth experienced between 10 and 20 moves while in care. There were five youth who each moved more than 30 times while in care. They accounted for 227 of the 776 moves. Put another way, these five youth represent nine per cent of the youth in this sample who were in care, but account for 29 per cent of the total number of moves.[5] This degree of instability and disruption in relationships no doubt led to significant challenges in the lives of these youth, already challenged by so many life circumstances.

At the time of the critical injury or death being reported to the Representative, 65 per cent of the youth were in ministry care, and more than half of these youth (53 per cent) had remained in care on a continuing basis since they were first placed in the care of the ministry. In three of the cases, the youths had been placed into care on five or more occasions. Child in Care Service Standard 12 recognizes that a change in placement can be disruptive and detrimental to the development of a young person.

[5] It was not possible to determine on the basis of a file review the exact reason why each move happened. The most common reasons included youth-initiated moves, foster parent-initiated moves, incarcerations in custody centres, and placements in residential treatment centres.

Case Example

This girl was born to First Nations parents who struggled with drug and alcohol addiction and undiagnosed mental illness. As a result, her parents could not meet her needs. They lived in poverty and did not have the skills to provide a safe home. There were reports to the ministry that the child was being neglected.

Her circumstances didn't improve when she was taken into the care of the ministry at age two, because she and her siblings were moved frequently between foster homes and their parents for several years. Eventually, she and her siblings were taken into permanent care. Moves to different foster homes continued.

As she matured, the girl's behaviour became more challenging for her foster families to manage. Diagnosed with Attention Deficit and Hyperactivity Disorder, Fetal Alcohol Syndrome and Post Traumatic Stress Disorder, she was abusing alcohol and drugs in an effort to ward off what one clinician described as "the continuous pain she feels."

She lived in 34 different placements after her initial involvement with the ministry as an infant, not including the time she spent in hospital or drug and alcohol treatment. She was drinking to the point of blacking out and stealing psychiatric medications from her siblings. Given her history, it is little wonder that she didn't form trusting, long-term relationships, or trust that caregivers would really help her.

In the incident reviewed for this study, the girl had gone missing from the staffed specialized resource where she was living, and had made her way back to her reserve. She then phoned the staffed resource and told a worker there she was despondent because of a recent argument with other family members and that she had taken "a bunch of medication." She would not tell the worker where she was.

Police finally found her, and an ambulance took her to hospital. She was certified for involuntary admission to hospital because she was found to be a risk to her own safety. She was treated, released from the hospital, returned to her residence, and made a full recovery. Workers from CYMH, a local family resource centre, and the hospital were involved in planning for her care after the incident.

Of the 31 youth in this review who had been in care continuously, 14 had spent at least 50 per cent of their entire lives in care.

The ministry has the ongoing responsibility of assessing and planning for the needs of children and youth in care. Having taken on these responsibilities, the ministry is expected to play the role of a kind and prudent parent. This is important, because one-third of these youth were in care continuously for 10 or more years prior to the incident that was reported to the Representative. Only 42 per cent were in care for three years or less.

Of the group of 58 youth who were in care, 84 per cent (including the three who died as a result of suicide) had a history of self-injury, 64 per cent[6] had previously received mental health services through CYMH, and 79 per cent were involved in a service of some kind at the time of the incident.

Half of the youth attended school only sporadically or had stopped attending school or extra-curricular activities altogether.

File information alone does not enable conclusions to be drawn about precipitating events. It is noteworthy that 50 per cent of the youth with no known prior history of self-injury had a significant conflict with a romantic partner within the 24 hours prior to the incident. This included one of the three youth in care who died as a result of suicide. Among those youth in care with an established history of self-injury, 27 per cent had experienced a romantic conflict in the preceding 24 hours. Substance use was present in a little over one-third of these incidents.

Among this group of youth who were in care, based on these observed patterns, a composite, representative profile would include:

- Early contact with MCFD at age five or younger.
- Coming into care around age eight.
- Developing various behavioural and mental health issues.
- Becoming increasingly difficult to manage
- Developing a history of repeated self-injury.
- Coming to the attention of the Representative around age 16 as the result of a reported critical injury or suicide death.

The pattern for Aboriginal youth was generally similar, except that they were more likely to have entered the system in the child welfare stream as a result of a variety of safety and well-being concerns including neglect, exposure to violence in the home, physical abuse, or sexual abuse. All three of the youth in care who died by suicide were Aboriginal. They were removed from their parents as the result of substantiated concerns about their safety and well-being, and all had histories of repeated self-injury.

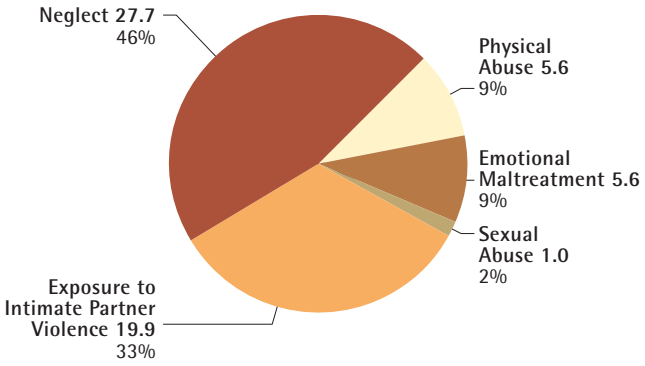
One of the significant issues giving rise to concerns about safety and well-being of children and youth is neglect. In First Nations families, the prominence of neglect is highlighted by a recent analysis of child protection investigations published by the Assembly of First Nations (2011) and based on the 2008 Canadian Incidence Study. Although the analysis deals specifically with First Nations children rather than all Aboriginal children, the findings highlight that neglect is the dominant factor in substantiated concerns related to safety and well-being for children.

[6] The percentage of youth referred to CYMH is much higher than those who received treatment. A number of youth were referred to CYMH but declined the service.

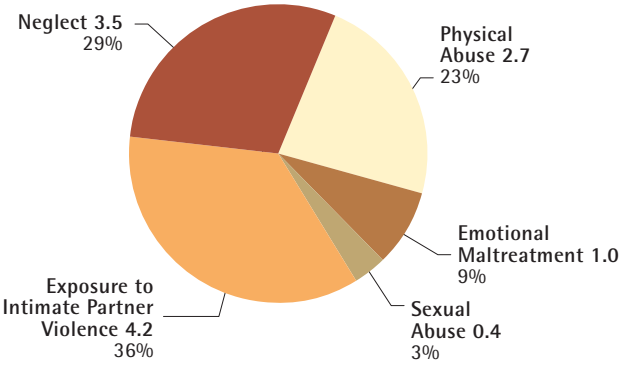
Table 9 illustrates that neglect accounts for 46 per cent of substantiated maltreatment investigations involving First Nations children. The primary form of neglect found in the study was parent or caregiver failure to supervise, which led to the child suffering or being likely to suffer physical harm as a result.

Table 9: Primary categories of maltreatment in substantiated maltreatment investigations, involving First Nations and non-Aboriginal children, conducted in sampled agencies in 2008

(rate per 1,000 First Nations or non-Aboriginal children in areas served by sampled agencies and per cent)[7]



First Nations
59.8 Substantiated Maltreatment Investigations
per 1,000 Children in Areas Served by Sampled Agencies



Non-Aboriginal
11.8 Substantiated Maltreatment Investigations
per 1,000 Children in Areas Served by Sampled Agencies

[7] Sinha, V., Trocme, N., Fallon, B., et al. (2011), pg. xix.

Case Example

This First Nations boy died as a result of suicide by hanging. Ministry child protection services had been involved with the family throughout his life – there were more than 19 child protection reports. These reports involved severe substance abuse by the parents, domestic violence, and possible sexual abuse of the children by a relative.

The file documented a family history of intergenerational abuse and neglect in the parents' families of origin. It appears that a number of the reports involved concerns that the children were unsafe when the mother was drinking, when they would be left unsupervised and there were incidents of domestic violence. It appears that the children were assessed as being safe if the mother had arranged for the children to stay with relatives or friends when she was drinking.

The children were removed six times, the first removal when this youth was four-years-old. These removals were, for the most part, short term and placements were with relatives. The second removal, when the boy was seven-years-old, resulted in an order for supervision. The children were removed for the third time during this supervision period.

A second supervision order was granted and was subsequently extended. At the end of the supervision order, the file was closed. It was re-opened a month later following another child protection call. A third supervision order, this time without removal of the children, was granted. Three months later, the children were removed for the fifth time and a fourth supervision order was granted. During the term of this supervision order, a further child protection report was received and the children were removed for the sixth time. An interim care order, and later a temporary care order, were granted.

The children remained in care for more than a year. As little had changed in the family circumstances, MCFD planned to apply for a Continuing Custody Order, but did not make the application within the time frame required by the *CFCS Act*. Instead, the children were returned to the parents under a fifth supervision order. Another child protection report was received within two months and the children were again removed. The children were returned to the mother under the same supervision order. At the expiry of this order, the file was closed.

Subsequent to the file closure and four months before the youth's death, four more child protection reports were received. The children were assessed to be safe and no court orders were requested. The family was referred for support services. Later, the youth was suspended from school.

One evening, he was observed alone in the community after midnight, and was returned home by the police. His mother was reported to be still drinking heavily.

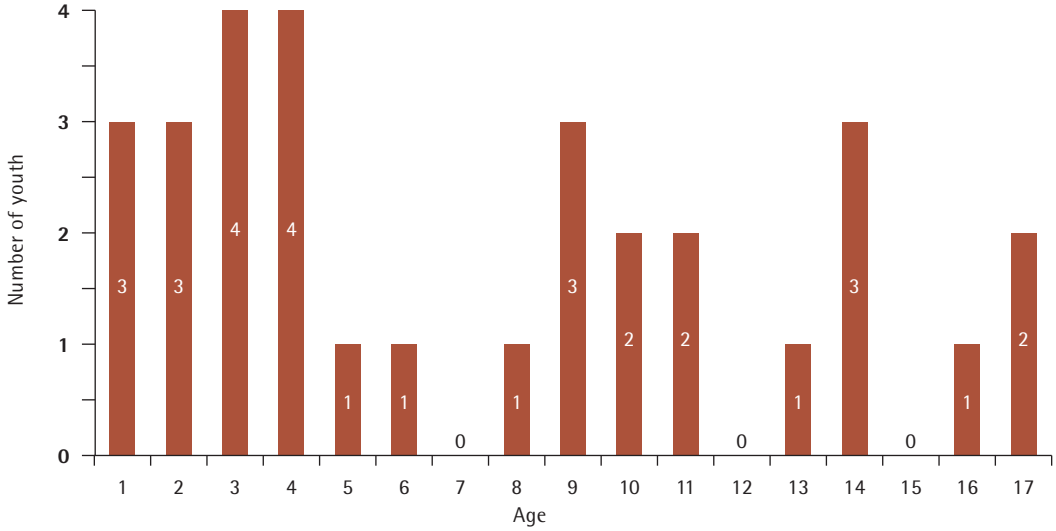
About a month later, the youth died as a result of suicide. MCFD conducted a review of its involvement with his family. The review concluded that intervention was not effective in achieving any positive change. It was noted that the ongoing chaos in the home was not responded to by MCFD workers. The emotional impact of this environment on the children was not recognized or addressed.

Pathways of Youth Not in Care

The other group of youth in this review was not in care at the time of the reported incident, but they were receiving services from MCFD. Approximately one-third of these 31 youth had previously been in care on more than one occasion. In addition, it is notable that almost all of these youth had a history of self-injury.

The age at first contact ranged from one-year-old to 17-years-old.

Table 10: Age at first MCFD contact



In this group of youth, 35 per cent were involved with the ministry as a result of their behaviour rather than having been found to be in need of protection. In fact, three-quarters of them remained living at home with parents. There was also a significant incidence of violence toward family members. In contrast to the youth in care, who tended to be victims of abuse or neglect, file records did not depict these youth as victims of mistreatment.

This group of youth also showed the pattern observed in the youth in care group – an incident occurring within 24 hours of having a significant conflict with a romantic partner.

Substance use was also present in 38 per cent of the incidents.

Ministry Services

MCFD has established practice standards, based on ministry policy and legislative requirements, to guide staff in delivering services. Delegated Aboriginal Agencies follow practice standards called Aboriginal Operational Practice Standard Indicators (AOPSI). For the purposes of this review, focus was placed on key aspects of service delivery, particularly those that could be reasonably assessed on the basis of file information. The practice standards that were assessed were consistent between the ministry and AOPSI.

The youth in this review were involved in five streams within MCFD. These include children in care, child and family services, youth agreements, youth justice, and Child and Youth Mental Health.

This limited review of adherence to practice standards revealed varied results. The complete set of findings is in Appendix D.

It is important to note that the following information is not the result of a formal audit. It does not survey all aspects of practice, and is not a deep or rigorous assessment of compliance with standards. However, it helps us paint a broad picture of some aspects of ministry services to these particular children and youth.

The Representative is in the process of completing a formal audit of Comprehensive Plans of Care (CPOC), which she will report on in the coming months.

Children in Care

When a child is brought into temporary or permanent care, the ministry assumes guardianship and becomes responsible for his or her growth and development.

Specific guardianship practices were examined for all 58 youth in care at the time of the reported incident. The focus was on safety, planning, placement stability and specific responsibilities with respect to Aboriginal children and youth:

- 32 per cent of the youth in care were the subject of more than one Reportable Circumstance,[8] ranging from two to seven reports.
- The CPOC mentioned services intended to support the identity and cultural needs for 73 per cent of the Aboriginal youth in care. The adequacy of the identified services could not be assessed based on file information.

[8] The ministry's Child and Family Service Standard 25 requires the reporting of serious incidents of children in care or receiving services. Serious incidents can include: injuries; deaths; allegations of mistreatment; allegations of criminal involvement; missing children or high-risk situations; or life threatening medical difficulties. Reports are generated in the MCFD service regions and distributed to analysts and managers in MCFD as well as the RCY. The Representative released a Special Report in December 2010 covering MCFD's Reportable Circumstance mechanism and its relation to the *Representative for Children and Youth Act*. The report can be found at http://www.rcybc.ca/content/Publications/Reports/2010.asp

- 41 per cent of Aboriginal youth in care were in an Aboriginal placement.
- On average, Aboriginal youth spent 37 per cent of their time in care in Aboriginal placements.
- 38 per cent of Aboriginal youth were served at least some of the time by a delegated Aboriginal Agency.
- 89 per cent of the youth were meeting regularly with their worker (e.g. at least once a month and for significant life events).
- For the youth in care, 88 per cent had one or more CPOC on file. These varied in quality and completeness.
- In 69 per cent of the cases, the CPOC appeared to be current at the time of the incident that was reported to the Representative.
- On average, the youth in care had been in care for half their lives and experienced 12 moves while in care.

Child and Family Services

Child and family services are provided to support parents in raising their children. They are sometimes put in place to assess the level and severity of risks to the children, and to develop a plan to reduce and mitigate risks that will allow children to remain in their parents' care.

For the 13 youth who were not in ministry care or in a Youth Agreement (YAG), but were receiving child and family services:

- In 91 per cent of cases where the youth was found to be in need of protection, there was a completed Comprehensive Risk Assessment (CRA).
- In 70 per cent of the cases requiring a CRA, there was a current Risk Reduction Service Plan on file.
- For the Aboriginal youth receiving services at the time of the incident reported to the Representative, all of them had their community and family members involved with case planning.
- In all of the cases where the child or family were receiving services, these youth and/or their families had been offered services by the ministry at the time of the incident, including such services as parent-teen conflict mediation, drug and alcohol counseling/treatment or respite care.

Case Example

This Aboriginal child was born to a mother who struggled with alcohol and drug use during the pregnancy. When the baby was still very young, her mother was left alone to care for her.

Over a seven-year period, the ministry undertook 13 investigations into the child's safety in response to reports of drinking, domestic violence and neglect in the home. The child was moved repeatedly from her mother's care to foster care.

As the girl moved into adolescence, she began drinking heavily. Her foster parent reported that she was drinking four or five nights a week, and was routinely brought home by police who would find her in an advanced state of intoxication.

The girl was referred twice to an Aboriginal drug and alcohol treatment program, but left both times before completing treatment. A peer family program didn't work out, as the girl continued to engage in high-risk behaviours during the program. The girl attended a six-month healing lodge program that, although not focused specifically on drug and alcohol treatment, did include counseling in that area.

However, during weekend visits home, she and her mother would drink. She formed a relationship with another program participant, who was himself struggling with substance use. All of this added up to a continued struggle with drinking.

Although testing showed her to have average to high-average intelligence, the girl was not successfully engaged with the school system. She attended many different schools because she was frequently expelled or suspended for behavioural issues. Being disconnected from school contributed to her vulnerability.

High-risk use of alcohol also left her vulnerable to sexual victimization. Although there were concerns that she had been sexually assaulted on at least one occasion, she refused to co-operate with police. She also became aggressive when intoxicated, and she was convicted of robbery after two incidents in which she attacked other women and tried to take their purses.

The incident that is included in this report occurred when the girl, upset after an argument, returned to her foster home and overdosed on anti-depressants. As she was passing out, she called 9-1-1 and was taken to hospital. After being treated for potential organ damage and monitored in hospital overnight, she was released the following day into the care of her foster parent, with whom she had a strong relationship. She made a full recovery from the overdose and subsequently completed a residential drug and alcohol treatment program.

Youth Agreements

A Youth Agreement (YAG) is an alternative to bringing a youth into care and is put into place with the goal of assisting the youth in achieving independence or providing a measure of support and ensuring safety and well-being while efforts are underway to return the youth to the family home. YAGs are an option for youth ages 16 to 19. Seven youth were in a YAG with the ministry at the time of the incident that was reported to the Representative.

Specific practices were examined, focusing on short- and long-term assessments, service planning, and monitoring the well-being of youth on agreements:

- All of the youth under a YAG at the time of incident had received both an immediate assessment and, later, a longer term assessment.
- All of the youth under a YAG at the time of incident had been referred to service and support providers, and there was evidence on the file to indicate they were attending.
- In all of the files, workers were physically checking on the youth at least once a week.

Youth Justice

Specific practices were examined for 54 youth who were in different streams of the youth justice program, focusing primarily on assessment and planning:

- In 87 per cent of the youth who had community sentences, probation officers had completed multiple Youth Community Risk/Needs Assessments, and Supervision Plans.
- 87 per cent of youth who were detained in custody centres had multiple Youth Needs Assessment case plans on file.
- All but one[9] of the youth ordered to undergo a forensic assessment were assessed or received an assessment.

Child and Youth Mental Health

CYMH services are offered throughout B.C. to help treat a wide range of mental health issues using a variety of treatment methods. They are offered to children, youth and their families and participation is voluntary. Prior to the incident that was reported to the Representative, 62 of the youth had involvement with CYMH.

Specific practices were examined, focusing primarily on assessment and participation with services:

- 90 per cent of the youth who were referred were formally assessed.
- 91 per cent of the youth who were assessed attended some of their scheduled sessions.

[9] The examination could not be complete due to the youth's sporadic attendance.

Case Example

This young girl came to the attention of the ministry as a five-year-old, when her mother was arrested for public intoxication. She was placed in temporary care when her mother was jailed. Her father was no longer involved with the family.

Over the next few years, the ministry conducted numerous child protection investigations. These were often the result of the mother abandoning the child, sometimes because she had been drinking.

The child was placed in foster homes and was twice returned to the mother under a supervision order. The mother had attended numerous alcohol treatment programs, with varying degrees of success, but ultimately was unable to manage her addiction. Because of this, the mother was unable to adequately care for the child, who lived with relatives for several years, and then went into foster care.

By about age 16, the youth was drinking heavily and using drugs, and she began to get into fights with her foster parents. She succeeded in getting some control over her substance use issues and began to stabilize. She then lived in a supported independent living arrangement while still in care of the ministry. Although things seemed to be going well, she engaged in self-injury by cutting.

Case Example

This youth achieved high grades in school and was actively engaged in sports and recreational activities. Around age 12, she developed symptoms of anxiety and depression after having been sexually assaulted. Although this was reported to a family physician, it was not reported to police, and she later said it hadn't happened.

As a teenager, she got into high-risk behaviours, including frequent alcohol and marijuana use, street drug use and self-inflicted cutting. There were also significant parent-teen conflicts in the home.

About six months after the reported sexual assault, the youth took approximately 200 non-prescription pills. Drug use escalated to include hallucinogens, heroin, cocaine and crystal methamphetamine. After living on the streets and in shelters for several months, she was admitted to detox facilities three different times.

She was admitted to an inpatient psychiatric facility four times over an approximately one-year period after suicide attempts and other high-risk behaviours.

She also became involved with Youth Justice Services after a shoplifting charge. She did not offend again, but was in trouble for having breached a court order repeatedly. Over the next year, there were several referrals to community service agencies. She made several more suicide attempts.

Eventually, the youth was placed in a foster home, and she went into a drug and alcohol program. While she was in that program, she took her own life.

Analysis and Recommendations

Overall Finding

Generally, these youth had a lengthy history of concerning behaviour and a lack of safety and stability in their lives. This means that, for most of them, there were many opportunities to reduce their vulnerabilities and improve outcomes. There were no consistent approaches to addressing deep factors such as the persistence of trauma and its impact on parenting and mental health.

The vast majority of these youth came from remarkably similar family backgrounds, characterized by poverty, domestic violence, parental substance abuse, or various combinations of these factors. Generally, several types of maltreatment occurred together. For example, domestic violence, substance addiction and neglect frequently occurred together rather than singly.

Among the small group that came from families where there were no major problems noted, or there was no history of maltreatment, there was typically a traumatic event in the youth's life that occurred outside the family. In general, the youth were engaged in multiple behaviours that posed risks to their health and well-being, including clear incidents of self-injury.

Most of the youth became involved in the service system early in their lives. Although outcomes were not generally positive, these youth had extensive involvement with the service system, including MCFD and the medical system.

Pathways Through the Service System

Finding: *The patterns observed in this aggregate review reinforce what we know from the literature about self-injury and suicide: youth with extremely difficult backgrounds have an increased susceptibility to self-injury and suicide death. It was common for youth in this review to self-injure with lethal and non-lethal intent at different times. There were similar patterns in life circumstances between those youth who came to the attention of the Representative as a result of self-injury and those youth who died by suicide. They experienced similar problems, and they received similar services.*

Examination of the life experiences and history of services of these youth paints a vivid picture of the circumstances in their lives, and their parents' lives, that created serious risks to their health and safety. Most of the youth in this review came from families that faced a number of difficulties. All of the youth faced significant challenges in their lives.

Among the youth in care, a large majority had been victims of abuse and neglect, and had experienced violence in their homes, including domestic violence. These youth experienced a remarkable lack of stability in their lives and numerous moves. Most of them were involved with many different service providers at many different points in their lives.

More than 75 per cent of these 89 youth were in ministry care at one time or another in their lives, and 65 per cent of them were in ministry care at the time of the incident that was reported to the Representative. The majority of the youth who died as a result of suicide (12 out of 15) were not in care of the ministry at the time of their deaths, although seven had been in care at some point in their lives.

As they were growing up, these youth had lives rife with unpredictability and they regularly had to cope with adversity. For most of them, their personal histories were lost in the chaos of constant change, including a parade of caregivers and service providers coming through their lives. What could they see as a future for themselves? For some of the youth, there was not enough hope to keep them going.

The life experience and challenges faced by these youth are outside the frame of reference of most British Columbians. Children and youth in the child welfare system have a significant chance of engaging in behaviours that threaten their health – for example substance use, depression and suicidality, and aggressive behaviour (Leslie, K.L., James, S., Monn, A., et al., 2010). Swannell, Martin, Page, et al. (2012) have reported a strong association between child maltreatment and subsequent non-suicidal self-injury.

Moreover, 34 per cent of the youth in this review had used substances, mostly alcohol, at the time of their injury or death. This observation has been frequently identified in research about self-injury and suicide attempts among adolescents (Schilling, E.A., Aseltine Jr., R.H., Glanovsky, J.L., et al., 2009). These researchers note that consuming alcohol can play an important role in suicides and suicide attempts because it can increase impulsivity and aggression, and decrease the ability to think clearly. For youth who have a tendency towards aggression and impulsivity, similar to some of the youth in this sample, alcohol may have increased their risk of suicidality.

Perhaps the most troubling finding was the high number of moves faced by these youth in their lives. Stability of placement is a complex issue, requiring a robust inventory of placement resources, as well as difficult judgment calls about returns to family.

For some of the youth in this sample, the number of placement changes was extreme. It is noteworthy that, as the young people in this review moved into adolescence, the number of placement changes increased drastically. Frequent moves can have serious consequences for young people as noted by O'Neil, Risely-Curtis, Ayon, and Williams (2012), such as further traumatizing already vulnerable children, higher levels of anxiety, feelings of loss and depression, and negative impacts on their social and emotional development.

The placement changes observed in this review occurred for a variety of reasons (for example, repeated entries into care, foster parents requesting a move, youth requesting a move, allegations of mistreatment in a placement, stays in treatment centres, or residing in youth custody centres).

There is some evidence that youth with the emotional and behavioural challenges described in this review have an increased risk for frequent changes (Barth, R.P., Lloyd, C., Green, R.L., et al., 2007) to such an extent that it can form a mutually reinforcing cycle. In other words, youth who develop emotional and behavioural challenges are more likely to act out, youth who act out experience a change in placement, and a placement change increases the likelihood of future placement changes (Rosenthal, J.A. & Villegas, S., 2010).

It should not be surprising that youth who have had turbulent backgrounds act out, or present challenges to traditional services and institutions. Can we imagine what it feels like to lose our family, move homes and live with different people and parent figures time after time, while remembering violent incidents and chaotic circumstances in our past? At the very least, for most of these youth, an overwhelming burden of loss and sadness has been part of their daily lives.

In an earlier report, *Kids, Crime and Care – Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes*, the Representative recommended that whenever a child or youth in care or in the Child In the Home of a Relative program has more than three changes in placement outside of the parental home within one 12-month period, a report should be made to the Regional Director of Integrated Practice. To date, this recommendation has not been implemented, however MCFD indicates it is working on a reliable tracking process so that such cases can be readily identified. The youth in the current review would have no doubt benefited from closer attention to the number of placement moves.

Another very troubling observation is that less than half of the youth whose cases were reviewed for this report were attending school on a regular basis. Lack of attachment to school is not surprising given the few stable personal supports available to these youth, and the often negative reactions they receive from others. Lack of school attachment has major consequences beyond academic outcomes. In addition to compromising educational achievement, it means that the youth were missing out on chances to have caring adults support them and to have positive social extracurricular activities. When youth such as those described in this report are acting out and the school suspends them, the system is divesting itself of a major responsibility to provide support and guidance to this highly vulnerable group.

MCFD Services

Finding: *Overall, adherence to practice standards was mixed. Better attention was paid to care planning, offering mental health services, youth justice services and monitoring youth on Youth Agreements. There was less success in meeting standards for placing Aboriginal children in Aboriginal homes. Following standards, while important, is not enough, because services were not geared to addressing the trauma in the lives of these youth or their parents, and inter-generational trauma was prominent in their lives.*

Measures related to service standards for children in care showed that having Aboriginal children placed with Aboriginal caregivers remains a challenge. Among the Aboriginal youth in this review, fewer than half were in an Aboriginal placement and, on average, less than half of their total time in care was in an Aboriginal placement. Delegated Aboriginal Agencies provided service in 33 per cent of cases. The Representative encourages ongoing work to better support cultural continuity for Aboriginal children and youth, and preservation of their Aboriginal identity.

Placement of Aboriginal children with Aboriginal caregivers is important in order to foster identity and cultural continuity. Recruitment and retention of Aboriginal caregivers to enable such placements is a goal that remains unmet. Addressing this issue will require supporting Aboriginal families and communities in reconciling past trauma and developing specialized skills.

It is important to note that for all of the Aboriginal youth who were involved with the system but were not in care, community and family members were involved in case planning. This is an important and necessary component of maintaining cultural continuity and family ties for Aboriginal youth. The current review did not assess whether the family and community participation in planning was meaningful. That would require extensive consultation with family and community members, which was not within the scope of this aggregate review.

With respect to CPOCs, a current plan was on file in only 69 per cent of cases reviewed for this report. This is a situation that must improve. In future months, the Representative will report on an audit of plans of care that will provide an in-depth picture of compliance with standards.

The Representative is encouraged that youth were meeting with their workers on a regular basis – at least once per month in addition to times of significant life events. However, given the profound challenges faced by this group of youth, the Representative believes that more frequent contact may be prudent and, in at least one way, improve stability in the lives of these youth.

Seven of the youth in this review were on Youth Agreements. Two aspects of relevant standards were reviewed – referrals to services and ongoing monitoring of the youth. In all of the cases, workers provided youth with referrals to services and engaged in ongoing monitoring of the youth. These two practices can be important to support youth to make better judgments and encourage healthy and positive decision making.

There were also high levels of adherence to practice standards for planning and assessment of youth in community youth justice as well as youth custody and youth forensic services.

In terms of CYMH services, 90 per cent of the youth were formally assessed and, of that group, 91 per cent were attending at least some of their appointments with service providers. The nature of this review does not allow for evaluation of those services.

Even when youth were successfully engaged in services, attendance tended to be spotty. Does this mean that the services were not well-matched to the individual youth? Or does it simply demonstrate that adolescents require more personal support to engage and attend when they are in despair?

Although that cannot be determined on the basis of the data in this review, the friendliness of – and ease of access to – support is a question of great interest to the Representative. Fuller engagement in services can only lead to improved outcomes. An evaluation of services to youth such as those in this review will be an important foundation for service design in the future.

Supporting High-Risk Vulnerable Youth

Finding: *It is not possible to conclude whether these deaths and critical injuries were preventable. Even with the highest quality interventions, not all outcomes will be positive. These youth had multiple challenges in their lives, and most of them were extremely vulnerable from birth. Many of them also experienced a significant adverse event in adolescence, compounding their vulnerability. The opportunity is there to promote better practice to address trauma, as outlined below.*

The Representative has heard through her advocacy work that youth who are, or who have been, in care are profoundly hurt and traumatized. They do not have the benefit of the personal and institutional supports they need to plan ahead for their transition into adulthood and improve their mental health. Observations from this review suggest that innovative ways need to be found to shift from episodic, crisis-based approaches to approaches that provide stability and continuity, meaningful, nurturing relationships, and a sense of commitment to the youth that spans years.

These youth had highly disrupted lives, characterized by early losses and wrenching instability. Services did not address the tremendous trauma they had experienced and opportunities to promote recovery from trauma, when these youth first came to the attention of the system, were missed. As a result, they did not have the benefits most children enjoy – the stability and the role models that support positive development. Nor did they have the skills or opportunities to advocate for what they needed.

We know from research that adverse, traumatic childhood experiences, similar to the abuse and neglect experienced by the youth in this study, can lead to significant health consequences as children become adults. An emerging movement aimed at reducing the effects of trauma is the 'trauma-informed systems' perspective – one that has gained

traction at the federal level in the U.S. Administration on Children, Youth and Families. This is a relatively new field of study, but it shifts the treatment focus of practitioners from the problematic behaviour of the child, to the traumatic events they experienced and the ensuing implications for intervention. Conradi and Wilson (2010) describe a trauma-informed system as:

> ...a wider system impacting children and families, with multiple components designed to meet the varying needs of traumatized individuals who are receiving services. These include collaboration across service agencies...partnership with youth and families receiving services, knowledge and understanding of trauma and its symptoms, and supporting the workforce in trauma work (p. 622).

Conradi and Wilson suggest 12 key components of a trauma-informed system:

1. Individual and organizational knowledge that trauma is pervasive and includes numerous short-term and long-term effects.
2. Trauma-specific screening and assessment.
3. Integrating the use of evidence-based and evidence-supported trauma-focused treatment and 'core components' of trauma treatment.
4. Safe, nurturing and predictable social environment, including psychological safety.
5. Helping children build attachment and relationships.
6. Partnership with youth and families receiving services.
7. Training and self-care for practitioners/front-line workers to prevent secondary trauma and burnout.
8. Treating the entire person.
9. Interventions tailored to meet the individual needs of the child and family.
10. Strengths-based.
11. Cross-system collaboration.
12. Acknowledgement and incorporation of trauma-specific knowledge and thinking into local, provincial and federal policy.

Based on the information in the files of these youth, trauma was not a primary focus of service delivery. The components listed above are not evident in the ministry's approach to children and youth, and it is clear that better outcomes will require a trauma-informed approach.

CYMH services are among ministry services that are sometimes called "voluntary" services. In other words, they are not statutory programs like child protection or youth justice. In British Columbia, we have a reasonably well-developed child and youth mental health system. However, the system of services can be difficult to navigate for youth and their caregivers, including ministry staff acting as guardians.

There is little systematic information available about CYMH services across the province. Have family-focused mental health strategies been developed for Aboriginal children and youth? Is the system sufficiently geared toward early identification and prevention? Are there barriers to access? Do these youth have strong caregiver advocates to help them get what they need? Do the services work to actively engage youth? Is there consistency of services from one community to the next, and across regions?

It is not always clear which youth are eligible for which services, and under what conditions they will be admitted. Is access to a service based completely on the willingness of the client? Will the service tolerate challenging behaviour? The answers to these questions are unclear.

It is also not clear what the outcomes are, overall, for youth with mental health challenges. The October 2010 joint report by the Provincial Health Officer and the Representative for Children and Youth, *Growing Up in B.C.,* noted that there is a lack of data both on the positive aspects of child mental health and on mental illness. In absence of this information, as well as a lack of solid information about effectiveness of services, it is impossible to draw conclusions about access to services, adequacy of services and outcomes.

In May 2012, MCFD released a three-year *Operational and Strategic Directional Plan*. It identifies CYMH services as one of its core service lines and identifies a key action of reviewing and undertaking a two-year action plan to strengthen CYMH. This provides an excellent opportunity for the ministry to develop a system of effective evidence-based services.

A significant re-focusing will be required, along with a commitment to invest the resources needed to meaningfully address the needs of highly vulnerable children and youth across the province. Targeted strategies will also be required to meet the special circumstances of Aboriginal children and youth and their families. The Representative looks forward to significant improvements in CYMH and will be monitoring and reporting on the implementation of the two-year action plan.

The information in this aggregate review provides important food for thought. It identifies a need to address trauma early on in the lives of children and to find approaches to services that will engage and benefit children and youth such as those described in this report. The Representative is in the process of conducting a review of CYMH, including input from youth, families and service providers, which will also provide important insights into required changes to services.

The Representative will issue a report on her review of CYMH services in the coming months, and at that time will make recommendations for required improvements. The results of the current review will help to inform that report.

Because the experiences of the youth described in this report call out for an urgent response, the Representative makes the following recommendation at this time.

Recommendation 1

That MCFD address the need for trauma-informed services for children in care in its 2012–2013 action planning on strengthening child and youth mental health services.

Detail:

The plan should include the following components:

- A thorough assessment of children when they are taken into care to identify patterns of trauma they may have experienced.
- Planning for services that will help them recover from that trauma.
- Triggering trauma-specific screening and assessment when significant life events occur, and a review of the plan of care in each such instance.
- Review of need for specialized therapy each time a plan of care is developed.
- Funding for enhanced services to meet these needs, including family-based interventions and therapies, accessible for children throughout the province.
- Clear strategies to reduce the number of moves and disruptions experienced by children in care.

The plan should be complete by March 31, 2013, with implementation beginning in fiscal 2013–2014.

Domestic Violence

Finding: *Exposure to parental domestic violence was a prominent feature in the backgrounds of more than half of these youth. There is ample evidence of serious negative developmental consequences when children live in homes where domestic violence occurs.*

Domestic violence creates an atmosphere of anxiety and fear and it perverts power relationships within a family. For most children, the more they are exposed, the more they are affected by violence among their parents. Often abuse is not limited to the adults in the home. Children are often caught in the cross-fire during violent events between parents (Jaffe & Juodis, 2006). Direct injury to children may occur because children are trying to intervene in the violent event such as calling for help, or children are sometimes used by their father as a means of harming or threatening the mother (Edleson et al., 2003).

Domestic violence, like disruption and moves, leaves a child with emotional pain, deep stress, and sometimes physical trauma. In addition, domestic violence and child abuse often co-occur and this has consequences for children's development and outcomes (Moffitt & Caspi, 2003; Gewirtz & Edleson, 2007). The consequences of child abuse and exposure to domestic violence include:

- Emotional consequences such as isolation, shame, guilt, low self-esteem and fear.
- Psychological consequences such as post-traumatic stress disorder, anxiety and depression.
- Behavioural consequences such as eating disorders, teen pregnancy, school dropout, suicide attempts, delinquency, violence and substance use.
- Relational consequences such as insecure attachment, and poor conflict resolution skills (Herrenkohl et al., 2008).

Domestic violence also affects development of effective coping skills in young people. Most children who live in constant fear of triggering an explosion of violence learn that their own needs are not important, and they learn not to expect a calm and rational response if they do seek help. Jaffe and Juodis (2006) report that children who have lost a parent in a domestic homicide often blame themselves for perceived failure to protect their parent and this can show up in the form of suicidal thoughts and attempts.

Children exposed to domestic violence tend to develop insecure attachment, making it difficult for them to relate to people. These children also tend to have many placement changes, difficulties maintaining meaningful relationships, and difficulties expressing themselves (Kaplan, Black, Hyman & Knox, 2001). While these effects are common, some youth show resilience (Jaffe, 2003).

Case Example

This Aboriginal youth died as a result of suicide. Her family had been involved with ministry child welfare services for approximately 10 years. Their first contact with the ministry was a result of domestic violence in the home and suicide attempts by the mother. The children were first removed from the mother's care when the girl was eight-years-old. The youth came into permanent care two years later. The children were returned to the mother a few years later, and the file was closed.

Approximately one year after the children were returned, several calls were received by the ministry over a six-month period regarding the children, including this youth having suicidal thoughts. She disclosed having been sexually assaulted by another youth. She received services from CYMH and community agencies and later was taken into care. After coming into care, she received services, including CYMH, other community-based services, and a one-to-one worker. She was hospitalized several times as a result of suicidal thoughts. The youth wanted to return home, but it was not safe for her because of domestic violence at home.

The youth engaged in self-harm behaviours such as cutting and burns to the body. She began using marijuana, crystal meth and alcohol. A mental health clinician also had concerns about the youth's escalating and intense thoughts of suicide. The youth was hospitalized for a drug overdose. Her use of street drugs increased and, according to file information, the psychiatrist declined to continue treatment. Later, the youth was referred for community support/transition services, detoxification, and a semi-independent living program, which included a counseling component. Several assessments were completed. The CYMH file was closed.

Shortly thereafter, the youth was hospitalized for a drug overdose. A few months later, the CYMH file was re-opened with a new counselor. The youth attended a residential treatment program, but shortly after died as a result of suicide.

MCFD conducted a comprehensive review. The review found that there were a number of committed individuals involved with the youth and that many appropriate and supportive services had been offered. The review also found that there were weaknesses in the assessment process in all areas, that there was a lack of collaboration between professionals and that critical information was not shared between program areas. The review found significant documentation gaps on the youth's guardianship file, indicating the social worker may not have been aware of some significant information. The review also identified a number of significant events in the youth's life that occurred just prior to the death.

The impact of domestic violence on parenting can be immense and there is support for the claim that the mother's ability to care for her children is often compromised when she is in a violent relationship (Appel & Holden, 1998, Kelleher, 2008, Levendosky & Graham-Bermann, 2000). The mother spends a great deal of emotional resources when resisting the violence; therefore, the provision of effective resources and supports at the right time can go a long way in helping a mother to adequately care for her children.

From file documentation, it does not appear that issues such as grief, loss or recovery from domestic violence are a primary focus of attention when children first come into the system, whether they are brought into care, or receiving support services while remaining in their homes. However, we know that the best chance of recovery and resilience comes with early identification, harm-reduction measures and interventions aimed at stopping cycles of abuse and violence.

For Aboriginal children and youth, additional trauma comes in the form of broken cultural and community ties.

Fetal Alcohol Spectrum Disorder

As noted elsewhere, this review found significant documented evidence of substance use problems in mothers of youth requiring mental health services, and of youth with significant mental health and behavioural challenges. This review does not include data related to Fetal Alcohol Spectrum Disorders (FASD) because it was not typically referred to in the documents reviewed and there were no records of formal diagnosis. However, it is reasonable to assume that some, if not many, of the children and youth in this review were dealing with FASD since many of the challenging behaviours and cognitive limitations noted were consistent with the characteristics and symptoms of the disorder.

FASD includes a wide range of impairments to a youth's physical, mental, behavioural and learning capacity caused by the mother's consumption of alcohol during pregnancy. There is no single defining characteristic of FASD because the degree of prenatal exposure affects each child in unique ways. This has created challenges in assessment and has led to misdiagnoses and under-diagnoses because of the similarities to other mental health disorders, lack of trained professionals and limited resources, especially in remote areas.

Life is challenging for youth with FASD and it can be especially daunting for youth in care, who are often dealing with the traumatic early life experiences of being removed from their families, physical and sexual abuse and the resulting painful memories. These youth are of great concern to the Representative and she intends to focus her work on learning more about the system of supports and services for these children and youth in future reviews.

Conclusion

This aggregate review is a first step to a better understanding of the circumstances of a specific group of highly vulnerable children and youth and the system of services and supports that works to keep them safe and help them cope. Although its scope is limited by the aggregate method and the nature of the information that is available in the youth's files, as the first such study of its kind in British Columbia, it makes an important contribution. It furthers our understanding and it raises compelling questions. Most importantly, it points out the critical need to collect the kind of outcome data that will give us the tools to assess whether meaningful improvements are being made.

Although this review is not a formal evaluation, it enables the Representative to make observations about the system of supports and services. It is abundantly clear that ongoing and persistent attempts were made by ministry staff to intervene and provide supports. Most of these youth were formally assessed and were in contact with social workers.

It is also abundantly clear that the system falls short of meaningfully addressing the depth of vulnerability and trauma in lives of children and youth such as these, or the intergenerational issues that permeate the lives of their families. When families face compounded challenges such as domestic violence, substance abuse, mental illness and poverty, they lack the means to take control over their environment. They lack the means to provide the stability and guidance their children need for optimal development.

When children wake up in countless different homes, always starting over with strangers, they lack the chance to form meaningful attachments. When we consider that this is often layered on top of a life experience of abuse or neglect, and countless social workers and service providers, the sense of despair that permeates this report is understandable.

In the coming months, the Representative will release a major review of CYMH services in British Columbia, and a formal audit of plans of care for children in care. In these reports, specific recommendations will address issues raised by this review. However, more urgent action is recommended in addressing pervasive trauma in the lives of children in care.

Glossary

"**Aboriginal**" is a broad term which, according to the *Constitution Act* of 1982, includes the Indian, Inuit and Métis people of Canada. However, the term "Aboriginal" is generally more broadly interpreted as including people who are registered status Indians, non-registered Indians, Inuit and Métis. Non-registered Indians are generally people who self-identify as having Aboriginal heritage, but who are not eligible to be registered under the *Indian Act*.

Child in care: any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act*.

Child protection report: a report received about a child's need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include: taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth, or conducting a child protection investigation.

Child protection investigation: a process of inquiring into or tracing through inquiry, collection of information, and interviews with parents, teachers, daycare providers, public health nurses, physicians, and extended family members to evaluate whether a child is in need of protection.

Comprehensive Plan of Care: an action-based planning tool for children in care, used to identify specific developmental objectives based on continuous assessments of the child's evolving needs and the outcomes of previous decisions and actions. Care plans are completed by the child's worker with the involvement of the child, the family, the extended family and Aboriginal community if the child is Aboriginal, the caregiver, service providers and significant people in the child's life.

Comprehensive Risk Assessment: a process and document that describe the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. A Comprehensive Risk Assessment is completed whenever a child is found in need of protection.

Delegated Aboriginal Agency: through delegation agreements, the First Nations Director (the Director) gives authority to delegated Aboriginal Agencies, and their employees, to undertake administration of all or parts of the *Child, Family and Community Service Act (CFCSA)*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency and the level of delegation provided by the Director.

First Nation(s) is a term that became more common during the 1970s to replace the term "Indian." While there is no legal definition for term "First Nation(s)," it is meant to describe those persons who are registered as "Indians" under the federal *Indian Act*.

Hughes Review (*The BC Children and Youth Review*): the 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was a review that recommended the appointment of an independent Representative for Children and Youth.

Initial Reportable Circumstance: Initial written report of death, critical injury or serious incident provided by ministry front-line staff to the provincial director.

Intake: The process by which child protection reports and requests for service are introduced into an office. These reports and requests for service are assessed and assigned to social workers for follow-up.

Reportable Circumstance: The ministry's Child and Family Service Standard 25 requires the reporting of serious incidents of children in care or receiving services. Serious incidents can include: injuries; deaths; allegations of mistreatment; allegations of criminal involvement; missing children or high-risk situations; or life threatening medical difficulties.

Reviewable service: any of the following designated services:

(a) Services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*;

(b) Mental health services for children;

(c) Addiction services for children;

(d) Additional designated services that are prescribed under section 29(2)(b) (e.g. health care).

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Appendix A: Representative for Children and Youth Act

Part 4 – Reviews and Investigations of Critical Injuries and Deaths

Section 11 – Reviews of critical injuries and deaths

(1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for review under subsection (3).

(2) For the purposes of subsection (1), the public body may and provide that information to the representative in time intervals agreed to between the public body and the representative.

(3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to inform improvements to reviewable services or broader public policy initiatives.

Appendix B: Documents Reviewed

Ministry of Children and Family Development

- Family service files including electronic records
- Child service files including electronic records
- Resource files including electronic records
- File reviews and Comprehensive reviews
- Provincial office and Regional Director office records
- Reportable Circumstance reports
- Youth Justice files including electronic records
- Child and Youth Mental Health files

Healthcare

- Hospital records
- MSP records
- Pharmanet records

Coroners Service

- Kimble reports
- Pathology and toxicology reports
- Coroners reports

Education

- School attendance records

MCFD Legislation, Policy and Standards Documents

- Aboriginal Operational and Practice Standards and Indicators (AOPSI)
- Child, Family and Community Service Act and Regulations (1996)
- Child and Family Development Service Standards: Child and Family Service Standards, November 2003
- Child and Family Development Service Standards: Child in Care Standards, November 2003
- Quality Assurance Standards
- Child and Youth Mental Health Service Standards (2006)
- Child and Youth Mental Health Suicide Risk Intervention Policy (2005)
- Community Youth Justice Programs Manual of Operations
- Violent Offender Treatment Standards and Guidelines
- Standards for Youth Support Services and Agreements
- Youth Custody Operations Manual
- MCFD Operational & Strategic Directional Plan 2012/13-2014/15

Other Material References:

Hughes, E. N. *BC Children and Youth Review: An independent review of BC's child protection system*. April 2006. Victoria, B.C.

Appendix C: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry for Children and Family Development (MCFD) within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a Regulation outlines the terms of appointment of members of the Team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, child protection
- Policing
- Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and development disabilities
- Public health

Multidisciplinary Team Members at the Time of This Review

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation, and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Lucy Barney – Lillooet Nation, RN, completed her Masters of Science in Nursing from the University of British Columbia, and is currently employed as a perinatal nurse consultant with the BC Perinatal Health Program. She is the vice president of the Native and Inuit Nurses' Association of BC, and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal health and she developed the braid theory which looks at the mind, body and spirit, and demonstrates a holistic view on health.

Beverley Clifton Percival – Ms. Percival is from the Gitxsan Nation, and is a negotiator with the Gitxsan Hereditary Chief's Office in Hazelton. She holds a degree in anthropology and sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator, and instructor at the college and university level.

Jim Gresham – Supt. Gresham is the superintendent and officer in charge of the RCMP E Division Major Crime Section. He has been a plainclothes investigator involved since 1991 in the investigation of crimes against persons, including homicides and historical unsolved homicides. He is a member of the E Division Major Case Management Committee, and an accredited Team Commander for the investigation of major crimes.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Doug Hughes – Mr. Hughes is currently the Provincial Director of Child Welfare for the Province of British Columbia. He has 26 years experience in child welfare as a child protection social worker, community development worker, community services manager, regional executive director and finally as an Assistant Deputy Minister. He graduated from the University of Calgary with Master of Social Work in 1992.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service, who has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of paediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses' Association of BC, and is an instructor in the provincial Paediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Paediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital, and assists the BC Coroners Service on an ongoing basis.

Appendix D: MCFD Practice Standards

Ministry Practice: Children in Care

When a child is brought into temporary or permanent care, the ministry assumes the primary responsibility for his or her growth and development. This is referred to as the ministry's guardianship responsibilities. Of the 89 youth in this review, 58 were in ministry care at the time of the incident that was reported to the Representative.

Specific practices and outcomes relating to seven practice standards for children in care were assessed. These focus on safety, planning, placement stability, and specific responsibilities with respect to Aboriginal children and youth.

CIC Standard #5: Ensuring child's safety and well-being while in care
According to this standard, one of the ministry's primary responsibilities for youth in care is to keep them safe. When a youth is involved in a situation that threatens his or her safety or well-being, it is recorded as a Reportable Circumstance and tracked. This is an important aspect of guardianship because it calls attention to potential case management issues, or a requirement for additional supports or interventions.

In relation to this standard, the following relevant outcomes were observed at the time of incident:

- 32 per cent of the youth in care had more than one Reportable Circumstance, ranging from two to seven Reportable Circumstances.

CIC Standard #1: Preserving the identity of an Aboriginal child in care

CIC Standard #2: Preserving service that respect a child's culture and identity
According to these two standards, ministry services provided to Aboriginal youth should nurture their Aboriginal identity and relationships with their people, support their current cultural practices and facilitate further exploration of their culture.

In relation to these standards, the following information was gleaned from the files:

- The Comprehensive Plan of Care (CPOC) identified services required to support the identity and cultural needs for 73 per cent of the Aboriginal youth in care.
- 41 per cent of Aboriginal youth in care were in an Aboriginal placement.
- On average, Aboriginal youth spent 37 per cent of their time in care in Aboriginal placements.
- 38 per cent of Aboriginal youth were served by an Aboriginal agency.

CIC Standard #9: Developing and maintaining a meaningful relationship with a CIC
When children are in continuing care of the ministry, the ministry is their legal parent and guardian. Foster parents provide the day-to-day supervision and support of children and youth in care, but it is important for children and youth to have regular contact with their guardianship worker. The worker can assess the changing needs of the young person and plan accordingly, and hear updates on the status of their placement.

In relation to this standard, the following information from the files was noted.:

- 89 per cent of the youth were meeting regularly with their guardianship worker, e.g. at least once a month and for significant life events.

CIC Standard #11: Assessing and Planning
Like all children and youth, children and youth placed into care have specific and unique needs across a wide array of dimensions, including physical health, education, and social development. Attending to these needs through the provision of appropriate services requires thorough assessment and planning. A Comprehensive Plan of Care (CPOC) is the mechanism the ministry uses to specify the types of services a youth requires to meet his or her developmental needs, and to track his or her progress. CPOCs should be updated every six months, or more often if needed.

In relation to this standard, the following information was found in the files:

- For the youth in care, 88 per cent had one or more CPOC on file.
- In 69 per cent of cases, the CPOC was current at the time of the incident that was reported to the Representative.

Based on the file information alone, an accurate assessment of compliance with the plan of care was not possible for the purposes of this review. However, the Representative is conducting a formal audit of plans of care using a larger sample, and will report the results of this audit in the future.

CIC Standard #12: Supporting and Assisting a Child With a Change in Placement
The standard recognizes that a change in placement can be disruptive and detrimental to the development of a young person.

In relation to this standard, the file information yielded the following information:

- On average, the youth in care had been in care for half their lives and experienced, on average, 12 moves while in care.

Ministry Practice: Child and Family Services

Child and family services are provided to families to support parents in raising their children, to assess the level and severity of risks to the children and develop a plan to reduce and mitigate risks that will allow children to remain in their parents' care, or to improve overall functioning.

For the 13 youth who were not in ministry care or entered into a Youth Agreement, but were receiving child and family services, four practice standards were assessed. These related to assessment, risk reduction planning, and assimilating the views of Aboriginal communities and families through various assessment and planning stages.

CFS Standard #18: Developing and implementing a plan to keep a child safe
When concerns regarding the safety and well-being of a youth are brought to the attention of MCFD and the youth is found to be in need of protection, workers need to assess the risks and strengths of a family and develop a plan to keep the youth safe. This can be accomplished through the use of a Comprehensive Risk Assessment (CRA) and a Risk Reduction Service Plan (RRSP).

In relation to this standard, the following information resulted from the file review:

- In 91 per cent of the files where the youth was found to be in need of protection, there was a completed CRA
- In 70 per cent of the same files, there was a current RRSP on file.

CFS Standard #2: Children and families from Aboriginal communities
This standard is designed to incorporate the views and opinions of the family and community of Aboriginal youth with respect to planning and support services in order to promote better outcomes for children and youth.

In relation to this standard, the following information was recorded in the files:

- For Aboriginal youth and their families receiving services at the time of the incident reported to the Representative, all of them had their community and family members involved with case planning.

CFS Standard #7: Support services to strengthen capacity
When the needs of parents and youth are brought to the attention of the ministry this standard suggests that workers offer services appropriate to the family's unique needs.

In relation to this standard, the following was recorded in the files:

- In all cases, these youth and/or their families had been offered services by the ministry at the time of the incident, including such services as parent-teen conflict mediation, drug and alcohol counseling/treatment or respite care.

Ministry Practice: Youth Agreements

Youth Agreements are an option for youth ages 16 to 19. A Youth Agreement (YAG) is an alternative to bringing youth into care with the goal to assist youth in achieving independence, or to provide a means of support and ensure safety and well-being while efforts are underway to return a youth to the family home. Seven youth were on Youth Agreements when the report was made to the Representative.

YAG Standard #5: Assessing for and Providing Short-Term Supports

YAG Standard #6: Assessing for Longer-Term Service
Short term safety plans are intended to meet a youth's immediate basic needs while further assessment, service planning and the potential for family reintegration is explored. Longer-term service planning begins once a youth service worker has attended to a youth's immediate needs and safety concerns.

In relation to these standards, the following information was noted in the files:

- All the youth under a YAG at the time of incident had received both an immediate assessment and, later, a longer-term assessment.

YAG Standard #8: Longer-Term Service Determinations and Planning
Based on the outcomes of the planning and assessment stages, youth service workers are to make referrals and organize supports that will meet the youth's identified needs.

In relation to this standard, the following information was noted in the files:

- All the youth under a YAG at the time of incident had been referred to service and support providers, and there was evidence on the file to indicate they were attending.

YAG Standard #14: Monitoring a YAG
Because YAGs are used with high-risk youth, they typically require frequent face-to-face meetings to monitor how well a youth is doing.

In relation to this standard, the following information was noted in the files:

- In all cases, workers were physically checking on the youth at least once a week.

Ministry Practice: Youth Justice

Community Youth Justice provides a range of community-based services to meet the needs of youth who are alleged to have committed a crime, but who have not been sentenced to custodial care. These services are designed to promote an increase in law abiding behaviour and help contribute to public safety. Twenty-three youth in this report had Community Youth Justice involvement prior to the incident that was reported to the Representative.

Policy: Section D – 2.12 Assessment and planning
To provide the appropriate community-based services for youth, probation officers complete a Youth Community Risk and Needs Assessment and develop a Supervision Plan in conjunction with the youth. The assessment and planning describe the services youth are required to attend as part of their supervision in the community.

In relation to this standard, the following information was recorded in the files:

- In 87 per cent of cases, probation officers had completed multiple Youth Community Risk and Needs Assessments and Supervision Plans.

Youth Custody Services are specialized facilities that house and service youth offenders who have been court ordered to serve time in custody, or for youth who are required to remain in custody while they await their court appearance. Fifteen youth in this report had previously been involved with Youth Custody Services.

Policy: Section I – 5.02 Assessment and planning
To provide the appropriate services for youth who are in custody, case managers complete a Community Risk and Needs Assessment and develop a Supervision Plan in conjunction with the youth. The plan describes the services youth are required to attend as part of their rehabilitation and reintegration in the community.

In relation to this standard, the following information was recorded in the files:

- In 87 per cent of cases of youth who were detained in custody centres, there were multiple Youth Community Risk and Needs Assessment case plans on the file.

Youth Forensic Psychiatric Services provides inpatient and outpatient assessment and select treatment services for youth involved with the youth justice system. When a youth is charged with a criminal offence, a judge can order a medical, psychiatric or psychological report. The collection of these reports forms a forensic assessment, a comprehensive evaluation of a youth and his or her family and social background. The results of the assessment are submitted to court and can be shared with other professionals working with a youth for which it may serve an important part in formulating ongoing treatment plans. Sixteen youth in this review were ordered to receive a forensic assessment.

There are only a few general standards governing the administration of a forensic assessment. The Representative's interest here is in determining whether or not a court-ordered forensic evaluation was carried out.

In relation to this, the following information was recorded in the files:

- All but one[10] of the youth ordered to undergo a forensic assessment were assessed.

Ministry Practice: Child and Youth Mental Health

Child and Youth Mental Health (CYMH) services are offered throughout B.C. to help treat a wide range of mental health issues using a variety of treatment methods.

They are offered to children, youth and their families, and participation is voluntary. Prior to the incident that was reported to the Representative, 62 of the youth had involvement with CYMH.

CYMH Standard #5 - Policy B-4: Mental Health Assessments

CYMH Standard #6 - Policy B-8: Treatment
CYMH follows a basic referral-assessment-treatment model with workers using evidence-based treatment methods. Youth and their families can voluntarily seek service. They can also be referred to services by community health professionals or social workers. Upon initiating contact with CYMH, cases are prioritized in terms of urgency of need for service in relation to the other youth seeking service and they are either seen immediately or placed on a wait list.

In relation to these standards, the following information was noted in the files:

- 90 per cent of youth who were referred were formally assessed.
- 91 per cent of youth who were assessed attended some of their allotted sessions.

[10] The examination could not be completed due to the youth's sporadic attendance.

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REPRESENTATIVE FOR
CHILDREN AND YOUTH

This is Exhibit "G" referred to in the Affidavit of Mary Ellen Turpel-Lafond, sworn before me, on this 7th day of November, 2019.

A commissioner for taking Affidavits

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Fragile Lives, Fragmented Systems:
Strengthening Supports for Vulnerable Infants

Aggregate Review of 21 Infant Deaths

January 2011

January 27, 2011
The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, BC V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. E. George MacMinn, QC
Clerk of the Legislative Assemby

Ms. Joan McIntyre
Chair, Select Standing Committee on Children and Youth

Contents

Executive Summary

This review looks into the lives of 21 infants who died before the age of two years old between June 1, 2007 and May 1, 2009.[1] All of the infants' families were involved with the Ministry of Children and Family Development (MCFD).

This is an aggregate review – a collective look at deaths that occurred under similar circumstances. This is the Representative's first aggregate review, and it is different from any of the reviews or reports published to date. An aggregate review allows us to learn from these tragedies and see if there are ways to improve the systems that support vulnerable families in British Columbia.

As the Honourable Ted Hughes, QC, said in the 2006 *BC Children and Youth Review*: "The primary method of reviewing child injury and deaths will be to examine aggregated information and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives."

As such, this is a more analytical, less personal report than others done by the Representative on the deaths of children. The nature of this type of review requires that all personal facts that could identify the infants be removed. However, to illustrate the life situations of some of the infants, case examples are provided throughout the report.

All of the infants in this review were born into families facing tremendous challenges. Many of the 21 families struggled with circumstances like serious poverty, inadequate housing and fragmented systems that failed to provide the supports they needed and failed to identify and respond to the risks that were in many instances obvious. Nine of the mothers were either single or very young parents. Five were first-time mothers. These families faced multiple risk factors that can have a significant impact on an infant's well-being. All of the 21 families had at least two significant risk factors, and the majority had four or more.

An alarming number of the infants – 15 of the 21 – were Aboriginal, and nine of these 15 were from Vancouver Island. The high proportion of Aboriginal deaths and the total number that occurred on Vancouver Island (13) are both areas of concern. The mortality rate for Status Indian infants in B.C. is twice that of non-Aboriginal infants, a fact which has been previously noted by the Provincial Health Officer.

Common challenges in the lives of the infants and their families include:

- 20 of the 21 families had intergenerational trauma in the parent's family of origin.
- 15 of the 21 families had a documented history of abuse or neglect in the mother's family of origin.

[1] Two of the 21 infant deaths were outside of this time frame but were referred to the Representative by the Select Standing Committee on Children and Youth.

- 14 of the 21 families had domestic violence issues in the immediate family. Eight of the families had documented domestic violence in previous generations.
- 16 of the 21 families had substance abuse in their immediate family, and 15 of the 21 had substance abuse in previous generations.
- 12 of the 21 families had documented mental health issues such as depression, suicidal behaviour and anxiety.

While acknowledging the significant challenges these families would present to those providing support from the medical, child welfare and public health systems, this review revealed a patchwork of services and limited supports to vulnerable families and their newborns in the province.

The lack of rigorous, integrated planning, sharing of information and system-wide tools for proper risk assessment and intervention resulted in many opportunities lost for these infants and their mothers.

The lack of a coordinated and responsive government approach to poverty is also a significant concern in this review. As a group, these infants lived in serious poverty as well as inadequate housing. These cases starkly show the inability of families to improve their life circumstances across generations, with devastating results. The families in this review, particularly the Aboriginal families, were often stuck in chronic, deep poverty that was the single largest risk factor in their environment.

B.C. continues to have the worst child poverty rate in the country,[2] and the Representative continues to advocate strongly for a comprehensive provincial poverty reduction plan. As this review shows once again, poverty is directly correlated with compromised outcomes for children. Concrete and effective prevention measures are required to make a difference in the lives of infants, children and families in this province.

All of these infants died unexpectedly and in unsafe sleep arrangements. Although the cause of sudden infant deaths remains a mystery, we do know that the risk of sleep-related infant deaths is reduced when the known risk factors are mitigated.

Although good prenatal education and information about safe sleeping is important to creating a safe environment for an infant, it is also important to note the role of the interacting factors of poverty, inadequate housing and family functioning in this circumstance. Increasing public awareness, particularly with vulnerable families, about the importance of safe sleeping is critical, but it should be done with the understanding that other significant underlying conditions of infant vulnerability also require attention.

Public health nurses identify family needs and provide support through intervention and connection to resources and services, as well as provide training and education. With their unique role, public heath nurses have an opportunity to observe infants in the home environment in a non-intrusive way while assessing their health and development.

[2] Using LICO, B.C.'s after-tax child poverty rate was 10.4 per cent, compared to a national rate of 9.1 per cent. *2010 Child Poverty Report Card.* BC Child and Youth Advocacy Coalition, Nov. 2010.

However, there is no provincial coordinated standards-based program for postnatal public health nursing services in B.C. The province's regional health authorities offer a variety of programs that are not available everywhere in the province. In addition, inconsistent practice exists within and across health regions, and funding varies across program areas and regions. This is concerning, especially considering the vital role these nurses could play in helping assess families with vulnerabilities and collaborating as part of a support team to identify opportunities to reduce risks and improve the safety of these infants.

Targeted public health nurse home visiting programs that begin in the prenatal period and continue after birth have demonstrated effectiveness, including improving prenatal outcomes and child health. This is clearly an area where great benefit could come from a more consistent, standardized approach to the services provided.

The purpose of this review is to identify areas where the systems that support vulnerable families and infants can be improved. Whenever there is an opportunity to learn from these kinds of tragedies, self-examination and improvements in policy and practice must occur.

It is important to note that other reviews of some of these deaths have also occurred. However, it is not clear whether any of these reviews has resulted in any organizational learning or improvement. Of the 21 infant deaths, 14 were identified for a ministry case review by MCFD and in one circumstance the death underwent two reviews, for a total of 15 reviews for 14 deaths. Fourteen reviews are now complete, with one still in progress. The remaining seven deaths were not reviewed. It is not clear why these deaths were not also reviewed, despite active service delivery by the ministry to the child and/or family.

The 14 completed MCFD reviews were examined as part of this aggregate review. The following concerns arose from this examination:

- It was not clear how the decision was made to conduct a review or which type of review to conduct.
- The terms of reference were not always adequate, given the identified concerns.
- The analysis in the reviews missed key issues.
- In some cases, the issues identified in the analysis were not addressed in the recommendations.
- When recommendations are noted as complete, it was unclear if the actions taken actually fulfilled the requirement of the recommendations.
- Too few of the reviews met the ministry's quality assurance standards time frame for completion.

By not conducting reviews of all the deaths and conducting reviews that were inadequate in several areas, the ministry lost a valuable opportunity for learning and sharing information.

Some of the specific areas of potential learning from these infants deaths included:

- challenges of working in isolated communities
- effective intervention with drug-addicted parents
- impacts of domestic violence
- better integration of services and interagency communications
- appropriate discharge planning.

In addition, there does not seem to be a consistent and formalized procedure for sharing the results of reviews with other ministry staff or with other involved professionals. This is a concern that was also raised in the Representative's 2008 report *Amanda, Savannah, Rowen and Serena: From Loss to Learning*. For learning and change to occur, these results must be shared openly and consistently with all who have a role to play in these types of situations, regardless of the service they provide.

These families were known to have been facing significant life and parenting challenges, yet somehow the risks to their children associated with these challenges were ignored or not dealt with effectively. Too often in this review the documentation shows that many professionals from the public health, medical and child welfare systems saw these families and noted part of the issue, but didn't connect the dots to create a whole picture that would have clearly revealed a fragile situation where intervention and additional supports were critically necessary.

We know that intervention, support and consistent information for pre- and postnatal mothers can make a world of difference in their lives and the lives of their babies. It is not possible to say that with adequate services, all of these infants would be alive today, but as birth circumstances play a significant role in the healthy development of an infant, it is possible and reasonable to say that some of them very likely would be.

Introduction

This review examines the circumstances of 21 infants who died and the system of supports and services that were involved in their lives. These infants and their families were involved with the Ministry of Children and Family Development (MCFD).

> There are many more lessons to be taken from children's lives and from their experiences with the ministry, with their families, with the medical system, their schools and communities. A public health perspective can help us to find and use the information that [may] make a difference to children's lives and, we hope, further reduce the number of children who needlessly die.
>
> **Honourable Ted Hughes, QC**
> *BC Children and Youth Review*

The death of a child is heartbreaking. When an infant dies, we are struck by their utter vulnerability and helplessness. The Representative for Children and Youth recognizes the immense sadness and emotional impact these deaths have had on the families, communities and those involved with the infants and their families.

An aggregate review such as this compounds our sorrow as a community – when we realize the numbers we are examining aren't "just numbers," they represent young lives lost, and entire families devastated. One can't help but feel the weight of those losses, when we pause to think of the grief that lies behind the statistics.

The intent of this review is not to look for blame or assign fault but rather to understand the system of services and supports that were involved in the lives of the infants and their families, to determine how the systems worked and to make recommendations intended to improve support to vulnerable families.

Many circumstances and factors can lead to a family becoming vulnerable, including poverty, substance abuse, domestic violence, physical and mental illness and a lack of adequate housing. These circumstances often lead to families coming to the attention of child welfare services and have significant impact on children's healthy development, safety and well-being.

Birth circumstances play a significant role in the healthy development of infants, and the Representative believes much can be learned from the 21 infant deaths reviewed in this report. Their deaths challenge us to strengthen our supports to the most vulnerable members of our society.

Terminology

For the purpose of this report, the term "infant" is used to describe a child under the age of 24 months. This is consistent with the definition in Webster's New World Medical Dictionary, which defines an infant as a child up to two years of age.

However, it is recognized that the usage of the term "infant" varies for different purposes and by different organizations. For example, the term "infant death" is defined by the

Provincial Health Officer in a 2003 special report, *A Review of Infant Mortality in British Columbia: Opportunities for Prevention,* as the death of a liveborn infant less than one year of age. The BC Coroners Service defines "infant mortality" as the deaths of infants during the first year of life per 1,000 live births.

The term "prenatal" refers to the period prior to birth and the term "postnatal" refers to the period after birth.

The term "Status Indian" refers to a person registered under the *Indian Act* and is recognized as legally entitled to a range of programs and services available to them.

The term "First Nations" is used to refer to individuals who have identified as having a specific First Nations ancestry, and the term "Métis" is used to describe individuals who have identified as having Métis ancestry. The term "Aboriginal" is used in the report to include individuals who identify as being First Nations, Status Indian, non-Status Indian, Inuit or Métis.

The term "Aboriginal infant" is an inclusive term for First Nations, Status Indian, non-Status Indian, Inuit or Métis infants.

In this report statistics for Status Indians are reported as there are no available comprehensive data for the more broadly defined group of Aboriginal peoples.

RCY Aggregate Reviews

Deaths and critical injuries of children in care and children who have received *reviewable services* within the year prior to their deaths or injuries are reported to the Representative. The Representative's mandate is to review and investigate these deaths and injuries, report to the public and make recommendations for improvements to the child-serving system as required. The Representative determines if a death or critical injury will be reviewed on its own or collectively with other deaths or injuries with similar circumstances in an aggregate review.

Reviewable services

Any designated services, including services and programs under the *Child, Family and Community Service Act* and *Youth Justice Act*; mental health services for children; addiction services for children; and additional services prescribed under the *Representative for Children and Youth Act*.

In the 2006 *BC Children and Youth Review,* Hughes stated that the Representative for Children and Youth "should have the discretion to determine the kind of review that is appropriate in the circumstances. It may be a matter of collecting and reviewing information on a number of deaths with similar characteristics to identify trends or patterns that will inform or educate the child welfare system and the public."

This is the first aggregate review completed by the Representative's Office. Aggregate reviews involve reviewing and analyzing a group of deaths or critical injuries as well as related legislation, policies and practices to determine if there are any recurring circumstances or trends.

The purpose of an aggregate review is to explore lessons that can be learned from a group of cases that share some common factors. This review was guided by a realistic assessment of policy and practice during the review time period and an evaluation rooted in reasonable practice by a qualified person exercising professional judgment.

MCFD social workers and health service providers negotiate complex systems and delicate circumstances on a daily basis and are often responsible for making difficult decisions. Even the best practice and best analysis cannot predict the future with certainty, and it would be unfair to hold service providers to impossible standards.

The Representative acknowledges the important work of all of the service providers involved with the families in this review and did not undertake this review as a fault-finding process. Rather, the Representative examined whether the response from the systems of services was reasonable in relation to the circumstances at the time.

In this report the infants and families are not identified by name, and care has been taken to present the information in a way that does not otherwise identify them.[3]

Rationale for Conducting this Aggregate Review

This review focuses on the circumstances of 21 vulnerable infants and their families and the services and supports provided to the families. Thirteen of these 21 infants resided on Vancouver Island.

The review seeks to build a deeper understanding of these young lives and how we may be able to mitigate risks and improve the circumstances in which vulnerable infants and their families live.

The deaths of these infants are of particular concern to the Representative because of the possibility that they may have been preventable. Typically, they involved factors that are known to increase risk of death, and they raise a number of questions, such as:

- Were the infants and their families receiving the information and systems of support required for positive outcomes?
- How were the infants' lives impacted by broader factors like poverty, housing or limited social supports?
- How can systems such as the child- and family-serving agencies, the public health system, hospitals and health care providers work together to provide support, education, prevention and health promotion in a coordinated and consistent manner?
- How are these systems supporting and responding to vulnerable infants and families?

[3] Section 16(1) of the *Representative for Children and Youth Act (RCY Act)* specifies that reports based on aggregated information not contain information in individually identifiable form.

Methodology

The Representative's mandate to review and investigate deaths and critical injuries of children receiving reviewable services came into effect on June 1, 2007, and is set out in section 11 and section 12 of the *Representative for Children and Youth Act (RCY Act)*. MCFD is responsible for reporting these deaths and critical injuries of children to the Representative.

The sample for this review was drawn from all deaths of infants age two and under reported to the Representative from June 1, 2007 to May 31, 2009. This time frame was chosen because most of the investigations by other public bodies had been concluded and the files closed when the review began.

During that time period, the deaths of 66 infants under the age of two were reported to the Representative. The Select Standing Committee on Children and Youth had referred an additional three infant deaths that occurred prior to June 1, 2007 to the Representative, for a total of 69 deaths of infants aged two years and under.

The 69 deaths were screened to determine if they met the Representative's criteria for review as set out in the *RCY Act*. The following criteria were applied:

- the infant or the infant's family received a reviewable service within the year previous to the death; and
- the policies or practices of a public body or director may have contributed to the death; and
- the infant's death or circumstances of the death were an example of a recurring circumstance observed in other deaths; or
- the death occurred in unusual or suspicious circumstances; or
- the death was or may have been due to child maltreatment.

The Select Standing Committee on Children and Youth (SSCCY) is a parliamentary committee with a mandate to increase the awareness and understanding of the B.C. child welfare system among legislators and the public.

The SSCCY's role includes the following:

- receive and review the annual service plan from the Representative for Children and Youth
- be the committee to which the Representative reports (at least annually)
- refer to the Representative for investigation the critical injury or death of a child
- receive and consider all reports and plans delivered by the Representative to the Speaker of the Legislative Assembly of British Columbia.

Thirty-two deaths met the criteria for review. The following additional selection criteria were then applied:

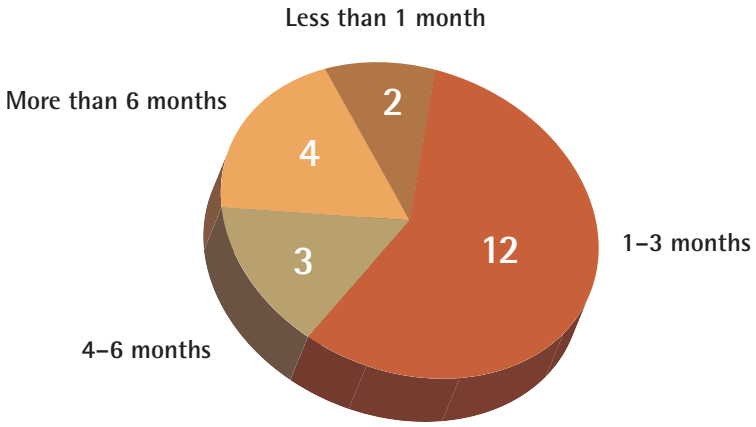
- The infant's death initially appeared to be unexpected and sleep-related, based on the circumstances reported.
- The infant's death was not the subject of an ongoing criminal investigation.

This resulted in 21 infant deaths being selected for the aggregate review.

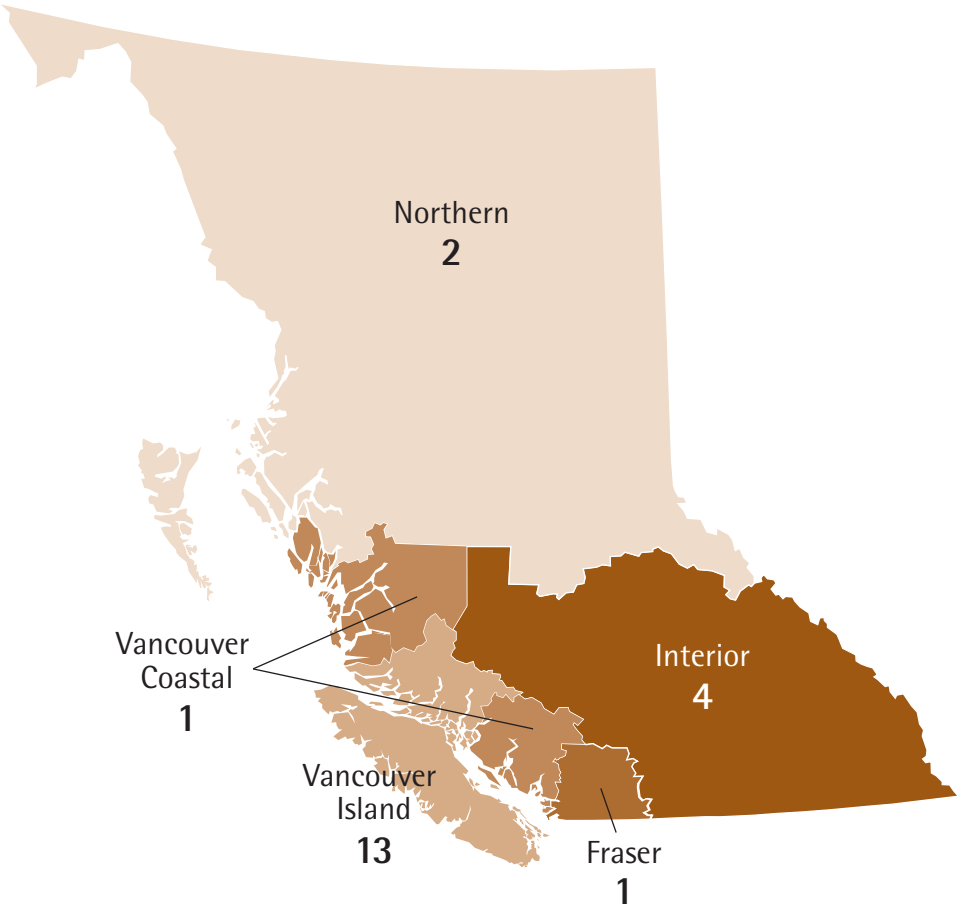
Process for Selecting the 21 Infants and Families for this Aggregate Review

Police attended the scenes of all 21 infant deaths. The police investigations determined that the deaths did not occur in suspicious circumstances, and criminal proceedings were not initiated. At the time of their deaths, the infants ranged in age up to 21 months.

Over half of the deaths occurred between the ages of one and three months.



The map below illustrates the regions where the infants lived with their families.



Nineteen of the infants and families were primarily served by MCFD, and two of the infants and families had been solely served by a delegated Aboriginal Agency. Three of the 21 infants were children in the care of the ministry.

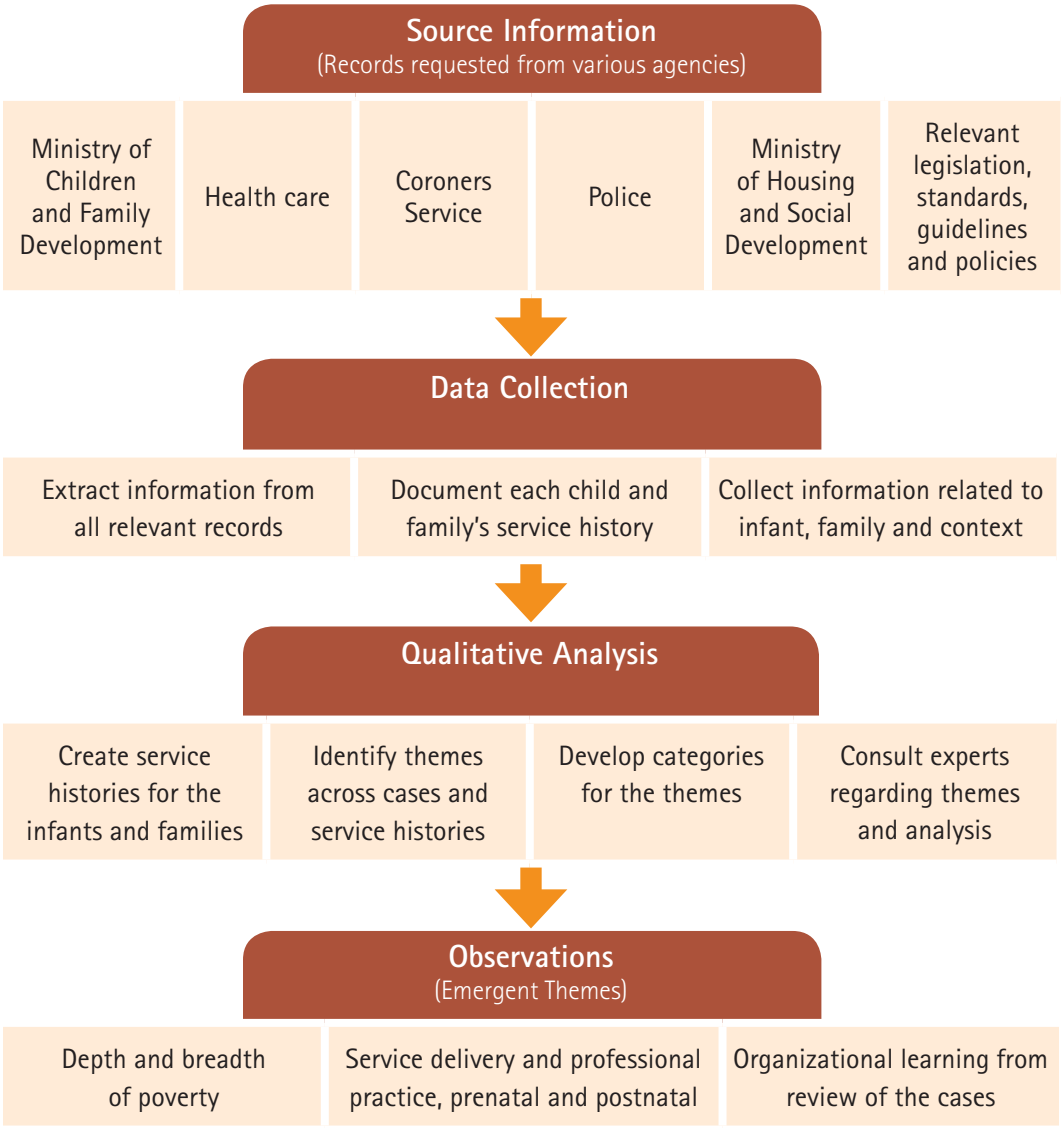
Records relating to each of the infants and their families were requested and received from MCFD (which also provided relevant records from delegated Aboriginal Agencies), the Ministry of Housing and Social Development, the regional health authorities, the Ministry of Health Services, the BC Coroners Service, the RCMP and municipal police departments (see Appendix B for a detailed list of documents reviewed).

These records were thoroughly reviewed to identify any patterns or common factors that may have presented risks to these infants, as well as the nature, level and intensity of services or supports that their families received.

The data collected from source records was examined by two reviewers. Service histories were documented for each infant and their families. The service histories were analyzed using a qualitative approach.

Themes were identified across the infant and family service histories, and categories were developed for the themes. The Multidisciplinary Team was consulted to assist with the analysis (see Appendix D, Multidisciplinary Team members). The following diagram illustrates the data collection and analysis process used in this review.

Data Collection and Analysis Process



Because this was a review under the *RCY Act* rather than an investigation, family members and service providers were not individually interviewed by the Representative's Office.

Background

Historically, sudden infant death syndrome (SIDS)[4] was the term used to classify deaths of infants who died suddenly and unexpectedly with no conclusive physical finding. Over the years, risk factors for sudden infant death have been recognized. In B.C. there has been a shift in definition, and external risk factors are now being noted and tracked by the BC Coroners Service in collaboration with the BC Vital Statistics Agency.

The BC Coroners Service is responsible for the investigation and classification of all unnatural, sudden and unexpected, unexplained or unattended deaths. The Coroners Service has provincial responsibility for determining the facts surrounding a death as well as determining the classification of deaths. Deaths are classified as natural, accidental, suicide, homicide or undetermined.

In 2004 the Coroners Service adopted the term "sudden unexplained death in infancy" (SUDI) to reflect the sudden, unexpected and unexplained death of an infant under one year of age where there is no anatomical cause of death at autopsy, but known external risk factors are identified that could have been contributory to the death. Examples of risk factors include sleep position, sleep environment and sleep surface.

In 2007 the Representative, the Chief Coroner, the Provincial Health Officer and MCFD observed that an unusual number of sudden infant deaths were occurring on Vancouver Island. The Chief Coroner at the time directed staff to take a detailed look at the sudden infant death cases on both Vancouver Island and throughout the province. The Coroner's preliminary information was that the majority of deaths involved unsafe sleep practices.

In 2008 the BC Coroners Service issued a public safety bulletin on infant deaths confirming that unsafe sleep practices were risk factors identified in sudden infant deaths. The bulletin encouraged parents and caregivers to follow the recommendations of the Canadian Paediatric Society on infant safe sleep environments and practices (see Appendix C).

In 2009 the Child Death Review Unit (CDRU) of the BC Coroners Service, which has a mandate to examine how and why children die, released *Safe and Sound: A Five Year Retrospective - Report on Sudden Infant Death in Sleep-related Circumstances*. The report made recommendations in a number of areas, including prenatal care, public education and public health home visiting and research (see Appendix C for report recommendations).

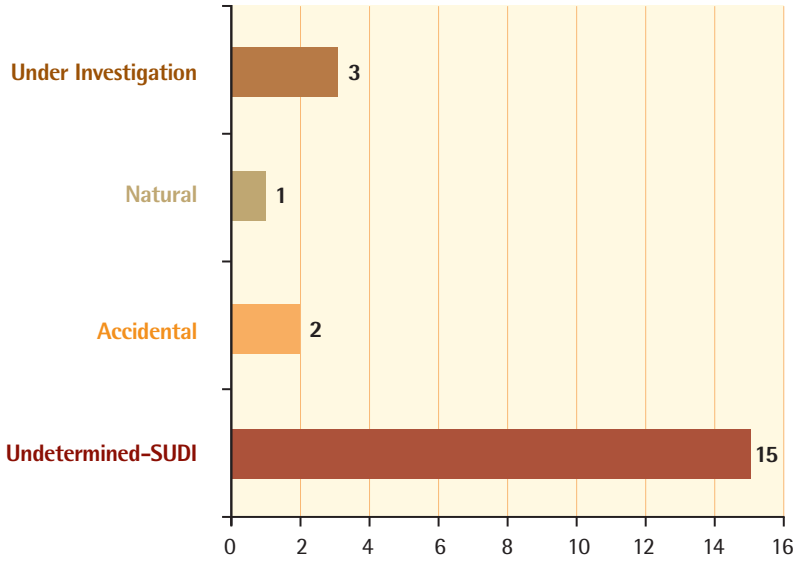
A "cluster" review was also completed by MCFD in 2008 following the deaths of five infants on Vancouver Island who had received child welfare services. These infants died within a one-month period in 2007. The purpose of the review was to analyze the five deaths to determine if immediate policy or practice changes were necessary. The overall

[4] BC Coroners Service (2009, p. 41) *Safe and Sound: A five year retrospective - Report on Sudden Infant Death in Sleep-related Circumstances.*

conclusion of the resulting report was that known risk factors related to SIDS and safe sleeping practices were present in each death. (The recommendations arising from the MCFD cluster review are available in Appendix C.)

The Coroners Service has completed investigations into 18 of the 21 infant deaths in this review. Three remain under investigation. To date, 15 of the deaths have been classified as undetermined – sudden unexplained death in infancy. Three have been classified as natural or accidental.

The diagram below indicates the Coroners Service classifications of the deaths.



Over the 10-year period from 1999 to 2008, 1,716 infants under the age of two died in B.C.[5] Although the numbers vary from year to year, there is no significant overall trend in the number of deaths that occurred during this time period.

This aggregate review covers the time period from June 1, 2007 to May 31, 2009. During that period, according to BC Vital Statistics, 348 infants under the age of two died in British Columbia. Nineteen of those deaths are included in this review. The other two deaths were outside of this time frame but were referred to the Representative by the Select Standing Committee on Children and Youth.

BC Vital Statistics Agency also uses the International Classification of Diseases-10 codes (ICD-10) for classifying deaths. The ICD-10 is "a system of coding diseases, signs, symptoms, social circumstances and external causes of injury or disease endorsed by the World Health Organization."[6] Sleep-related deaths in this system are all referred to as sudden infant death syndrome (SIDS). External risk factors are listed within the SIDS classification group as sub-groups. The term "sudden unexplained death in infancy" does not exist in the ICD-10 classification system.

[5] BC Vital Statistics Agency, 2010.

[6] BC Coroners Service (2009, p.40). *Safe and Sound: A five year retrospective - Report on Sudden Infant Death in Sleep-related Circumstances.*

Since the terminology used by the Coroners Service to describe and classify sudden infant death in sleep-related circumstances has changed over time, and because terminology and classification of infant deaths varies across organizational sources and jurisdictions, it was not possible for the purposes of this review to reliably determine and compare infant death rates from unexplained deaths within and between jurisdictions or over time.

Aboriginal Infant Mortality

The number of Aboriginal infant deaths cannot be accurately reported at this time because quality data for this group does not exist. However, valid statistics are available for Status Indians. A new methodology is currently being developed in partnership with First Nations communities to improve accuracy in reporting on Aboriginal population data.

Fifteen of the 21 infants who were included in the review were Aboriginal. Nine of these 15 infants lived on Vancouver Island. The high proportion of Aboriginal infant deaths and the number that occurred on Vancouver Island are of concern.

The infant mortality rate measures the number of infants who die in the first year of life, expressed as a rate per 1,000 live births. About eight of every 1,000 Status Indian[7] infants die in their first year, compared with a rate of about four infant deaths per 1,000 non-Aboriginal British Columbians. According to 2006 data from the Ministry of Health, there is an average of 27 Status Indian infant deaths each year in British Columbia.

In 2003 the Provincial Health Officer for British Columbia issued a report highlighting the disparities in infant mortality rates between various population groups. Status Indian infants were noted to have an increased rate of mortality between the ages of 27 days and 374 days, and infants born with a low birth weight[8] also showed an increased risk of mortality.

The Provincial Health Officer's report suggested ways to improve infant mortality rates in B.C. and highlighted disparities in infant mortality rates, particularly in First Nations communities. The state of maternal and child health and child welfare services in B.C. was not a focus of the Provincial Health Officer's report.

One tentative explanation for some Aboriginal infant deaths is a particular genetic variant that is prevalent in certain Aboriginal populations, known as CPT 1. This genetic variant is being investigated in studies in Nunavut, Alaska and B.C. to clarify its association with sudden unexpected infant death (see Appendix E for more information).

[7] Status Indian – Recognition by the federal government of persons registered under the *Indian Act* is referred to as Registered Indian Status. Status Indians are entitled to a wide range of programs and services offered by federal agencies, provincial governments and the private sector.

[8] Low birth weight: birth weight of less than 2,500 grams.

Lives of the Infants and Families

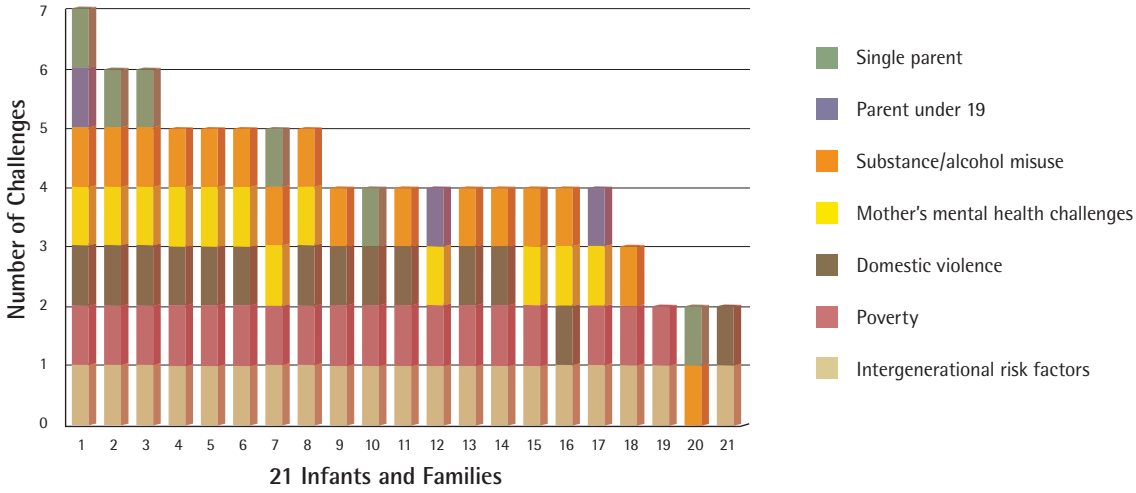
It is important to understand the life circumstances of these 21 infants and their families.

The infants and families included in this aggregate review lived in vulnerable circumstances with multiple risk factors present in their lives. The risk factors noted in the files reviewed include poverty (both deep and/or transitional), exposure to domestic violence, parental mental health challenges, parental substance and/or alcohol misuse as well as intergenerational trauma in the parents' families of origin.

The compounding effect of multiple risk factors is particularly noteworthy and may have had a large impact on infant well-being. All of the families had at least two significant risk factors, and the majority had four or more.

Displayed below are the multiple risk factors and demographic factors present in the records reviewed for each of the infants and their families.

Common Challenges in the Lives of the Infants and Families



Within the infants' families there were significant patterns of intergenerational issues associated with vulnerability spanning multiple generations. Interventions from child welfare agencies in the previous generation had not generally been effective in reducing or eliminating these risk factors, suggesting they were either persistent despite public supports or those public supports were not effective or responsive.

Intergenerational trauma, also called intergenerational transfer of psychosocial risk, is the tendency of a person when they become a parent to repeat the abuse or neglect that they themselves suffered as a child. The *World of Abnormal Rearing* identifies this as the first factor in assessing risk to a child and notes that a child raised in this environment may go on to repeat the abuse when they become a parent (Helfer, 1987). This is particularly true regarding the impact of residential schools on First Nations families which "created a veritable wave of suffering that continues to wash over generation after successive generation of Aboriginal people" (Smith, Varcoe, Edwards, 2005).

Intergenerational challenges included:

- documented history of abuse or neglect in the mother's family of origin in 15 of the 21 families
- substance abuse in previous generations of 15 families
- six of the infants' mothers had been in the care of MCFD at some point during their own childhood
- documented mental health issues in previous generations of six families
- documented domestic violence concerns in previous generations of eight of the families.

Information related to the father's family of origin was not documented in a systematic manner in the files; therefore, data related to the infant's fathers and their families of origin is not presented in this report.

Similar patterns were observed and documented within the infants' immediate families:

- domestic violence in the immediate families for 14 infants
- substance abuse in the immediate families for 16 infants
- mental health issues such as depression, anxiety and suicidal behaviour in the immediate families for 12 infants.

Neglect and maltreatment in childhood is known to be a variable that can be used to predict the likelihood of a parent mistreating their own child. It has been estimated that one-third of children who are maltreated become abusive or neglectful parents."[9]

In families where there is a history of maltreatment in either of the parent's family of origin, maltreatment is more likely to occur if other risk factors are also present.[10] In the cases reviewed for this report, the most frequently cited issues in both the immediate family and the families of origin were substance abuse, mental health, domestic violence, neglect, suicide attempts and family instability.

The 2010 Canadian Incidence Study of Reported Child Abuse and Neglect found that being a victim of domestic violence (46 per cent) and having mental health issues (12 per cent) were the most frequent concerns identified by social workers in relation to primary caregivers.

Domestic Violence: The abuse and/or assault of adults or adolescents by their intimate partners.

[9] Peirson, Laurendeau & Chamberland, 2001.
[10] Mikkonen & Raphael, 2010.

Case Example

The mother of this First Nations infant was actively involved with MCFD child protection social workers during the prenatal period due to concerns regarding the care and safety of an infant sibling.

The MCFD file information indicated a lengthy history of involvement with the infant's family over a number of generations. When the infant's mother was a child, she had been removed from the care of her own parents due to domestic violence, mental health issues, neglect, sexual abuse and lack of medical attention. The infant's grandparents had suffered the impacts of attending residential schools and lived in severe poverty. The infant's mother was suspected to have been affected by prenatal exposure to alcohol.

Numerous health hazards in the family's home had been reported to MCFD. Despite the information regarding the historical abuses affecting the family and active child protection involvement, no discharge planning was done by MCFD and the hospital when the infant was born. MCFD did not make contact with the family until six weeks after the birth. Public Health had extensive and frequent contact, noting the infant's medical concerns relating to care and hospitalization for failure to thrive. MCFD was not advised of the hospitalization, nor did they appear to be monitoring the situation in order to know that the infant had been hospitalized.

MCFD received another report regarding the infant's care, and the infant was removed from parental care at approximately four months of age. At the time of placement in the foster home, the foster parent noted that the infant's body was covered with eczema and that the infant made "odd sounds." The foster parent attempted to access medical care for the infant at a walk-in clinic but did not get to the clinic before it closed for the day. The infant died that night. The death was identified as sudden unexplained death in infancy with contributing health problems.

Analysis and Recommendations

Overall Finding

Given the significant risks these infants faced, it is not possible to conclude whether their deaths were preventable. However, the lack of rigorous, integrated planning and system-wide tools for risk assessment and intervention both within and across the public health, medical and child welfare systems led to many missed opportunities for prevention and effective response.

This review illustrates a patchwork of services and limited supports to vulnerable infants and their families in British Columbia. It raises questions about why, in a number of situations, the response to significant concerns about an infant's safety did not address the severity of the presenting circumstance. One might question whether service providers had the tools they needed to intervene in a preventive manner, were unclear about their roles and responsibilities, were frustrated by a lack of resources or had, over time, become desensitized to the desperate circumstances of these families and infants. The life circumstances of the Aboriginal infants and their families in this review were particularly challenging.

An integrated, collaborative and consistent system of services may have made a significant difference in the lives of these infants. It can reasonably be presumed that had such a system been in place, some of these deaths may have been prevented. An effective system must address barriers to integration, including divided service responsibilities such as those seen between the provincial and federal governments. Until we have such a system in place, we cannot assume that vulnerable infants are safe and that unnecessary infant deaths are being prevented.

Infants are completely reliant upon adults to meet their needs, including the essentials of life. A baby born into a family struggling financially, socially and emotionally faces significant risks to its health and well-being and is highly vulnerable.

Research indicates that the risk of negative outcomes is increased by the presence of more than one vulnerability at the same time.[11] The vulnerability of a child is increased when other risk factors such as prenatal exposure to harmful substances, poverty and inadequate housing are co-occurring.[12]

Resilience refers to the internal and external qualities that help a person, family or community cope with difficult situations and overcome adversity. Some of the factors that contribute to resilience include social and/or community support, a sense of competence, self-esteem, temperament, social maturity, past coping ability, positive relationships, humour and morality.[13] The importance of consistency and quality of

[11] Nelson, Laurendeau, Chamberland & Peirson, 2001.
[12] Mikkonen & Raphael, 2010.
[13] Winfield, 1994; Brackenreed, 2010.

care and support to children during development as well as adequate and consistent role models continues to be discussed in the literature on family resilience.[14]

The familes included in this report were struggling for a number of different reasons and were at risk due to a variety of social, financial, emotional and medical factors. They were all known to the child welfare system, some for generations, and had been identified as vulnerable or requiring services. The degree, intensity and consistency of support they received generally was inadequate.

Economic Well-Being

Observations: ***As a group, these infants lived in serious poverty and inadequate housing. They lived in conditions that would be difficult for mainstream British Columbians to imagine, and their quality of life suffered as a result.***

Child poverty and inadequate housing are issues that are well known, and they are acknowledged by all levels of government. These cases starkly illustrate the inability of these families to improve their life circumstances across generations, with devastating results. Concrete and effective prevention measures are required to make a difference in the lives of infants and children. Supports to enable change may not have been adequate or effective for previous generations.

There is no "official" definition and measure of poverty in Canada or in British Columbia. Different organizations in Canada measure poverty in different ways. It can be thought of in economic terms or in terms of social impact (e.g., marginalization). Some definitions of poverty take in a broad range of factors, including:

- standards of living
- ability to meet survival needs
- whether poverty is transitional, chronic or intergenerational
- the causes of poverty, from individual to societal and systemic inequalities.

The receipt of income or social assistance is closely connected to poverty, especially among Aboriginal people. For this report, records were reviewed to determine if the families received some form of financial support, including provincial income assistance or federal social assistance for families residing on reserve.

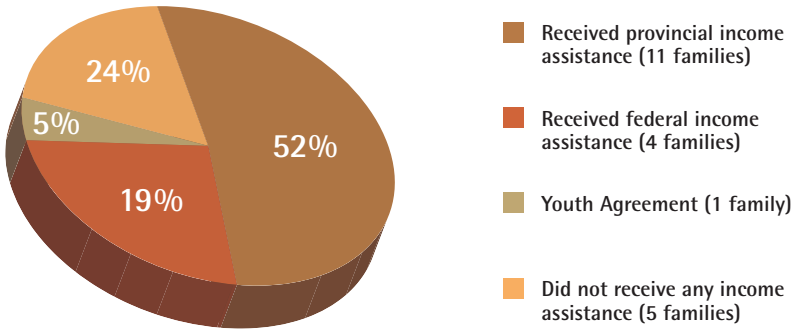
Income assistance rates, whether provided by the B.C. government or, in the case of Status Indians living on reserve, by the federal government can be described as subsistence incomes.[15]

For example, an employable one-parent family with four children under the age of 18 would receive a minimum of $375.58 support allowance per month and a shelter allowance of $750 per month. Expecting mothers are eligible to receive a prenatal

[14] West & Farrington, 1973; Brackenreed, 2010.
[15] Statistics Canada (2008) *Income in Canada.* Statistics Canada Catalogue no. 75-202-XIE (as cited in First Call, 2010)

allowance of $45 per month for up to six months following birth. Depending on family circumstances, income can be affected by other provincial and federal government supports, such as the child tax benefit, GST/HST tax credits and disability benefits.[16]

Families Receiving Financial Support



From the prenatal period up to and including the time of the infants' deaths:

- Of the 21 families, 16 were receiving financial support (one parent received financial assistance through a youth agreement with MCFD).
- Of the five families that were not receiving financial support, two resided with extended family. No income assistance or support was indicated for three of the families during the reviewed time period.

Youth Agreement: A provision of the *CFCS Act*. A youth agreement may provide one or more services, such as "residential, educational or other support services" and/or "financial assistance." These youth are not considered to be "in care."

According to the 2010 Child Poverty Report Card,[17] Newfoundland, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba and the Northwest Territories have committed to provincial poverty reduction plans. In October 2010 Nunavut announced the beginning of a public engagement process that may lead to an anti-poverty strategy for the territory. British Columbia does not have a provincial plan to reduce poverty.

Despite a drop in B.C.'s overall child poverty rate between 2007 and 2008, B.C. continues to have the worst child poverty record in the country for the sixth year in a row based on after-tax measures, specifically low income after cut-off (LICO).[18] Provincially, the rate of child poverty is 10.4 per cent, higher than the national average of 9.1 per cent. The Canadian Paediatric Society rated B.C. "poor" in addressing child poverty in their 2009 report.[19]

[16] Ministry of Housing and Social Development, 2007 (now Ministry of Social Development).
[17] First Call, BC Child and Youth Advocacy Coalition, 2010.
[18] Statistics Canada. 2008. *Income in Canada.* Statistics Canada Catalogue no. 75-202-XIE.
[19] A "poor" rating means a province has neither legislation nor a strategy to reduce child poverty. (Canadian Paediatric Society, 2009).

In B.C. most poverty data excludes on-reserve First Nations due to data limitations. Generalized results of poverty assessments fail to capture the depth and breadth of the deprivation and marginalization of this experience.

> The percentage of children living in low income is possibly the most widely used indicator of child well-being. Low income has a negative influence on a number of dimensions of child-health and development. Socio-economic disadvantage is associated with increased risks of poor outcomes, both in the short term and the long term, in the areas of health, safety, education and family stress. Children living in low-income families are more likely to have problems with one or more basic abilities (vision, hearing, mobility and speech) and are more likely to experience developmental delay in vocabulary development, difficulty in school, injuries due to accidents or physical abuse or neglect. They are more likely to be involved with the child welfare and youth justice systems, to become teen parents, to earn less as adults and to be more frequently unemployed.
>
> *Growing Up in B.C.,* BC Representative for Children and Youth and Provincial Health Officer, 2010, p. 37.

Poverty experienced by children and youth is usually linked to parental poverty (e.g., poor nutrition or inadequate shelter) and childhood deprivation (e.g., being forced to leave school early or do dangerous work) and can have implications across the life-course.

The key drivers of chronic poverty include the following:

- severe and/or repeated shocks (e.g., ill health and injury, market and economic collapse, violence and conflict)
- ineffective institutional support (e.g., lack of effective social protection)
- poverty occurring at certain points in an individual's or household's life-course (e.g., in utero, childhood, old age, youth and youth households).[20]

Different explanations for the cause of poverty have influenced social policy approaches to "curing the problem of poverty." The approaches range from providing financial support directly to families to providing support services available outside the home.[21] None of the approaches taken seem to have made a difference for the families included in this review. The social policy foundations for responding to poverty issues in B.C. are not clear, and there have been inadequate measures to address the need for mobility.

The families in this review, particularly the Aboriginal families, were typically mired in chronic, deep poverty that was the single largest risk factor in their environment. Changing the lives of children in these families requires strategies to deal with the immediate poverty circumstance as well as strategies to encourage more long-term solutions.

[20] Moore, 2004.
[21] Mayer, 1998.

The Representative continues to advocate strongly for a comprehensive provincial poverty reduction plan, and has frequently addressed the Select Standing Committee on Children and Youth on this matter because of the correlation of poverty with compromised child development outcomes. Given that poverty was the most significant and common risk factor in the lives of these infants, the Representative once again urgently calls for the development and implementation of this plan.

The families of the infants in this review also faced significant issues in obtaining stable and adequate housing, which is critical to an infant's well-being and ability to thrive. Inadequate housing is connected to poor health outcomes.[22] Inadequate housing conditions independently cause negative health outcomes, even when considered apart from other issues such as poverty.[23] Twelve of the 21 infants lived in inadequate housing, and 10 of the 12 were Aboriginal.

In this review, housing was found to be inadequate if any of the following were referenced in the file information:

- the family was living in housing described as overcrowded or inadequate
- the family lived in shelters, group homes, motels or transition housing
- the family was on a waitlist for housing.

Some families resided in the most extreme circumstances of deprivation, including:

- a home that was severely contaminated with mould
- frequent moves
- lack of a permanent residence
- regular use of transition homes and motel accommodation in lieu of permanent, stable housing.

[22] Durbin, 2009.
[23] Mikkonen and Raphael, 2010.

Case Example

This First Nations child was born into a home with other young children. The family lived in poverty and often relied on relatives, transition housing and motels for accommodation. MCFD became aware that the mother was expecting early in her pregnancy.

The mother had been admitted to hospital after being assaulted by her spouse during her pregnancy. Prior to the infant's birth, 14 child protection reports had been made to the ministry, primarily about alcohol abuse and domestic violence. Four of these reports were made while the mother was pregnant with this infant; they included concerns about inadequate housing, emotional abuse of the infant's siblings and substance abuse. One of the reports was investigated and not substantiated. The other three were not investigated. The MCFD file was closed before the infant was born.

According to the MCFD file information, the newborn was assessed at birth by a program in the local hospital that worked in conjunction with the public health unit. The program reportedly assessed newborns for medical as well as social/emotional risk factors. The newborn was assessed by the program as low risk and was discharged from hospital the following day. It does not appear the hospital was aware that the family had no reasonable housing and a history of substance abuse and family violence. It appears this MCFD information was not shared with the hospital following the infant's birth.

The infant was seen three times by public health nurses from birth to three months of age. At the second visit, the mother reported that the infant had noisy breathing while asleep, which a doctor thought was possibly the result of a floppy epiglottis.

Approximately two months later the mother took the infant to see a doctor because the noisy breathing persisted and a cough had developed. The doctor thought these symptoms were possibly due to an infection and prescribed amoxicillin. At the third visit with the public health nurse, the mother informed the nurse that the infant's noisy breathing persisted, and she also informed the nurse about the previous visit to the doctor. No follow-up regarding the infant's breathing was noted on the record of the visit.

The infant died four days after the last visit with the public health nurse. On the evening of the death the infant had been left in the care of adolescent babysitters. There was no crib in the home. The babysitters placed the infant to sleep in a car seat that was on top of a soft mattress. Sometime later the car seat turned over, and the baby was asphyxiated.

At a special meeting on child poverty convened by the Select Standing Committee on Children and Youth on May 21, 2010, the BC Child and Youth Advocacy Coalition, stated: "The poorest of the poor don't have access to supports for adequate housing... because of inadequate housing, children are being removed from their families because of concerns about neglect. Safe neighbourhoods and safe housing make a huge difference – and support parents. When we invest in that, communities support each other. But when you're living in an impoverished community and nobody has anything extra, how do they support each other?"

Case Example

One of the infants resided with an adolescent mother and a grandmother in a motel. Over a two-month period, 10 individual service providers had some involvement with the mother and infant, including child protection social workers, hospital social workers, public health nurses, hospital workers and a family support worker.

A public health nurse had observed the infant's living conditions and documented that the family was to be "observed" for emotional status, postpartum depression and family functioning; however, the nurse also recorded "no apparent problem" in the notes of the visit. A second nurse who visited also documented that the family should be observed for provision of a safe environment and support systems.

During at least one of the visits, the nurse noted that two adults were smoking inside the motel room with the infant present. It was also noted that the mother smoked and used marijuana. The nurse advised the mother to wait two hours after doing so before breastfeeding the infant. However, in a follow-up conversation with the child protection worker, the nurse expressed no concerns related to the infant's care. The infant's living conditions were not noted as a concern for the service providers.

First Nations communities consistently struggle with a shortage of adequate housing. It has been estimated that 17 per cent of on-reserve housing is in need of major repairs and that 5,000 housing units nationwide require replacing.[24]

Waitlists for on-reserve housing can be lengthy. Waitlists for adequate housing in some B.C. First Nations communities can range from two to 10 years. In addition, housing allocation policies do not typically consider family needs in prioritizing who gets access to housing when it does become available. Nor is there a market housing solution for those who can afford to pay so that social housing can be better targeted to need.

In the following case example, services were provided to the family in an apparent effort to address their struggle with inadequate housing. However, the services provided did not match the family's needs.

[24] Office of the Provincial Health Officer, 2009.

Case Example

The mother of this infant was involved with MCFD child protection social workers during her pregnancy. She had two toddlers. The family lived on reserve in a home that had extensive mould. The pregnancy was assessed as high risk, and the mother was confined to bed rest.

A service agency was contracted to provide assistance to the family to address housing-related issues. One of the stated goals of the service provider was for the family to find adequate housing. During the final weeks of her high-risk pregnancy and in the first few weeks following the infant's birth, it appears that the infant's mother was expected to locate adequate living conditions. In the months following the infant's birth, it appears that the only help the mother received from the service provider was housing lists and contact phone numbers for low-income housing agencies.

The infant was brought to the hospital three times between the ages of one month and five months for coughing, vomiting, fever and breathing difficulties. At approximately six weeks old, the infant was diagnosed with respiratory syncytial virus. At that same time a sibling was admitted to hospital and diagnosed with pneumonia. In the hospital the infant's mother advised the treating physician of her concerns with regards to the mould in the family's residence.

A few weeks after the infant was born, an MCFD social worker wrote a letter to B.C. Housing and a low-income housing provider requesting that the family be given priority on a waitlist for housing because all of the children were frequently ill with respiratory illnesses thought to be related to the mould in the house. A year later the family was still waitlisted for housing and had to move off reserve into a motel with the young children when the infant was one year old.

One day while the mother was at work, the children were being cared for by their father. The infant was placed to sleep on an adult bed in the room, propped up with a pillow and covered with a blanket. The infant began to vomit and defecate. The infant's breathing became noisy and irregular, and the infant became unresponsive. Emergency health services were called and took the infant to the hospital, where the infant was pronounced dead.

Locating adequate housing off reserve can be equally challenging for families and can mean the loss of association with other members of their families and First Nation communities.

In 2008, during the time frame covered by this review, the B.C. Office of Housing and Construction Standards released a summary report titled *Aboriginal Housing in B.C.* The authors of the report conducted community engagement sessions around the province and heard from members of both First Nations and Métis communities.

The report found a shortage of housing for Aboriginal people residing off reserve was connected in part to barriers such as income, inconsistent information about waitlists and racially based discrimination. Furthermore, the report noted that more than 28 per cent of the Aboriginal population in B.C. is deemed to be in core housing need compared to 16 per cent of the non-Aboriginal population.[25]

In 2008 a memorandum of understanding (MOU) on housing for First Nations in B.C. was signed by the First Nations Leadership Council, Indian and Northern Affairs Canada and the government of British Columbia. The MOU stated:

> "Housing and infrastructure quality are among the factors linked to the socio-economic disparities faced by some First Nations in British Columbia. Actions to support safe and affordable housing and infrastructure for First Nations communities, individuals and families will assist in addressing these disparities. The Parties agree to work together to develop a comprehensive approach to housing and explore opportunities to address issues along the full range of the housing continuum for First Nations communities, individuals and families both on and off reserve."[26]

This MOU is a positive step; however, action has been slow on tangible improvements. Housing issues for a First Nations family were the subject of a prior investigation by the Representative for Children and Youth in the case of a serious injury of an infant. The overall finding of the investigation was:

> "The child welfare system entered into [the] child's life in response to child protection reports from the community, but its ongoing impact on the child's life related to his parent's poverty and inability to afford housing that met the ministry's standards." The investigation also found that in the child's First Nations community, many lived in overcrowded conditions "not by choice… [rather] as a practical way of coping with a lack of housing in the absence of any real alternative."[27]

The housing situation for poor families, especially Aboriginal families, can be described as a provincial crisis that has extremely negative impacts on the health and well-being of infants and children. Although the issue is acknowledged by all levels of government, a detailed action plan with performance measures to track improvement is required to give today's children, and the generation to come, the chance to thrive.

[25] BC Office of Housing and Construction, 2008. Core Housing Need is the national standard measuring housing need. Canadian households are considered to be in core housing need if they do not live in and could not access housing that is in adequate condition and of suitable size without paying more than 30 per cent of gross household income to rent.

[26] The Union of BC Indian Chiefs, 2008.

[27] *Housing, Help and Hope: A Better Path for Struggling Families*, Representative for Children and Youth, 2009.

Recommendation 1

That B.C. develop a non-partisan child poverty plan, with leadership from the Premier's Office, through a special initiative that identifies strategies to address all aspects of child poverty in the province, including specific strategies to address poverty affecting Aboriginal children and families.

Detail:

The plan should have the following characteristics:

- involve Aboriginal leaders and the federal government as partners
- provide an integrated set of cross-ministry initiatives to address child poverty
- include measures to address adequate housing for families in poverty
- include measurable targets
- provide opportunities for meaningful public reporting on a semi-annual basis
- include initiatives to improve educational outcomes
- include non-partisan social and economic policy research and evaluation of strategies.

That the Representative be provided with a progress report by June 1, 2011.

Prenatal Service Provision and Professional Practice

Observations: *All of the families in this review had been involved with MCFD during or prior to the prenatal period. There is no comprehensive approach to prenatal public health care that is available to all expecting mothers in B.C.*

In a number of the 21 families, concerns were related to other children in the family. In some circumstances child protection investigations were conducted. In many circumstances MCFD's own standards for those investigations were not met. There was little evidence of follow-through or of available information about risk being used to develop an integrated plan to address vulnerability.

Health Care

The availability of prenatal services depends on the size of the community, the geographic location and the resources available. They are delivered by a variety of health professionals, including physicians, midwives, community-based services, public health nurses and pregnancy outreach programs.

Although all women in B.C. are eligible for prenatal medical care, access to and use of these services varies. In the 2009 report *Pathways to Healing* the Provincial Health Officer identified 15 or more prenatal visits with a physician as more than adequate, nine to 15 prenatal visits as adequate and fewer than nine visits as inadequate prenatal care.

The Provincial Health Officer noted the association between inadequate prenatal care and infant mortality rates and that inadequate prenatal care was twice as common among Status Indian mothers.

Information with respect to prenatal care provided by physicians of the mothers of 19 of the 21 infants was available in the form of Medical Services Plan physician billing records. In two cases no information about prenatal care was available because the mothers moved to B.C. shortly before giving birth.

The available information was reviewed with the help of a consultant pediatrician. Although the information was limited by its nature, it was apparent that all 19 of the mothers had prenatal contact with a physician. The frequency of contact varied. The nature and quality of the contact cannot be determined because the available information was contact information rather than detailed medical records.

Based on the Provincial Health Officer's criteria of nine to 15 visits, approximately two-thirds of the mothers had an adequate number of prenatal visits. There did not appear to be a difference between the Aboriginal and non-Aboriginal mothers. For the remaining five mothers, all of whom were Aboriginal, file information gave rise to concerns about clearly suboptimal prenatal care:

- One mother did not attend her first medical visit until she was at 30 weeks gestation, much later than recommended.

- Two mothers had significant breaks in prenatal medical care, although they had an adequate number of visits.
- One mother received no prenatal care.
- One mother had few contacts with her physician.

There is currently no provincial prenatal public health program with standards or performance accountabilities delivered consistently across B.C.[28]

A 2005 report entitled *Public Health Nurse Home Visiting for Vulnerable Families*[29] states that the "lack of Public Health Nursing (PHN) programming in the prenatal period is a pressing issue in Canada as well as B.C." The report also noted that public health literature demonstrates that intensive public health nurse home visiting from the prenatal period into early childhood results in the best outcomes for vulnerable families. Unfortunately, in B.C. the programming for the prenatal period has not been an area of focus despite the pivotal role that public health nurses could play in improving early childhood outcomes through involvement in the prenatal period.

Historically, public health units in B.C. provided prenatal classes. However, at present, prenatal classes are typically contracted by the health authorities and pregnancy outreach programs. Prenatal classes are not usually free. A bursary is available for those in need. Some prenatal classes can cost up to $300. Aboriginal women living on reserve can also access programs provided on reserve.[30]

Records of services provided by public health nurses were also reviewed. These records did not generally indicate prenatal contact. There was one circumstance observed where a public health nurse participated in an integrated case management meeting prior to the infant's birth. In the rest of the cases it appears that public health involvement began after the infant was born.

Pregnancy outreach programs are established in B.C. for women who may not access prenatal services and for those who are at risk of poor birth outcomes. Indicators of this risk are poverty, poor nutrition, isolation/poor social support, substance use and family violence. It is not known how many of the 21 mothers accessed services through pregnancy outreach programs or attended prenatal classes, as this information was not part of the health records reviewed. However, a mother of one of the infants was unable to receive services from her local pregnancy outreach program as the program was full. In five of the 21 cases reviewed, the infant was the mother's first child. In these circumstances access to prenatal information would be critical.

[28] Ministry of Healthy Living and Sport (2010).
[29] Interior Health Authority, 2005.
[30] Office of the Provincial Health Officer, 2009.

MCFD Practice

All of the families were involved with MCFD during or prior to the prenatal period. MCFD was involved for a variety of reasons, including:

- receiving a new child protection report
- participating in a youth agreement
- providing services for a child with special needs
- providing ongoing protective family support
- historical child welfare involvement.

The response of the child welfare system to requests for service or concerns about the safety and well-being of a child is mandated under the *Child, Family and Community Service Act* (*CFCS Act*). MCFD's 2003 Child and Family Development Service Standards: Child and Family Service Standards (CFS) direct the assessment, investigation and response to reports of child protection concerns.

MCFD also has various guidelines and practice advisories that apply regionally for staff responding to concerns regarding an expecting mother. The policies and protocols vary in each region, and there is no provincial standard. This has resulted in the five MCFD regions developing their own policies, procedures and guidelines, resulting in inconsistent practice across the province.

MCFD provided a number of regional protocol documents dealing with their working relationship with the health authorities and hospitals. Some focused on infants who are high risk due to substance abuse by parents and provided a guideline regarding identification of risk, roles and responsibilities, discharge planning, referral, and community follow-up. Others address the reporting of and response to child protection concerns, including concerns about an expectant mother's ability to care for the expected infant. Some also include procedures for removal of infants from their mother's care at birth, and some include direction regarding prenatal integrated case planning. Some protocols include reference to delegated Aboriginal Agencies, and in one the delegated Aboriginal Agency is a signatory to the document.

There is no provincial consistency with respect to the structure and content of the protocols:

- Some provide specific and detailed direction, whereas others are very high level.
- There does not appear to be consistency with respect to interagency collaboration/ planning regarding services to high-risk parents.
- There does not appear to be a consistent expectation regarding discharge planning.
- There is an inconsistent message regarding reporting requirements and MCFD's response to reports of concerns during the prenatal period.

- There is no consistency in what constitutes high-risk circumstances where infants are prenatally exposed to harmful substances.
- Some of the protocols are out of date.

On Vancouver Island, where a guideline has been in place since 2005, it does not appear that procedures were consistently followed. It also appears that MCFD staff are confused about their role in their work with high-risk expecting parents.

When there are safety concerns regarding an expectant mother and there are no other children in the family, the *CFCS Act* does not provide the mandate to intervene on a child protection basis, but support services can be offered. When there are child safety concerns reported regarding a family that already has children and the mother is expecting, the mandate is clear. In the cases reviewed for this report, the pregnancy was not always adequately considered in risk assessment and service planning.

An expectant mother involved with child protection due to concerns about another child in the home presents a complex challenge for workers in the child protection field. They have the responsibility for assessing safety and care of the child and the capacity of the family to provide adequate care. Consideration must be given to the mother's pregnancy and the impact of an additional child in the family.

Standard 12 of CFS outlines the approach to be used when responding to a report that a child may be in need of protection. It states: "Assess every report received about a child's need for protection, and determine the most appropriate response within five calendar days of receiving the report." Appropriate responses include:

- taking no further action
- referring the family to informal and formal support services
- providing a family development response
- if the child is a youth, providing a youth service response
- conducting a child protection investigation.

In circumstances when there are active child protection concerns involving an expectant mother, the mitigation of vulnerability requires a rigorous and timely assessment and thorough planning. An incomplete assessment of the information can result in the safety and vulnerability of a child going unaddressed.

During the prenatal period 25 child protection reports were received regarding 15 of the families. The reports were made by police officers, health professionals, community professionals and community members. They generally involved concerns for the safety of the existing children in the family due to domestic violence, substance abuse, inadequate housing or inadequate supervision. Seven of the reports involved alcohol or substance abuse. Five reports involved domestic violence. In one family, four reports were received during the prenatal period, and only one of these reports was investigated. One of those not investigated involved domestic violence.

Investigations were conducted in 12 of the cases. In the other three cases there was no investigation. In one of the three cases the report was assessed and provision of support services was planned. However, the infant died before the services began. For the other two families an investigation was not conducted, although a family service file was open at the time.

Of the 12 investigations, four had not been completed by the time the mother delivered her baby. In one case three child protection reports had been made prior to the infant's birth, but the investigations were not completed until the infant was three months old.

In these cases, concerns regarding the safety of the existing children were not adequately assessed or addressed even though the mother was expecting another child, increasing the risk to all the children. Completion of these investigations would have allowed planning to occur prior to the birth of the infant to mitigate these risks. When investigations of this nature are not completed, the infant is more vulnerable at birth, especially when there has been known substance abuse or domestic violence.

Despite MCFD involvement and the expected addition of another child to the family, evidence of planning for the infant at birth and prior to discharge from the hospital was found in only three circumstances. An appropriate intervention prior to the birth of an infant would include assessing the report and developing a plan to meet the family's needs.

In 2008 MCFD released the report *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth*. The document identified a five-pillar approach to improving child welfare services over five years through prevention, early intervention, intervention and support, an Aboriginal approach and quality assurance. The document noted: "Government will place a primary focus on preventing vulnerability in children and youth by providing strong supports for individuals, families and communities...working with partner ministries...to make communities and families stronger while focusing resources where vulnerability to healthy development can be addressed."

Key actions outlined as part of the prevention pillar are indicated as development of an early years strategic plan and increasing education with regards to Fetal Alcohol Spectrum Disorders (FASD). Desired outcomes are described as an increase in the health and well-being of children and youth and a decrease in preventable vulnerabilities. The document does not describe how prevention will actually be addressed. It lacks a tangible framework for service delivery for workers who must face vulnerability every day in their front-line work with children and families. It does not describe how MCFD plans to provide workers with the tools necessary to carry out their work with families and communities and work in an integrated way with other ministries.

The Representative encourages a cross-ministry and multidisciplinary approach to lessen the vulnerability of children and families and feels strongly that every child should be cherished and that every child has a right to be safe, to have a home and a safe place to

sleep. The support of strong social work practice is critical when intervention is required with vulnerable children and families. Those working on the front lines with children and families need to be equipped with the adequate training, tools, skill sets and clinical supervision to enable them to be successful in this work.

Case Example

This infant was born to a First Nations mother who had one older child living with her. Two older children had been removed by the ministry in the past and were living with relatives. There had been 12 child protection reports over a 10-year period. The reports involved drug and alcohol abuse and domestic violence as well as exposing the children to dangerous situations and general lack of supervision and neglect. Investigations had found at one point that the family lived in very substandard housing requiring immediate attention due to the risks to the children.

The eleventh report regarding the care of the sibling was received when the mother was in the early stages of her pregnancy. It was not investigated. A second report was received subsequent to the infant's birth, which also was not investigated. Both reports were signed by a supervisor and closed. A number of months later, after another report that was not documented as a child protection report was received, the children were removed.

By not responding to the initial report, the opportunity was lost to assess the family circumstances and plan for the birth of the infant.

Hospitals

Hospitals in B.C. can set alerts on their system when requested by MCFD. Alerts may be used when an expectant mother who is considered high risk by MCFD comes to the hospital to deliver her baby. The alert notifies hospital staff to contact MCFD when the baby is born so that MCFD social workers are aware of the birth and can assess any child protection issues. The purpose of this function is to facilitate integrated service delivery between MCFD social workers and hospital staff from the time of the baby's birth.

Among the cases reviewed for this report, alerts were not commonly utilized despite knowledge of high-risk situations. Alerts with hospitals were documented in only three circumstances, despite active child protection concerns during the prenatal period. For example, in one circumstance the alert was placed six days after the infant's birth, and the hospital notified the social worker three days later.

Interagency protocols that define risk and outline the roles and responsibilities of the various agencies working with high-risk parents would minimize the likelihood of these families being missed by child welfare and the health care system and provide an opportunity for a strong, integrated approach in serving vulnerable expecting mothers and their babies.

Recommendation 2

That MCFD develop a clear policy and evidence-based strategies to support all vulnerable families in which the mother is pregnant.

Detail:

The policy and standards should require:

- collaborative assessment and case planning, including a common risk assessment tool that addresses child welfare and infant health risks
- active engagement on the part of service providers rather than passive referrals for service
- appropriate service strategies with Aboriginal communities
- clear identification of a case manager and of roles and responsibilities of all individuals on the care team
- documentation of the plan in the files of all service providers
- an implementation plan for the protocol and for any training required within each of the service sectors
- follow-up monitoring.

A progress report should be provided to the Representative by June 30, 2011.
Full implementation should be achieved by January 31, 2012.

Postnatal Service Provision and Professional Practice

Observations: *A number of agencies and professionals in B.C., including health authorities, public health programs, physicians and child welfare authorities, are involved in assessing, planning and providing support services to vulnerable infants and their families.*

This group of infants and their families were involved with a patchwork of service providers from across the health and child welfare systems. Opportunities to reduce risks and threats to the safety of the infants were lost as effective collaboration and clarity about roles and responsibilities were lacking. As a result, the responsibility for the duty of care for these infants was unclear and service responses were limited.

Health Care

Information from the B.C. Medical Services Plan's physician billing records was reviewed with the help of a consultant pediatrician. From the available information it appeared that the mothers and the infants had reasonable and expected contact with physicians in the postnatal period. A number of the infants required medical follow-up after birth for medical conditions ranging from cradle cap and thrush to respiratory issues and seizures. Although there were no instances of inattention to medical care needs, the nature and quality of the medical care received cannot be determined from the available records.

Public health services are voluntary. It is generally accepted that follow-up after a birth is a critical component of early infant care. Public health nurses generally contact mothers shortly after they go home from the hospital. Contact by a public health nurse can be in the form of a phone call or an in-person visit. Those who are not first-time mothers may receive a phone call instead of an in-person visit depending on the circumstances.

Through home visits, public health nurses have a unique opportunity to observe infants in their home environment in a non-intrusive way while assessing an infant's health and development. The nurse's role is to identify family needs and to support families through interventions and connection to resources and services, as well as to provide training and education.

In 17 of the 21 files examined, there was public health documentation titled "newborn assessment." The assessment documents identified the number of contacts with a public health nurse and the issues discussed; however, they did not include any recognizable assessment information. In some circumstances it was unclear if the contact was by phone or by a visit. In three circumstances the MCFD file noted contact with public health; however, there was no reference to that contact on the public health file.

Thirteen of the files clearly documented home visiting, which ranged from one to four visits. In one case, there was extensive and frequent public health contact. In addition, the public health records for three families noted postnatal support from a midwife.

There is no province-wide coordinated standards-based program of postnatal public health nursing services in B.C. Regional health authorities offer a variety of nurse home

In Canada the most commonly used postpartum screening tool is the Parkyn tool, developed in British Columbia in 1985. This screening tool is designed to assist health professionals in the assessment of risk factors such as congenital or acquired health challenges, developmental factors and family interaction factors that should be taken into account when determining priority and/or vulnerable families. Only one of the infants' families was assessed using this screening tool.

visiting programs, including a combination of targeted and universal prenatal, postpartum and early parenting services.

Although there are maternity discharge programs in the postpartum period, they are not available everywhere in the province. With the creation of the current regional health authorities in B.C., several public health nursing units were collapsed into larger organizational units. According to the 2005 report *Public Health Nurse Home Visiting for Vulnerable Families*, inconsistent practice exists within and across health regions, and funding varies across program areas and regions.

The report states that a "common theme across [Canada] of limited resources or declining resources dedicated to longer-term public health nurse follow-up for families is of great concern…. A provincially mandated and funded program has the benefits of identifying standards, frameworks and outcomes and supporting evaluation efforts."[31]

Approximately 15 per cent of women and children in B.C. are considered vulnerable or at risk for poor perinatal and child health outcomes due to socioeconomic disparities or other health-related issues.[32] A standardized provincial universal and targeted program of home visits for vulnerable families could potentially fill a gap in B.C. public health programming. New approaches are required, including an effective standardized approach to assessment.

Government has committed to launch a nurse-led, in-home individual parent training program for first-time, at-risk parents and their infants, provided during pregnancy and up to two years after delivery.[33] The development of a comprehensive plan and evaluation framework to guide the implementation and evaluation of this standardized, intensive home visiting program in British Columbia are also to be undertaken as part of this program.

Targeted public health nurse visitation programs, beginning in the prenatal period and continued for an extended period after birth, have demonstrated effectiveness, including:

- improved prenatal and child health outcomes
- improved economic self-sufficiency and maternal employment
- fewer emergency department visits
- fewer unintended injuries
- decrease in number of child abuse and neglect reports
- improved mother-child interaction and improved mental health.[34]

[31] Reiter, 2005.
[32] Ministry of Health Services, Ministry of Children and Family Development, Province of British Columbia, Nov. 2010.
[33] *Ibid.*
[34] Ministry of Healthy Living and Sport, 2009.

Processes and expected outcomes of targeted home visiting programs have been identified in one evidence-based program, the Nurse Family Partnership Program,[35] developed by Dr. David Olds, from the United States. Women enrolled in this program are visited one-on-one by a public health nurse in their own home throughout the pregnancy and for the first two years of the child's life.

The program is based on voluntary participation and is offered to women who meet eligibility criteria, including having a low income and being a young first-time mother. Women are enrolled in the program early in their pregnancy and receive their first home visit by no later than the end of the 28th week of gestation.

Key components for success include:

- fidelity to the program
- established prenatal intake and vulnerability criteria
- program delivery by public health nurses
- evidence-based curriculum
- defined visiting schedule and program duration
- evaluation.

The Representative is encouraged by these efforts to develop a targeted approach to public health for vulnerable families and supports government's efforts to move forward in the establishment of a nurse-led, intensive home visiting program for vulnerable women and families.

Another example of a program that takes an integrated, multidisciplinary and multi-agency approach is the Sheway program.

Sheway, a Coast Salish word meaning "growth," is a program located in the Downtown Eastside of Vancouver that provides health and social service supports to pregnant women or women with children under 18 months of age who are dealing with substance abuse issues. Established in 1993, the program has shown success in meeting the health and social needs of a population with highly complex needs. Services are provided through both outreach and drop-in.

Key program areas include food and nutrition services, primary health care services, counselling services, healthy children development, advocacy, community education and fundraising. Sheway is a partnership initiative among the Vancouver Coastal Health Authority, Ministry of Children and Family Development, Vancouver Native Health Society and the YWCA of Vancouver.[36]

[35] Olds, 2008.
[36] Office of the Provincial Health Officer, 2009.

MCFD Practice

In 16 of the 21 cases, MCFD received a new child protection report, completed a previous investigation or was involved in ongoing child protection actions after the birth of the infant.

In the postnatal period, at the request of mothers, professionals or health care providers, MCFD may provide a variety of support services and referrals to professionals such as infant development workers, speech and language pathologists, occupational therapists, audiologists, counsellors, psychologists and psychiatrists. The support services may include:

- parenting classes
- alcohol and drug treatment
- mental health counselling
- financial support for transportation.

These services are provided in response to specific needs. How or if they are provided depends on a number of factors, including resources and availability.

MCFD also has a mandate to respond to reports regarding the safety and well-being of infants. When a report is received, it is assessed to determine the most appropriate response. This can include referring the family to community agencies, providing support services and in some circumstances investigating the infant or child's need for protection.

When a decision is made to investigate a child protection report involving a vulnerable infant, the timeliness of the response is critical. The ministry CFS standard, Conducting a Child Protection Investigation, directs social workers to commence an investigation immediately if a thorough assessment determines that:

- the child's safety or health may be in immediate danger, or
- the child is vulnerable to serious harm because of age or developmental level.

The practice standard also sets out the minimum requirements for conducting an investigation:

- seeing the child and all other vulnerable children in the home
- interviewing the child and all other vulnerable children in the home, where developmentally appropriate and with supports if necessary
- directly observing the child's living situation
- seeing and interviewing the parent
- reviewing all relevant and necessary information related to the report, including existing case records and files
- obtaining information from people who may have relevant knowledge of the family and/or child
- throughout the investigation considering and providing services that ensure the child's safety, including out-of-home care options, and if the child is Aboriginal, working in partnership with the appropriate Aboriginal community or agency.

In seven of the 21 families, child protection reports were received and investigated after the birth of the infant. In another four families, reports received during the prenatal period were not responded to until after the infant's birth.

Responsiveness in commencing and conducting investigations was lacking in some cases. In one case, the social worker did not make contact with the infant's mother until 34 days after the decision was made to investigate. In another case, the investigation began 15 days after the child protection report was received by MCFD. Efforts to obtain information from people who may have had relevant knowledge of the family and/or the infant were not completed during child protection investigations in six of the cases.

MCFD audits specific standards of practice internally to assess rates of compliance. During the period of time covered by this review,[37] MCFD audits found that the overall provincial average of compliance with the standard for fulfilling the requirements of a child protection investigation was 65.8 per cent. The elements of a child protection investigation measured in this standard include:

- reviewing all necessary information related to the report, including case records and files
- obtaining information from people who have relevant knowledge of the child and/or family
- receiving documentation that a medical examination of the child has taken place
- directly observing the child's living situation.

Of note, the Vancouver Island region, where 13 of the 21 infants included in this review died, was assessed as having a 47 per cent rate of compliance in conducting child protection investigations.

MCFD audit information regarding the timeliness of completed child protection investigations was also examined for the two-year period covered by this review. The overall provincial average of compliance for completing investigations within the required 30 calendar day time frame was 35 per cent.

Less monitoring of the compliance with ministry standards is also a significant concern. MCFD internal audits for three periods were examined: the 29 months prior to the review, the two-year period covered by this review and the 18-month period since the review.

MCFD revised its internal audit program in 2004. It appears that since the new audit program came into effect, there has been a steady reduction in the number of files audited – a 23 per cent drop between the first and second periods examined and a further 53 per cent reduction in the third period examined.

[37] June 1, 2007 to May 31, 2009

Respite Care

Nine of the 21 infants were being cared for by a caregiver other than their parent at the time of their death. Four of the nine infants were being cared for by relatives. Five of the nine infants were being cared for in respite care or a foster home, and three of these infants were legally in care under the *CFCS Act.*

CFCS Act Section 5

Support service for families

5 (1) A director may make a written agreement with a parent to provide, or to assist the parent to purchase services to support and assist a family to care for a child.

(2) The services may include, but are not limited to, the following:

(a) services for children and youth;

(b) counselling;

(c) in-home support;

(d) respite care;

(e) parenting programs;

(f) services to support children who witness family violence.

Respite care is provided on a temporary basis for the purpose of providing a break to a parent by placing the child with a ministry-approved alternate caregiver for a short period of time. Section 5 of the *CFCS Act* provides the legal authority for support service agreements with parents to receive respite care. Standard 7 of the CFS standards directs social workers to provide services to families that build on strengths and promote resiliency within children, families and communities. However, the CFS standards are silent on respite care.

MCFD does not have policy regarding providing respite care to children whose families are involved with MCFD on a child protection basis. Furthermore, the ministry does not appear to track information regarding the number of children who are in respite care at any given time.

MCFD's 2006 Caregiver Support Service (CSS) standards are the standards of practice that apply to MCFD staff responsible for residential resources for children and youth. CSS standard 16 states that "all levels of caregivers may provide respite services (out-of-home care provided by a director for a child's parent with whom there is a support agreement) for families whose children are not in care." There is no further policy regarding respite care in the CSS standards.

There is a policy regarding the use of funding for respite care in programming for children and youth with special needs. However, the policy appears to apply only to children who have been designated by MCFD as having special needs, and the policy is not referenced in the CFS standards.

Following the case review of the death of one infant, an MCFD regional office developed a practice advisory to address the gap in policy with regard to respite care for children not in the legal custody of the ministry.

However, because it was developed in one regional office, this practice advisory did not automatically apply elsewhere in the province, and MCFD did not make it a standard practice for all regions. There are no provincial guidelines in place to assist front-line social workers in decision-making and information-sharing when a child is not in the legal care of the ministry but is receiving respite care.

Case Example

The mother of the infant had been diagnosed with FASD at a young age. Her capacity to parent was limited. Prior to the infant's birth she had transferred the care of her first child to her former spouse as she was unable to handle the child's behaviour. She used harmful substances while pregnant with her second child. Her prenatal substance use, limited capacity and lack of financial resources were factors that the staff in the hospital felt placed her at risk.

The infant was born prematurely and was transferred to the neonatal intensive care unit due to high medical needs. Prior to discharging the infant, health professionals noted concerns about the home the infant would be living in, the mother's capacity and her social situation. The infant was discharged at six weeks of age.

When the infant was two months old, the social worker contacted the public health nurse to request that she provide information to the infant's mother regarding safe sleep as the mother had informed the social worker that the infant currently slept in a car seat and also in the mother's bed. The public health nurse contacted the mother, who said that she did not have a crib for the infant and could not afford one. The mother said that the infant was currently sleeping in a playpen. The nurse discouraged the mother from using a playpen and encouraged her to purchase a crib. On the same day, the nurse contacted the social worker regarding financial assistance for a crib. The public health notes indicate that the nurse planned to follow up with the MCFD social worker in two weeks. However, there is no indication of any further follow-up regarding the infant's sleeping arrangements.

Over a number of weeks the mother's capacity to take care of the infant began to deteriorate, and beginning at three months old, the infant was provided temporary respite care with increasing frequency in three different homes. The ministry social worker requested and received approval for the purchase of a playpen for the infant to sleep in while in respite care in one of the three homes because the caregivers did not have an appropriate place for the infant to sleep.

The third home offering respite care was an MCFD-approved foster home. The foster home file information did not indicate that the foster parents had received any specialized training with respect to caring for infants or caring for infants with high medical needs. In this home the infant also slept in a playpen. On the night of the death the infant was put to sleep on its side in the playpen, with a blanket placed against its back. A couple of hours later the caregiver found the infant unresponsive.

A post-mortem examination following the infant's death indicated that an untreated kidney infection caused the death, and an inter-current viral infection and aspiration pneumonia were contributory. A pediatric review of the infant's medical and post-mortem information indicated that the kidney infection was treatable, had it been recognized earlier. However, the infant's symptoms may have been misinterpreted as a cold or flu.

Recommendation 3

That MCFD develop clear standards of practice for situations in which children and infants are placed in respite care under s. 5 of the *Child, Family and Community Service Act.*

Detail:

Standards of practice should afford the same protection as those provided to children in legal care, and include:

- taking into account the unique needs of infants and children who may be more vulnerable due to medical concerns, developmental levels and other such factors
- requirements for information-sharing, including medical information specific to a child's unique needs, among social workers, caregivers and other service providers
- requirements for safe sleep environments and how they are to be addressed when problems arise (e.g., when a caregiver does not have a crib)
- tracking and reporting on the number of children placed in respite agreements under section 5 of the *CFCS Act*
- province-wide application, including delegated Aboriginal Agencies.

A progress report should be provided to the Representative by June 30, 2011.
The standards should be fully implemented by January 31, 2012.

Foster Care

Three infants living in foster homes when they died were in the legal care of MCFD. The ministry's Caregiver Support Standards set out standards of practice with respect to the placement, documentation and selection of a caregiving home when a child is placed in foster care.

In reviewing the deaths of these infants, the following issues were identified:

- An assessment of the appropriateness of the home and documentation supporting the assessment and decision to place the infant in the home did not appear to be completed.
- Information regarding the infant's health and medical issues did not appear to be shared with the foster parent at the time the child was placed in the home.
- Prior concerns regarding the care of other children in the foster home did not appear to be adequately considered, assessed or investigated.

Despite the legal arrangement that results in the placing of an infant in care, whether in foster care or temporary respite care, the quality of care provided to the infant by the alternative caregiver should be the same.

The Representative is not questioning the level of care provided by the individual caregivers. However, it appears that there is a lack of policy and guidelines regarding the placement of infants, particularly those with identified risks. This leads to inconsistent information-sharing between the front-line social workers and caregivers who provide respite and foster care.

Case Example

This First Nations infant was 11 months old when removed from the parents along with two siblings for a second time. MCFD's Child and Family Service Standards and Caregiver Support Standards direct social workers when removing Aboriginal children from their parents to place the children with extended family or within their Aboriginal community whenever possible. The baby and siblings had been cared for by a relative in the past, and in fact the relative had custody of another sibling. The relative's home was not an MCFD-approved foster home.

When MCFD placed the baby and two siblings with the relative, there were 11 other people residing in the home. Several people shared each room. There was no adequate sleeping arrangement for the baby, who slept on a bed with one sibling. Another sibling slept on the floor in the same room. There is no indication that the relatives had been advised regarding safe sleeping practices or that MCFD staff observed the sleeping arrangements for the children. A notation on the MCFD file indicates concern about the children's safety due to the presence of another relative in the home.

Four days later, the infant died while sharing a bed with a sibling. While MCFD followed standards regarding placing Aboriginal children with extended family, it appears that other standards for safe infant care were not met.

Recognizing Aboriginal Status

Fifteen of the 21 infants in this review were Aboriginal. MCFD identified 13 of the infants as Aboriginal and incorrectly identified two infants as non-Aboriginal. Of the 15 Aboriginal infants and families, 13 were involved with MCFD and two were involved with Aboriginal Agencies that were fully delegated to provide child protection services.

In British Columbia the *Child, Family and Community Service Act* (*CFCS Act*) provides the legal authority for child welfare services. Under the *CFCS Act*, the "Director" is designated as the responsible authority. Under the current organizational structure, MCFD has designated a Director in each of its regions throughout the province. In turn, each Director delegates authority to staff to administer the child welfare provisions of the *CFCS Act*.

In addition, a First Nations Director is designated to provide authority to delegated Aboriginal Agencies and their staff to administer the *CFCS Act*. The level of responsibility undertaken by each delegated Aboriginal Agency varies depending upon the level of delegation provided by the First Nations Director. Currently, there are 24 delegated Aboriginal Agencies with various levels of delegation responsibilities.

Of the 13 families involved with MCFD, four were also receiving support services through either partially delegated Aboriginal Agencies or social development programs through their First Nation or Métis community.

MCFD service providers are legally required to consider the best interest of the child. If the child is Aboriginal, the importance of preserving the child's cultural identity must be considered in determining the child's best interests.[38] Given this legal requirement, the discrepancy in numbers raises questions about MCFD's process for identifying, documenting and following through with Aboriginal children in the welfare system and ensuring that their cultural connections are maintained.

Being identified as Aboriginal is important because it can impact the types of services offered and the funding available for the infant and family. In the event that a child is removed from the care of their parents, it is important that Aboriginal identity be recognized in order for planning to occur that ensures that the child remains connected to their culture and community. A secure sense of connection with caring people is critical to a child's personality development.

First Nations also provide support services to families that reside on reserve through the First Nations and Inuit Health Branch of Health Canada. Support is provided in areas such as prenatal nutrition, Fetal Alcohol Spectrum Disorders (FASD) and maternal and child health programs. Individual First Nations provide these services through their health, education and social development departments. Financial assistance is also provided by First Nations to families on reserve who qualify.

[38] *CFCS Act*, 2006, Part 1 (4).

The system of supports and services to Aboriginal families can be multi-faceted and complex. For example, a child welfare case can be managed by the ministry, by a delegated Aboriginal Agency or sometimes by both. At the same time, the family can be receiving support services from other agencies, and if they are living on reserve, from their First Nation.

This review found that when the delegated Aboriginal Agency had full delegation, the roles and responsibilities appeared to be clear. This may be because the agency had responsibility for all aspects of child welfare service and had significant capacity to address a range of concerns.

In circumstances where both MCFD and a delegated Aboriginal Agency or a band were jointly providing services, things were less clear, and there were gaps in service. For example, in two cases reviewed it appeared that MCFD was depending on the band for delivery of services without clarity on who was responsible for what.

When there are multiple agencies involved, it is essential that there be effective communication and coordination to reduce the likelihood of gaps in service. The MCFD reviews conducted in two infant deaths where some services were provided by MCFD and some by a delegated Aboriginal Agency or band recommended that protocols be developed to more clearly outline roles and responsibilities. MCFD has indicated that these recommendations have been completed.

In the 2009 report *Housing, Help and Hope: A Better Path for Struggling Families,* the Representative recommended that MCFD work in consultation with the delegated Aboriginal Agency, the child's First Nation and Indian and Northern Affairs Canada to ensure that sections 3(b) and 71 of the *CFCS Act* are fully realized and that the purpose and intent of the Delegation Confirmation Agreement are fulfilled.

The Representative indicated that this would require clarifying the nature and extent of the consultation and participation expected from each party in child welfare matters, and amending the delegation confirmation agreements to reflect this understanding. The report further recommended that the outcome of this work should be formally shared with MCFD staff, other delegated Aboriginal Agencies and First Nations across B.C.

The most recent update from MCFD is that training was undertaken in local areas regarding the protocol between MCFD and delegated Aboriginal Agencies. This protocol is under review by INAC, MCFD and delegated Aboriginal Agencies. There has been no progress on province-wide sharing of a specific outcome with MCFD staff and delegated Aboriginal Agencies.

Hospitals

In Canada there has been a reduction in the length of hospital stay following birth.[39] Between 1995 and 2005 the mean maternal length of hospital stay for childbirth declined considerably, from 2.6 to 2.2 days for vaginal delivery and from 5.0 to 3.9 days for caesarean delivery.[40]

In British Columbia between 2006 and 2007, 72.5 per cent of women stayed in hospital less than 48 hours following a vaginal delivery, and 86.3 per cent stayed less than or equal to 96 hours following a caesarean delivery.[41]

This has resulted in the delivery of postpartum care on an outpatient basis by a variety of care providers, including hospitals, health centres, public health nurses and primary care providers. Because the regional health authorities in B.C. are not required to comply with detailed province-wide standards that outline how care is to be delivered, there are many different models of postnatal care delivery across the province.

It is unclear what is expected or what is considered standard practice. The result is a fragmented system of unpredictable care, where the initiative for accessing services is often left with the mother. This is not a good method of reducing risks to vulnerable infants.

Newborn records were available for 20 of the 21 infants. Half of these infants were discharged within one day of being born, including two infants who were discharged from hospital on the same day of their birth. The remaining 10 infants stayed in hospital from three days to two months, depending upon the medical issues identified at the time of their birth.

[39] D'Amour, Goulet, Labadie, Bernier and Pineault, 2003.
[40] Public Health Agency of Canada, 2008.
[41] BC Perinatal Health Program, 2007.

Recommendation 4

That the Ministry of Health Services lead the development of a clear practice protocol to support effective and responsive public health nursing practice when nurses are working with high-risk infants in vulnerable families.

Detail:

The protocol should have the following characteristics:

- a clear definition of "high risk"
- a standardized risk assessment tool and identification of when it is to be used
- standards for home visiting, including frequency and length of service
- if possible, it should be informed by evaluations of the proposed B.C.-specific Nurse Family Partnership Program
- delivery of information on safe sleeping practice.

The protocol should also build on the MCFD protocol referred to in Recommendation 2 and provide for:

- collaborative case planning with MCFD and hospitals with respect to discharge planning and other services that are required prenatally
- active engagement on the part of service providers
- clear identification of a case manager and of roles and responsibilities of all individuals on the care team
- documentation of the plan in the files of all service providers
- a plan for implementation of the protocol and for any training required within each of the service sectors.

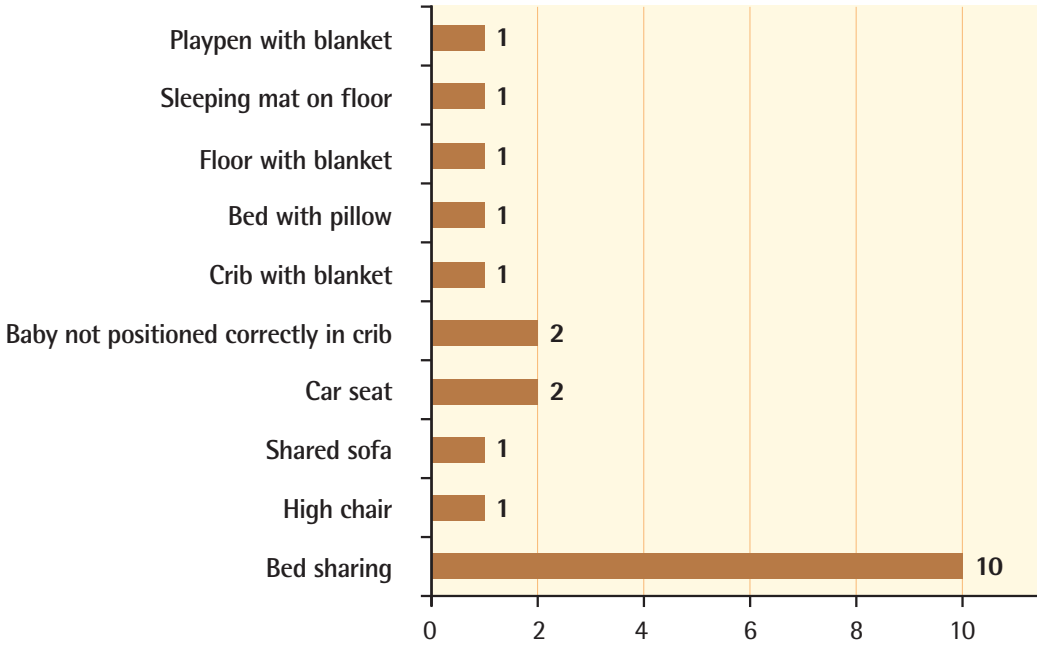
An update should be provided to the Representative by June 30, 2011.
The protocol should be fully implemented by January 31, 2012.

Safe Sleeping

Observations: *All 21 infants died unexpectedly. Initial information at the time of their deaths noted that sleeping circumstances may have been an issue. Despite a number of initiatives that have provided information about safe sleeping, there is some variation in what is promoted as safe sleeping practice. This could confuse parents, caregivers and service providers.*

A coordinated social marketing campaign about safe sleeping for infants is needed, with a targeted strategy for more vulnerable infants and families. The campaign should address interacting factors underlying vulnerability and specifically reach out to those most vulnerable in B.C.

The figure below illustrates the sleeping environment at the time of the infants' deaths.



Infants typically spend a significant part of their lives sleeping. On average, newborn infants sleep up to 16 hours per day. By six months, infants typically sleep between 11 and 12 hours per day. Therefore, their sleeping arrangements and conditions are an important aspect of their life circumstances.

Information about safe sleep practices for infants can be provided to parents and caregivers by physicians, midwives, public health nurses, prenatal classes, doulas, counsellors and social workers through home, hospital and clinic or office visits. Information comes in many different forms, such as brochures, website information, manuals, pamphlets, books, cards and information sheets.

The information provided needs to be clear and consistent. There is currently a range of information provided by different provincial organizations, which can be confusing. The provincial government's Best Chance website (www.bestchance.gov.bc.ca) informs families that "bed sharing is when your [infant] shares the same sleeping surface with you or another adult. Bed sharing is not recommended for infants because it increases the chance of suffocation."

By comparison, room sharing (also called co-sleeping) is when the baby sleeps in the same room as the caregiver, but not on the same surface (e.g., baby is in a crib beside the caregiver's bed). A review of the literature on room sharing/co-sleeping found that sharing a room with an infant may actually be a protective factor against SIDS deaths because room sharing tends to be associated with a mother who is actively breastfeeding.[42]

The Canadian Paediatric Society (CPS) recommends that infants under the age of 12 months sleep in their own crib (specifically one that meets the federal government's safety standards) and that the infant should be placed on his or her back to sleep. However, in circumstances when an infant does not sleep in a crib, the information regarding what constitutes a safe sleep surface appears to be unclear.

The 2010 edition of the *Baby's Best Chance Handbook*,[43] published by the B.C. Ministry of Health Services, states: "Your baby should sleep on a firm, flat mattress. Do not put your baby to sleep on a waterbed, sagging mattress, feather bed, air mattress, pillow-top mattress, sofa, couch, daybed or any other surface that is very soft." The use of a playpen as a sleep surface is not mentioned.

The Coroners Service Child Death Review Unit report *Safe and Sound: A Five Year Retrospective Review on Sudden Infant Death in Sleep-related Circumstances* notes that "surfaces such as car seats, strollers, sitting devices, adult beds, infant swings, playpens, couches, futons, waterbeds or air mattresses are not recommended." The report references the CPS recommendations dated 2009 for safe sleeping environments for infants and children.

The CPS information discusses the use of waterbeds, air mattresses, pillows, soft materials, loose bedding and car seats but does not reference playpens specifically.

MCFD's *Safe Sleeping for Babies* brochure states that infants "should sleep on a firm, flat, well-fitting mattress on a surface designed for infant sleep such as a crib, playpen or bassinet." In June 2009 the brochure was amended by removing "playpen."

Service providers require clear and consistent messaging regarding safe sleep in order to work effectively with families and infants. Recognizing this need, the Provincial Health Officer issued a directive in 2009 to each of the health authorities and advised of the risk of bed sharing. The directive required hospitals to ensure bed sharing did not occur in hospital after birth.

[42] Mckenna & McDade, 2005.
[43] Ministry of Health Services, 2010.

An important aspect of determining an infant's safety in his or her environment must include an assessment of the baby's sleep environment. Social workers on the front lines require the appropriate tools and skill sets to complete assessments adequately and appropriately. This includes having clear, consistent standards and policy and the tools to work collaboratively to ensure that support, education and help is provided to vulnerable families about safe sleeping for their children.

The Child and Family Service Standards do not set out specific criteria for a social worker to use when conducting a home visit as part of a child protection investigation. Standard 16 states that the worker must, at minimum "[see] the child in the home" and "observe the child's living situation." However, the standard does not speak to how the worker should assess these factors, especially when the child is an infant.

Currently, safe sleep is discussed in two of MCFD's 2006 Caregiver Support Standards, which refer to safe sleep on the foster home monitoring form. Both of the standards are vague, unclear and offer little description of what constitutes safe sleep practice and, perhaps more importantly, what is not considered a safe sleep environment. The standards are of little practical help to front-line social workers who work with families on a daily basis.

It is evident from this review that an organized, coordinated system to ensure that parents and caregivers receive the appropriate information about safe sleep practices and environments is lacking. This is especially important for Aboriginal families. However, although much more work is required to protect vulnerable infants, the Representative is encouraged by the efforts underway in some agencies to help address this issue.

One example is the work being done by the Child Death Review Unit of the BC Coroners Service in partnership with BC Vital Statistics to capture data with improved consistency. Sudden infant death cases are being recoded to include risk factors such as sleep surface, sleep position and prenatal exposure to substances. It is hoped that this recoding will result in improved identification, reporting and monitoring of risks.

Although public health educational programs and campaigns do exist, not much is known about their impact on mothers or the degree to which the information gets to them. We do know that the risk of sleep-related infant deaths is reduced when the known risk factors are avoided.

Although good education and information about safe sleeping is important in creating a safe environment for an infant, the Representative acknowledges the importance of the interacting factors of poverty, inadequate housing and family circumstances. Ensuring that a family has a safe crib is important, but it doesn't solve the problem if the infant is crowded into a smoke-filled motel room or the crib is placed in a mould-infested house. Therefore, the following recommendation is made with the understanding that all underlying conditions of infant vulnerability require attention.

Recommendation 5

That the Ministry of Health Services lead an initiative with MCFD and other partners to develop and implement a creative social marketing campaign on safe sleeping.

Detail:

The initiative should have the following features:

- be targeted to the needs and circumstances of vulnerable families, both in terms of the information and in the mechanisms through which it is delivered
- have a clear and consistent message that can be used by all agencies that serve vulnerable families
- provide information about how to create a safe sleeping environment for infants, including practical help such as how a family can receive a Health Canada–approved crib if adequate financial resources are not available.

The campaign should be fully implemented as soon as possible and no later than September 1, 2011.

Learning and Improving Practice

Observations: *Of the 21 infant deaths, 14 deaths were identified for a ministry review and one death was reviewed twice. Fourteen of the reviews have been completed, and one review is still in progress. The remaining seven deaths were not reviewed.*

Rigorous self-examination is crucial to ongoing learning and the improvement of practice. Case review is a critical component of MCFD's quality assurance activities. It can make an important contribution to the development of standards and policies and should also inform training requirements. The review of a death provides the opportunity to examine circumstances with a tragic outcome, reflect and implement change to prevent those circumstances from recurring.

The purpose of examining these reviews was to determine if MCFD reviewed the deaths of the infants in accordance with the legislation and standards and if learning occurred to improve service delivery to children and families. The Representative found that there were opportunities for learning that were not appropriately pursued. MCFD reviews were not conducted on the deaths of all the infants who died, and it is unclear how decisions were made with respect to the type of review conducted.

The reviews generally were not completed within the time frames set out in the standards. In some instances the findings did not encompass the presenting issues, and in some instances the recommendations developed did not address identified practice concerns.

Case reviews, both individually or as part of an aggregate review, can provide opportunities for improving practice. As a recent British report[44] states:

> "One local authority had experienced a number of child deaths and recognised the importance of learning lessons from each event and of noticing trends over a number of SCRs (Serious Case Reviews). The local authority has introduced a number of innovative methods to help practitioners and managers learn from previous cases. These have included the facilitation of workshops which have captured local and national issues and themes arising from SCRs….
>
> "Through these and other learning events, the local authority is able to evidence change and improvement through learning lessons and recognising recurring themes in their own SCRs. The learning is shared across agencies and is proving beneficial to social workers and health visitors especially."

MCFD's 2004 Quality Assurance Standards provide direction in determining if a review is to be completed, the type of review to be conducted and the time frame. The Regional Executive Director of Practice examines the information and makes a decision whether or not to conduct a review of practice and which type of review to conduct.

[44] Lord Laming, *The Protection of Children in England: A Progress Report,* 2009.

The duty of a director to consider conducting a case review is stated in the *Child, Family and Community Service Act* (*CFCS Act*) Regulations Part 5.1:

19.1 (1) In this section, "critical injury" means an injury to a child that may

(a) result in the child's death, or

(b) cause serious or long-term impairment of the child's health.

(2) After a director becomes aware of the critical injury or death of a child, the director must consider conducting a review of that critical injury or death if

(a) the child or the child's family was receiving a service under the Act at the time of, or in the year previous to, the critical injury or death of the child, and

(b) in the opinion of the director, the service received, or a policy or practice relating to the service received, may have significantly contributed to the critical injury or death of the child.

There are two types of case reviews: file reviews (formerly known as Deputy Director Reviews) and comprehensive reviews (formerly known as Director's Case Reviews).

File reviews examine only the information documented on the file. The fact base is outlined and analyzed using file records. Practice is analyzed against a set of standards. Recommendations are developed and tracked for implementation.

Comprehensive reviews include both a review of file information as well as interviews with relevant individuals. Terms of reference are established to define the scope of the review. Facts are established and verified. The information is analyzed, and findings are made. Recommendations are developed and tracked for implementation.

MCFD is in the process of revising its case review methodology to establish a more integrated approach to reviews. This development process appears to be ongoing.

Of the 14 infant deaths which were identified for review by MCFD, 13 have been reviewed and one is in progress. Six deaths had a comprehensive review, seven had a file review, and one death had a file and then a comprehensive review.

The following observations were made regarding the MCFD reviews:

- It was not clear how the decision was made to conduct a review or which type of review to conduct.
- The terms of reference were not always adequate given the identified concerns.
- The analysis in the reviews missed key issues.
- In some cases the issues identified in the analysis were not addressed in the recommendations.
- When recommendations are noted as complete, it was unclear if the actions taken actually fulfilled the requirement of the recommendations.

It is not known why seven of the infant deaths were not reviewed by MCFD despite active service delivery to the child and/or the family. The *CFCS Act* Regulations require a review only in circumstances where in the opinion of the director the service received or a policy or practice relating to the service received may have significantly contributed to the critical injury or death of the child. However, reviews can also be conducted at the Director's discretion. Few records from the Regional Director offices were provided. It is not known what standards are expected for documentation in the Regional Director offices.

From the file information examined it appears that a ministry review would have been prudent for all of the deaths. For example, in one case the lack of prenatal child welfare planning, lack of high risk discharge planning and an incomplete child protection investigation prior to the child's death were of concern. A review of practice would be an opportunity to understand how the child welfare system may have better served this infant and family.

In another case a decision was made to include the case in a regional review of five deaths of infants in 2007 rather than conduct an individual review. The cluster review did not examine practice in each of the five included deaths.

While many of these deaths were classified by the coroner as sudden unexplained death in infancy, in each there was reason to consider that the infant may be at risk, and in each there was recent or current service involvement by the ministry.

The above-noted circumstances demonstrate that the decision to not conduct a review in the death of a child can result in the loss of valuable information and learning. Specifically, these potential areas of learning were:

- challenges of working in isolated communities
- effective intervention with drug-addicted parents
- impacts of domestic violence
- better integration of services and interagency communication
- appropriate discharge planning.

Of the 14 reviews examined by the Representative, eight were file reviews. A file review can provide substantial information and can be adequate in some circumstances. However, in some of the circumstances it may have been more valuable to have conducted a comprehensive review.

For example, in one circumstance where a file review was conducted, a comprehensive review could have provided more insight into a complex case in which the child was in care at the time of death. The foster home where the infant died had been the subject of a number of complaints and investigations, there were concerns regarding the delay in following up on previous child protection concerns, and there was significant public attention.

The Quality Assurance Standards provide time frames for decision and completion of reviews:

- A decision to conduct a review is to be made within 20 working days of the serious occurrence.
- A Deputy Director's Review (File Review) is to be completed as soon as possible and within 90 days of the decision to begin a review.
- A Director's Case Review (Comprehensive Review) is to be completed as soon as possible and within eight months of the decision to conduct a review.

Meeting time frames with respect to reaching the decision to conduct a review was difficult to assess, as the necessary information was not in the files reviewed.

Fourteen completed reviews have been examined in terms of meeting time frames. Of the eight file reviews, only one met the time frame of completion within 90 days after the decision. One file review was completed more than two years after the death.

Of the six completed comprehensive reviews, two met the time frames for completion and four did not. One review took 19 months to complete, and the one outstanding is significantly overdue, as it has been 2 1/2 years since the infant's death.

The development of appropriate terms of reference is critical in ensuring that a full picture emerges. The right questions need to be asked to reach conclusions and to ensure that appropriate action can be taken that leads to learning and improves practice.

The terms of reference developed in six comprehensive reviews were examined. In one case the terms of reference were not examined as the review has not been completed. Of the six, five were found to be appropriate to the circumstances under review.

In one review the terms of reference did not provide for a full examination of the circumstances. The children in this family had been in care for eight months when the infant died, while family services had been provided for a number of years. There had been very active child protection activity for over a year prior to the children being removed. The Representative's review of this activity raises concern about the quality of the practice. The terms of reference when established were limited to the practice while the children were in care, although the review itself did consider the child protection practice prior to the children coming into care.

Evidence is the basis of making findings and developing recommendations. Practice standards, policies and relevant protocols provide a framework for careful analysis of practice. It is critical that the reviewer remain objective and unbiased.

The following is an example of a ministry review where the findings were not consistent with the fact base. The single term of reference for the review was as follows:

> Was the Ministry's response to and documentation of information received from [date] to the time of [the infant's] death consistent with legislation, policy, service standards and relevant protocols?

The finding of the ministry review was:

> The Ministry's response to and documentation of information received from [date] to the time of [the infant's] death was consistent with legislation and relevant protocols, and on occasion inconsistent with policy and service standards.

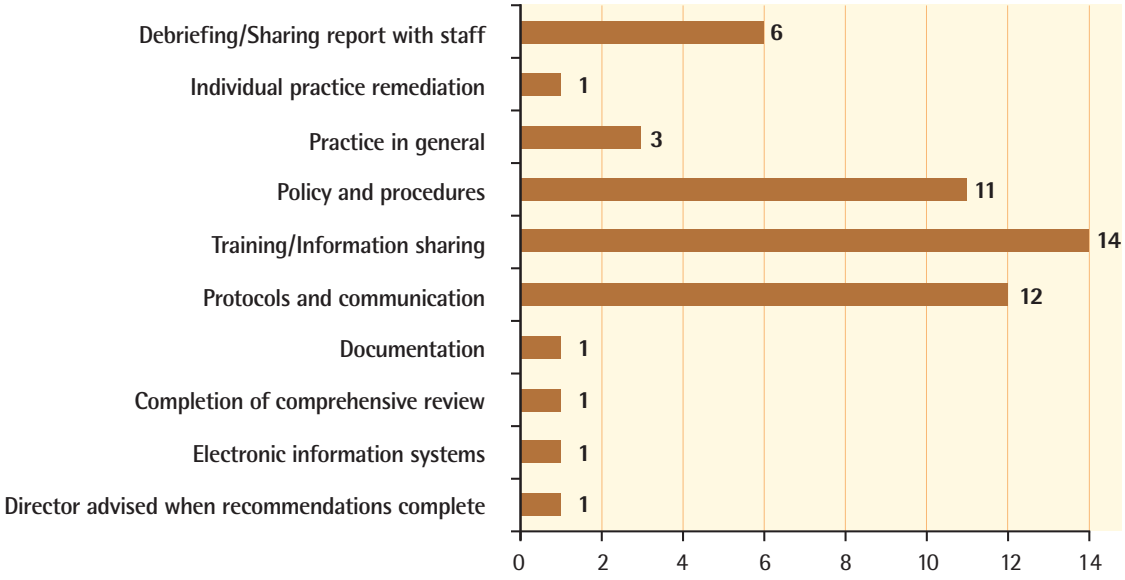
However, the ministry review identified a number of practice issues but failed to identify the lack of coordination between MCFD and the First Nations band in delivering services to the family and the reliance on After Hours service providers to contact the family.

Given the significant number of practice issues that were identified in the ministry review, it is unclear how it was determined that practice met standards except on occasion. The failure of the review to identify these practice issues or to develop recommendations from the findings was a missed opportunity to learn, identify remedial steps and make necessary changes. Instead, the review made only one recommendation: to distribute a pamphlet on safe sleeping for babies to staff in the region. While this is important, training social workers in assessing families where there are child protection concerns and the mother is expecting another child should also have been mentioned.

A total of 51 recommendations were developed as a result of MCFD reviews. One review didn't contain recommendations but included a number of activities with completion dates under the heading of Organizational Development. One review had no recommendations.

The following chart characterizes the focus of the 51 recommendations arising from the 13 reviews that contained recommendations.

MCFD Review Recommendations (n=51)



Of the 51 recommendations, 40 were identified as complete and closed at the time of writing. Eleven remain outstanding.

The development of and response to recommendations is a key component of a strong quality assurance framework and an opportunity for learning. This is particularly true when recurring findings and recommendations are shared and analyzed. Frequently the reviews include the recommendation that the findings be shared with involved staff. Occasionally this includes the recommendation that the finding be shared with the team leaders. As the reviews are completed within the regions, it is important that there be a process though which this information can be shared with MCFD staff and other professionals.

Unfortunately, there is a wealth of information in the reviews which is not collated in any meaningful way in order to inform practice. As a result, there does not appear to be a consistent and formalized procedure for sharing the results of reviews with other ministry staff or with other involved professionals.

The Representative has previously examined and made recommendations with respect to the case review process in the 2008 report *Amanda, Savannah, Rowen and Serena: From Loss to Learning*. It was noted that the ministry's case reviews of deaths did not serve as a stimulus for organizational learning. The report noted that it did not appear that there was a consistent and formalized mechanism for sharing the results of the reviews. The Representative's recommendations included:

- that the lead responsibility for Director's Case Reviews be situated in the provincial office of the Ministry of Children and Family Development
- that Director's Case Reviews be conducted in every case in which a child receiving services from the Ministry of Children and Family Development or in its care dies or is critically injured in unusual or suspicious circumstances
- that the Ministry of Children and Family Development share all case reviews with involved ministry staff, families and caregivers of the child fully and promptly.

To date, MCFD has indicated that responsibility for case review will remain with the regions and that issues relating to case reviews are part of an ongoing review of quality assurance that is not yet complete. However, it is of concern that the designated responsibility for the case review function under the *CFCS Act* was moved from the Provincial Director (a position which no longer exists) to Regional Executive Directors of Practice. In 2010, it was moved to Regional Directors of Quality Assurance Practice, which means there is no consistent provincial oversight or accountability for this function.

Recommendation 6

That MCFD take immediate action to implement improvements to the case review function to enable management and staff in the ministry and other agencies that serve vulnerable children to learn from the results of the reviews.

Detail:

Improvements required include:

- providing clear criteria for when and how to conduct a review
- at minimum conducting a file review on all sudden unexplained infant deaths
- fully documenting decisions to undertake a review, type of review, development of terms of reference and development of recommendations
- meeting standards for timeliness
- using a multidisciplinary, multi-agency approach to inform the analysis and recommendations of comprehensive reviews
- aggregating and reporting out on results to further add value to learning
- engaging other ministries and service providers in learning from the results of the case reviews.

An update should be provided to the Representative by June 30, 2011.
The protocol should be fully implemented by January 31, 2012.

Recommendation 7

That MCFD implement previous recommendations made by the Representative with respect to re-establishing the role of Provincial Director in order to support a more effective process for case reviews, to avoid conflicts of interest and accountability and to drive more effective organizational learning.

The role of Provincial Director should be re-established by April 1, 2011.

Conclusion

The life circumstances observed among the group of infants described in this aggregate review must command the attention of all British Columbians and move us to redouble our efforts to improve preventive practice so that deep-seated intergenerational patterns do not continue to burden the children of generations yet to come.

This is difficult and complex work, both for policy-makers and for front-line workers who are confronted with circumstances that can easily seem overwhelming. The policy foundation for work with families struggling with poverty and other significant challenges is weak, and as a result, the current practice is inconsistent and often not effective.

Vulnerable infants and their struggling families in B.C. today deserve better systems of support, and our duty of care requires much stronger efforts on their behalf as well as the rigorous monitoring of the results of our efforts.

We must do a better job of equipping the hard-working professionals in our child-serving and health care systems with the necessary tools, training and support to do a more effective job in these kinds of challenging situations. We must not become numb to these desperate situations. As a society, we must not accept that a crowded hotel room or a mouldy apartment is an adequate substitute for a real family home just because it provides a roof over their heads and is one step above sleeping on the streets.

The Representative cannot definitively determine whether or not the deaths of these 21 infants were preventable. However, we do know that reducing the kinds of risks and vulnerabilities described in this review can lead to fewer sudden infant deaths, particularly given the multiple common risks these infants faced.

British Columbians want the best possible chances for all of our children to be healthy and strong. However, this review clearly shows that the level of support in our systems to counter the barriers and the risk factors these families faced was insufficient.

Although there are no simple answers to these difficult situations, that must not deter us from action. There is ample evidence of measures that make a difference when strong systems build on the resilience and strengths of families.

We can do a better job for these families, and we can begin by better integrating the services we provide as well as the sharing of important information. And above all we must demand that our government work at all levels, in bold and responsive ways, to address the deep, persistent poverty and life circumstances that inevitably play a constant role in so many of these tragedies.

It is everyone's responsibility to support vulnerable children and families. When we undertake the difficult and sometimes painful process of going back to examine in detail the lives and deaths of infants lost, we as a community have an even greater obligation. It is a duty owed to the memory of the children we've lost, to their still-grieving families, and to all B.C. children beginning their life path. We have a responsibility to act decisively on what is learned.

Glossary

Child in care: Any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act.*

Child protection report: A report received about a child's need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth or conducting a child protection investigation.

Child protection investigation: A process of inquiring into or tracing through inquiry, collection of information, interviews with parents, teachers, daycare providers, public health nurses, physicians and extended family members to evaluate whether a child is in need of protection.

Delegated Aboriginal Agency: Through delegation agreements the First Nations Director (the Director) gives authority to Aboriginal Agencies and their employees to undertake administration of all or parts of the *Child, Family and Community Service Act* (*CFCS Act*). The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency and the level of delegation provided by the Director.

Hughes Review (BC Children and Youth Review): The 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was a review that recommended the appointment of an independent Representative for Children and Youth.

Intake: The process by which child protection reports and requests for service are introduced into an office. These reports and requests for service are assessed and assigned to social workers for follow-up.

Intergenerational trauma: The tendency of a person when they become a parent to repeat the abuse or neglect that they themselves suffered as children.

Reviewable service: Any of the following designated services:

- services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*
- mental health services for children
- addiction services for children
- additional designated services that are prescribed under section 29(2)(b) (e.g., health care)

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Appendix A:
Representative for Children and Youth Act

Part 4 – Reviews and Investigations of Critical Injuries and Deaths

Section 11 - Reviews of critical injuries and deaths

(1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for a review under subsection (3).

(2) For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.

(3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives.

Appendix B:
Documents Reviewed

Ministry of Children and Family Development

- Family service records, including electronic records
- Child service records, including electronic records
- Resource records, including electronic records
- File reviews, comprehensive reviews and Vancouver Island Cluster Review
- Provincial office and Regional Director office records received
- Reportable Circumstances reports
- Integrated Practice Analysis Tracking System (IPAT)
- Integrated Case Practice Audit Tool (ICPAT)

Health Care

- Hospital records
- Community and public health records
- MSP records
- Medical clinic records (if applicable)
- Pharmanet records (if applicable)

Coroners Service

- Kimble reports
- Pathology and toxicology reports
- Coroners reports

Police

- Sudden death reports and Occurrence reports
- Interview transcripts
- Scene photographs
- Witness statements

Ministry of Housing and Social Development (MHSD)

- Income assistance records

MCFD Legislation, Policies, Standards and Other Related Documents

- Aboriginal Operational and Practice Standards and Indicators (AOPSI)
- Child, Family and Community Service Act and Regulations (1996)
- Child and Family Development Service Standards: Child and Family Service Standards (Nov. 2003)
- Child and Family Development Service Standards: Child in Care Service Standards (Nov. 2003)
- Quality Assurance Standards (2004)
- Caregiver Support Service Standards (2006)
- Standards for Youth Support Services and Agreements (2004)
- Standards for Foster Homes (1998)
- The Vancouver Island Region *High Risk Expecting Parents Guidelines* (2005)
- The Fraser Region *Operating Policies and Procedures: Reports of Pregnant Women Whose Behaviour or Health are High Risk* (2006)
- The North Region *Protocol for Child Protection Risks in Pregnant Mothers*
- The Vancouver Coastal Region *Director's Office Practice Bulletin*
- The Interior Region *Practice Advisory Guidelines for Assessing Capacity of Youth to Care for their Own Children* (2009)
- Care of Substance Exposed Infants: Discharge from Hospital to Community, An Interagency Guideline Capital Health Region & MCFD (1999)
- Care of Substance Exposed Infants: Discharge from Hospital to Community, An Interagency Guideline Vancouver Island Health Authority & MCFD (Mid Island) (June 2008)
- Interagency Protocol & Procedures for Removing At-Risk Infants from the West Coast General Hospital (Feb. 2009)
- Cowichan District Hospital Protocol (2001)
- Vancouver-Richmond ICM Discharge Planning (undated)
- Protocol Agreement Between Interior Health-East Kootenay Regional Hospital and MCFD (2008)
- Fraser Health & Fraser Region Ministry of Child and Family Development: Child Welfare Alerts Protocol & Guidelines (Sept. 2009)
- Children & Women's Health Centre Protocol with MCFD (2008)

Appendix C:
Summary of Recommendations from Other Reports

The 2009 BC Coroners Service, Child Death Review Unit report recommendations were addressed to the government, health systems, industries, research bodies and community organizations and touch on the following areas:

- Prenatal care (e.g., safe sleep education in service delivery, early prenatal registration programs to increase early initiation of prenatal care, expand Pregnancy Outreach Programs for high-risk parents and families)
- Public education (e.g., establish best practices for safe sleep and disseminate safe infant sleep information in a consistent fashion)
- Education and training of health professionals (e.g., increase awareness, provide resource materials)
- Infant death classification (adopt standard criteria for defining and classifying sleep-related deaths and provide training to death investigators)
- Social determinants of health (e.g., pursue strategies that address social determinants of health, increase housing options, community-based crib lending program)
- Consumer product safety (e.g., include safe sleep information on labels of relevant infant products)
- Home visiting (e.g., provide intensive home visiting services for higher risk mothers and families that include education on preventive child health and safety and provision of increased monitoring and support when required)
- Research (e.g., pursue research that seeks to gain a better understanding of the relationship between sudden infant death and socioeconomic factors)
- Working with and supporting Aboriginal communities (e.g., work with Aboriginal communities to develop culturally appropriate, community-based, practical programs to promote safe sleep and reduce the risk of sudden infant deaths)

The 2008 MCFD cluster review report recommendations were addressed to internal MCFD teams:

- The Child Welfare Policy team will consult with the Provincial Health Officer and the BC Coroners Service Child Death Review Unit before finalizing the Safe Sleeping for Babies information bulletin.
- The Directors of Integrated Practice will disseminate the Safe Sleeping for Babies information to ministry staff and caregivers, the Aboriginal Policy and Service Support team will disseminate the information to delegated Aboriginal Agencies staff and caregivers, and the Integrated Quality Assurance team will disseminate the information to those who are involved with the ministry via the ministry's internet site.

- The Directors of Integrated Practice will demonstrate to the Regional Executive Directors how the Safe Sleeping for Babies information has been disseminated to the regions.
- The Learning Education and Development Team in Strategic Human Resources will incorporate the Safe Sleeping for Babies information in any update or revision to caregiver support training. In the interim, the Regional Council Support Team will advise the regions to include this information in any deliveries of training to caregivers.
- The provincial Integrated Quality Assurance team will disseminate the literature review portion of this report to ministry staff.

Canadian Paediatric Society's Recommendations for a Safe Sleeping Environment Journal of Paediatric Child Health, November 2004, reaffirmed February 2010.

Understanding the family dynamics and the reasons for choosing a particular sleeping environment, in conjunction with the awareness of dangerous bedsharing practices, are all important considerations in offering guidance to parents in their choices for sleeping arrangements. No sleep environment is completely risk-free, but much can be done to educate parents on the provision of safer sleeping environments for their infants. The advice given must be guided by the available evidence-based data, which indicate that when infants sleep in their own crib, they are significantly safer than when they bedshare.

Based on the available scientific evidence, the Canadian Paediatric Society recommends that for the first year of life, the safest place for babies to sleep is in their own crib, and in the parent's room for the first six months. However, the Canadian Paediatric Society also acknowledges that some parents will, nonetheless, choose to share a bed with their child. With these caveats in mind, the following recommendations are proposed with the understanding that no randomized studies can be performed to measure the potential impact of these recommendations for a reduction in the incidence of any sudden unexpected infant death.

- Infants should sleep on their back, in cribs meeting the Canadian Government's safety standards (46). This is the recommended sleeping arrangement for the first year of life, under all circumstances.
- The infant sleep environment must be free of quilts, comforters, bumper pads, pillows and pillow-like items. Dressing infants in sleepers should be considered to eliminate the need for any covers over the baby, other than a thin blanket.
- Parents should also be aware that room-sharing is protective against SIDS and that this type of sleeping arrangement is a safer alternative to bedsharing. This may be particularly appealing to mothers who breastfeed and want their baby to be near them without sharing the same bed surface.

- Effective counselling to prevent maternal smoking should begin at the onset of pregnancy, and ideally, well before that.
  - Mothers who smoke during their pregnancy should be informed that their infant has a greater risk of SIDS. Passive exposure to environmental tobacco smoke is also associated with an increased risk of SIDS.
  - When there is exposure to cigarette smoking, pre- or postnatally, the risk of SIDS is further increased with bedsharing.
- Hospitals should not allow mothers to sleep in the same bed with their newborns in view of the effects of postpartum maternal weakness or fatigue, analgesia or post anesthesia. This policy will also serve to educate parents on safe sleeping practices. However, it must not compromise in any way the maternal-infant interaction necessary for the initiation of successful breastfeeding.
- Parents should not place infants on waterbeds, air mattresses, pillows, soft materials or loose bedding, even for temporary sleeping arrangements (e.g., during travel). Car seats and infant seat carriers must not replace the crib as a sleep surface due to the risk of the harness straps causing upper airway obstruction.
- Sleeping with an infant, or letting the infant sleep alone on any type of couch, recliner or cushioned chair is dangerous, placing infants at substantial risk for asphyxia or suffocation. Any makeshift bed is dangerous as well.

Appendix D: Multidisciplinary Team

Under part four of the *Representative for Children and Youth Act* (see Appendix A: *Representative for Children and Youth Act*) the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry of Children and Family Development (MCFD) within the 12 months before the injury or death.

The Act provides for the appointment of a multidisciplinary team to assist in this function, and a regulation outlines the terms of appointment of members of the team.

The purpose of the multidisciplinary team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider.

The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The multidisciplinary team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- Policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and development disabilities
- Public health

Multidisciplinary Team Members

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Lucy Barney – Ms. Barney is a registered nurse from Lillooet Nation. She completed her Masters of Science in Nursing from the University of British Columbia and is currently employed as a perinatal nurse consultant with the BC Perinatal Health Program. She is the vice president of the Native and Inuit Nurses Association of BC and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal Health, and she developed the braid theory which looks at the mind, body and spirit and demonstrates a holistic view on health.

Karen Blackman – Ms. Blackman is currently the Senior Director of Practice Support and Quality Assurance with the Ministry of Children and Family Development. She has 21 years of experience, including work as a social worker, team leader, practice analyst and community services manager in the ministry. Ms. Blackman holds a Bachelor of Social Work degree and a Master of Arts in Leadership and Training.

Beverley Clifton Percival – Ms. Percival is from the Gitxsan Nation and is a negotiator with the Gitxsan Hereditary Chief's Office in Hazelton. She holds a degree in anthropology and sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Ruby Fraser – Ms. Fraser is Regional Director, Quality and Risk Management for the Northern Health Authority, monitoring health care incidents across the continuum from community to acute care.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service. He has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a registered nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations like the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Russ Nash – Mr. Nash is currently the Officer-in-Charge of a Major Crime Section with the RCMP. He has expertise in extensive criminal investigations and, in particular, in homicide investigations. He has been involved in a variety of RCMP programs focused on youth, including the D.A.R.E. program, and has also volunteered as a coach and manager of youth sports teams.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an assistant professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital and assists the BC Coroners Service on an ongoing basis.

Appendix E: CPT 1

CPT 1 is an enzyme in the body that helps change fat to energy. Fats are an important fuel source for the body between meals.

A complete lack of the CPT 1 enzyme is extremely rare; however, the consequences are serious because it places greater demand on sugar stores in the body, which can result in extremely low blood sugar, and sudden death can occur. Simple steps like frequent feeds and ensuring that fasting does not occur during illness can reduce the risk of sudden death.

A mild form, called the CPT 1 variant, occurs at a very high frequency in Canadian Inuit infants in Nunavut. Among 422 live births, the CPT 1 variant was observed in two out of three infants. Whether this variant contributes to the higher mortality rate seen in Canadian Inuit infants is the focus of ongoing studies. In Alaska 129 infants with the CPT 1 variant have been identified, and all of these infants' mothers are Alaskan Native Americans. When researchers at BC Children's Hospital were investigating the sudden unexpected death of young children, the same CPT 1 variant found in the Inuit and Alaskan Native Americans was seen also in B.C. infants of First Nations descent.

A blood test for treatable metabolic disorders is done on all B.C. newborn infants. Currently, CPT 1 is not part of that testing. However, the blood samples are stored after screening is completed and can be used for public health research. The UBC Clinical Research Ethics Board and the First Nations Health Council approved a study to determine the prevalence of the CPT 1 variant in B.C. and to determine if there was an association between the CPT 1 variant and sudden death.

The research has led to the conclusion that about 200 First Nations infants are born in B.C. each year with the CPT 1 variant. It is more common on Vancouver Island and along the B.C. coast. It is estimated that 19–24 per cent of First Nations infants born on Vancouver Island have the CPT 1 variant, compared to 4 per cent in the Interior of B.C. Historically, this may have been a genetic advantage for adult survival, but extensive research is needed to fully understand this issue.

A First Nations infant who has the CPT 1 variant is approximately three times more likely to die suddenly than an infant who does not have the variant. To put this into perspective, the mortality rate associated with the CPT 1 variant is approximately 1-2 per cent. On Vancouver Island the increased frequency of the CPT 1 variant mirrors the increased rate of infant mortality among First Nations. In B.C. a study is in the planning stages to get a better understanding of the natural history of the CPT 1 variant. Further research will continue to shed light on the role of this variant in the health of Aboriginal populations.

From Sinclair, Collins, Arbour, Popescu, and Vallance, to be published in the *Journal of Inherited Metabolic Diseases,* 2011.

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