

Office of the Children's Advocate

EMERGENCY PLACEMENTS FOR CHILDREN IN MANITOBA'S CHILD WELFARE SYSTEM

An Update on the Recommendations made by
The Office of the Children's Advocate in the
Hotel Review (2000) and the Review of the Operation of the
Winnipeg Child and Family Services Emergency Assessment
Placement Department (EAPD) Shelter System (2004)

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March 2009

Acknowledgements

The Children's Advocate wishes to extend acknowledgements and gratitude to:

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Special thanks to the children, youth, staff and managers who participated in this review

Information contained in this Report is based on data and facts obtained during and prior to the period from April 2007 to September 2008.

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Executive Summary

In April 2007, the Office of the Children's Advocate called for a review to update the progress on recommendations made in two previous reports, the Hotel Review (2000) and the Shelter Review (2004). Both reviews were conducted by the OCA as a result of public concerns about children and youth being cared for in hotel rooms and in emergency shelters. A total of 90 recommendations were made for changes that would eliminate hotel use and improve the emergency care system that uses shelter facilities to care for children and youth because of a lack of sufficient foster homes and alternative long-term placement resources such as group homes and treatment facilities. As the review of the progress in implementing the above recommendations commenced, several factors were immediately evident.

- Emergency placement resources continue to be utilized for the out of home care needs of children and youth.
- There is a shortage of foster homes and alternative longer-term placement facilities for large sibling groups and for youth with multiple needs and high-risk behaviours.
- The number of children in care has increased by over 1700 in the last five years.
- A total of 81% of children and youth in care are Aboriginal.
- The Aboriginal population of Manitoba is younger and growing at a faster rate than the overall population.
- Predictions of children in care, based on population trends and the overrepresentation of Aboriginal children in the child and family services system, will continue to increase over the years.

With this in mind, in addition to reviewing the progress of the previous recommendations, this review examined the current state of the emergency care system. Two groups of children are significantly over represented in the population of children and youth living in emergency placements such as hotels and shelter facilities. These include large sibling groups and youth with special or multiple high needs who may present a risk to themselves or others. For sibling groups of three or more, it is highly unlikely that many family foster homes will be able to accept this number of children and still meet regulatory standards. High-risk or special needs youth, on the other hand, may present with issues that are beyond the ability of most

foster families to manage, such as involvement with gangs, criminal activities and substance misuse. They can exhibit violent behaviours that may cause harm to their care providers and are difficult to place because they can be resistant to treatment and sabotage well-meaning placement plans. Emergency shelters have been developed to meet the placement needs of the above children and youth. However, without alternative resources to move to, these children/youth end up staying in emergency shelters far too long, obstructing movement in and out of emergency facilities and escalating the cost of emergency care. It is essential that a needs assessment of children/youth in emergency facilities be undertaken to develop placement resources that are able to meet their actual needs. For high needs youth in emergency care facilities, treatment plans developed collaboratively with other systems the youth are involved with, are essential to achieve positive outcomes for the youth.

The Department of Family Services and Housing and the Child and Family Services Standing Committee made a concerted effort to address the recommendations from the OCA reviews and approximately 63% of the recommendations have been completed, are in progress or have become part of on-going work by the department and the Standing Committee. Fifty new emergency foster bed spaces were added to the emergency placement system in Winnipeg in 2005 and this number had increased to over 160 by March 2008. At the same time, a province-wide foster home recruitment strategy produced almost 1000 additional new foster bed spaces in the province. While this is a positive move, there has been no reduction in the number of emergency shelter facilities in Winnipeg. In fact, the number of shelter facilities has increased from 42 in 2003/04 to 52 in 2007/08 to 60 in May 2008. Similarly, the cost of shelter care has increased from \$271 a day per child in 2003/04 to \$377 a day per child in 2007/08.

The hotel reduction strategy in November 2006 was effective in removing all children from hotel placements by July 31, 2007. However, sibling groups were an exception to the hotel placement policy and high needs youth are, once again, evident in hotel placement statistics. Although hotel placements are not considered suitable alternatives for children and youth, the haste in moving children from hotels only increased the strain on the emergency shelter system, as few long-term facilities

were available to meet the needs of the children and youth placed in hotels. With funds available from the reduction in hotel use, child and family service agencies across the province were tasked with developing alternative placement resources for children and youth who would have been placed in hotels. Several plans and proposals were developed, however, with the exception of new emergency placement resources in Winnipeg, very few emergency resources actually got off the ground in other parts of the province.

The state of emergency placement resources for children and youth who require emergency care is concerning. As each child and family services agency is responsible for developing its own foster care and alternative care resources, inequitable resources are evident in the province. Children and youth from northern and rural communities are transported to Winnipeg for emergency placements because of a lack of suitable resources in other parts of the province. Furthermore, while foster home recruitment strategies have effectively increased the number of foster homes in the province, these are not able to accommodate the larger sibling groups and special needs youth that consistently make up a large number of the children and youth living in shelter facilities. Locating suitable long-term placements for children and youth in emergency care is further compromised by the absence of a standardized, province-wide information system that tracks bed space vacancies. Without a standardized process for sharing bed space vacancies, child and family service agencies can closely guard their foster homes, keeping bed space vacancies for children in their own care. Presently there are 25 child and family service agencies in the province, each with their own set of foster homes, and no standardized system of accessing information on vacant foster bed spaces between the agencies.

A further concern is the fact that there are no standards in place that specifically regulate short-term, emergency facilities. Accordingly, without specific standards to guide the development of new emergency shelter facilities in the province, a two-tiered system has emerged where some facilities are being developed under the Place of Safety designation, where no provincial monitoring regarding the quality of care provided to children occurs, while others adhere to licensing standards developed for longer-term residential treatment facilities. Neither

of these provides standards on such critical issues as the length of stay in emergency care or the process of finding long-term placements or returning children home. These issues are specific to emergency placements. In view of the above, the OCA is concerned that the current system of emergency care is not conducive to meeting the best interests of children and youth in care, and that a specific regulatory system for emergency placements is essential. As a result, the OCA continues to support the recommendation made in the Shelter Review (2004) that the regulation of emergency placement resources for children and youth in care occur through the development of a centralized office, located in the Department of Family Services and Housing, and responsible for all aspects of out-of-home placements for children in care, as well as, regulating in-home programs to keep children from entering care. Based on the information gathered from the comprehensive review of the previous OCA recommendations in the Hotel Review (2000) and the Shelter Review (2004), along with an assessment of the current state of emergency placements for children and youth in care, the following recommendations are made to the Department of Family Services and Housing and the Child and Family Services Standing Committee:

1. **That the capacity for community resource development, both in-home and out-of-home, be developed, regulated and monitored through a centralized office created by the DFSH, with the Child and Family Services Authorities, and located within the Children's Resources Office of the Child Protection Branch. This centralized office will interrelate with the existing centralized services provided through the Provincial Placement Desk (PPD), the Child Caring Facilities Licensing Branch, and the Provincial Abuse Investigators (PAI). The tasks and responsibility of this office, will include, but not be limited to:**
 - **Improving the continuity of care, coordination and accountability in the provision of in home and out of home services to children and youth and their families.**
 - **Assessment of current in-home and out-of-home resources for children and youth.**
 - **Assessment of in-home and out-of-home resource needs of children and youth.**
 - **Developing a coordinated system of alternative care network with all Authorities, designated Intake agencies (DIA), child and family service agencies and provincially funded Group 2 resources, and with the external organizations that offer child/youth placement resources.**
 - **Developing and maintaining a tracking system of resources and child/youth needs.**

- Developing a strategy for intersectoral communication and treatment planning for children with multiple needs.
 - Developing standards and regulations for emergency, short-term care.
 - Reviewing standards and regulations for residential facilities in the province.
 - Providing a linkage between government departments and programs.
 - Providing a linkage between external resource facilities and child and family service agencies.
 - Providing support and direction to the Hotel Reduction Team and other committees working on specific terms of reference related to services to children and youth.
 - Providing logistical support to agencies developing in-home and out-of-home resources.
 - Ensuring a fair and equitable distribution of financial resources for in-home and out-of-home resource development across the province based on need.
 - Developing, regulating and monitoring hiring standards and training strategies for child and youth care workers in residential facilities.
 - Bringing services in line with “best practice” standards through quality assurance.
 - Regulating and monitoring all in-home and out-of-home services for children and youth open to child and family service agencies in the province.
2. That the service capacity of the Provincial Placement Desk (PPD), Provincial Abuse Investigators (PAI), and the Residential Care Licensing Unit within the Children’s Resources Office of the Child Protection Branch, be reviewed, strengthened and enhanced to align with the specialized, centralized office for community resource development.
 3. That the DFSH, along with Manitoba Justice, Education and Health, begin developing terms of reference for a coordinated and integrated services delivery system for children and youth with multiple needs that ensures fair and equitable accessibility to treatment programs, services and resources that meet their needs.
 4. That the Standing Committee reconvene the Hotel Reduction Team, or create another team, to continue working on the hotel reduction strategy with the centralized office for resource development, and in accordance with the proposed terms of reference.
 - A historical review of hotel placements, including child-specific information on children and youth placed in hotels, to obtain a comprehensive assessment of their needs.
 - Program standards establishing a criteria for admissions to hotel placements, programming and quality of care for children/youth in hotel placements and management of child specific costs for children in hotel placements.
 - A strategy for intersectoral communication and treatment planning for children and youth involved with multiple systems.

- A tracking system to compile hotel placement data that is connected with the needs of children/youth and is effective in developing treatment and care plans for them.
 - An action plan for developing appropriate short-term, emergency resources adequately suitable for high risk-youth and large sibling groups.
 - Recommendations for long-term placement alternatives for high-risk youth.
5. That the DFSH, the Child and Family Services Standing Committee, the General and Southern Authorities and the Joint Management Committee for ANCR carefully consider the recommendations that follow to strengthen and sustain the Emergency Placement Resources (EPR) in Winnipeg.
- That the Committees proceed in completing the transition process for the EPR program from the WCFS Branch to ANCR Agency. The program has been in a state of limbo for 5 years.
 - That while the Joint Management Committee for ANCR continues to plan for the transition of the EPR program to ANCR, all program planning and development should occur in conjunction with the centralized office for community resource development located in the DFSH.
 - That the Joint Management Committee for ANCR request Human Resources to review the model of supervision provided to shelter staff and recommend changes specifically to ensure the availability of supervision across all shifts.
 - That the Joint Management Committee of ANCR request a financial audit of the EPR program to determine actual costs and develop a plan to reduce the cost of the program yet maintain the quality of care that has been established.
 - That the Joint Management Committee for ANCR commence with a independent review of the use of purchased-service staff to support the EPR shelter and hotel staffing compliment with the requirement that the review confirm the accuracy of purchased-service use reports and develop both a short-term strategy for effectively integrating purchased-service staff into the EPR program without compromising a long-term strategy for phasing out the use of purchased-service staff.
 - That a strategy for the recruitment and retention of qualified residential child care workers be developed by the DFSH. Consideration should be given to providing educational incentives in cooperation with the RRCC, student mentorship opportunities and salary incentives. A retention strategy for residential childcare workers should be developed in cooperation with the Manitoba Association of Residential Treatment Resources (MARTR).
 - That all regularly scheduled shelter staff receive training in the *Child and Youth Care Workers Core Competency Training* program.
 - That Non-Violent Crisis Intervention (NVCi) training be scheduled on a regular basis and a method developed to advise shelter staff when

re-certification is required, similar to the method used to ensure First Aid/CPR re-certification.

- That the Systematic Tracking of Emergency Placements (STEP) database, managed by the WCFS EPR unit, is reviewed and either replaced or enhanced for the capacity to generate meaningful data for outcome analysis. Measurable outcomes in health, education, social skills, mental health, behaviour, life skills and family objectives are useful in guiding case managers in developing realistic case plans for family reunification or longer-term care that meets the needs of children and youth.
- That responsibility for data entry is assigned to one administrative staff person dedicated to input data and maintain the updated tracking system.
- That the WCFS Short Term Emergency Placement (STEP) Committee, a formal body used to review emergency placements within the EPR program and make recommendations for children that are in the shelter system over 30 days, expand to include a standardized process with consistent representatives from all Authorities, the PPD and external representatives from the child mental health system, youth justice and the education system.
- That an effective communication strategy be developed to ensure that the EPR Placement Desk is consistently informed of foster bed and alternative bed space availability on a daily basis by all child and family service agencies, in order to avoid an emergency placement if an appropriate longer-term placement resource is available.
- That the DFSH expand the provincial Outreach Workers program to include a position designated to the EPR program. This position would be responsible for providing outreach services to children and youth who run from an EPR program shelter facility.

6. That the DFSH develop an effective system of tracking and reporting bed space vacancies in foster care and alternative care, accessible through a secure site to all child and family service staff in the province. This system should have the capability to provide analysis of data for trends and future service demands and outcome measures to monitor effectiveness through comparisons to general population trends. This tracking system should be a part of the larger departmental managed care database.

1. INTRODUCTION

The Office of the Children's Advocate (OCA) previously completed two comprehensive reviews on the state of emergency placements for children in care in Winnipeg. The first review occurred in response to the numerous complaints to the OCA about the number of children placed in hotels by Winnipeg Child and Family Services (WCFS) and the quality of care that was provided to the children. The Hotel Review was completed in May 2000 but was never released to the public. There was difficulty in collecting comprehensive and accurate data, compromising the reliability of the review. However, the OCA found sufficient reason to suggest that children's best interests were not represented by being cared for in a hotel room and recommended the end to using hotels as emergency placement resources. Later that same year, the OCA responded to complaints about the care provided to children residing in two hotels in Winnipeg. This initiated a second part to the Hotel Review. A total of 23 children were interviewed and the OCA made several recommendations on improving the quality of care to children living in hotels being used as emergency placement facilities. The highlights from the first hotel review and the concerns and recommendations of the second hotel review were documented in the Manitoba Children's Advocate's Annual Report, April 1, 2000 – March 31, 2001.

The second review of Winnipeg Child and Family Services (WCFS) Emergency Assessment Placement Department (EAPD) shelter system was undertaken by the OCA in partnership with the Department of Family Services and Housing (DFSH), between 2002 and 2004. This review, requested by the Minister of Family Services and Housing at the time, involved a comprehensive assessment of the operations of the emergency shelter system. The Minister was responding to publicly raised concerns about the quality of care in the WCFS shelter system including the safety of children and staff, the cost of the program and the impact that emergency shelter care may have upon children and youth. A final report, *Review of the Operation of the Winnipeg Child and Family Services Emergency Assessment Placement (EAPD) Shelter System* was released in March 2004 (Shelter Review).

In April 2007, the Children's Advocate called for an update on the recommendations from the above reviews. A total of 90 recommendations were made to the Department of Family Services and Housing and the Winnipeg Child and Family Services Branch in the two reviews. Twelve recommendations resulted from the information obtained during two reviews on the use of hotels, while the remaining seventy-eight recommendations came from the detailed and comprehensive review of the WCFS Emergency Assessment Placement Department. Recommendations from the reports were made to the Manitoba Department of Family Services and Housing, the Child and Family Service Authorities, and the Winnipeg Child and Family Services Branch.

An update on the current state of the recommendations will be provided for the use of hotels as emergency facilities for children and youth, and for the use of the WCFS EPR shelter system.

This report will be divided into three parts;

- The first part of the report will examine the continued use of hotels as emergency placements, provide an update on progress in meeting the recommendations of the previous hotel reviews and discuss current policy and operations.
- The second part of the report will examine the WCFS EPR shelter system, including an update on the progress being made in meeting the previous recommendations of the OCA and an overview of the current operations of the EPR program.
- The third part of the report will review the current state of emergency placement programs, resources, services and operations in the province of Manitoba.

It is important to note that the state of emergency placement programs is in a changing and evolving state in response to the recent restructuring of the Child and Family Services system in Manitoba as a result of the Aboriginal Justice Inquiry – Child Welfare Initiative (AJI-CWI). Four unique Child and Family Service Authorities and approximately 25 Child and Family Service Agencies/Regional Operations have

responsibility for providing services to children and families in the province of Manitoba. At this time, emergency placement resources for children in care are the responsibility of Authorities and agencies and both Authorities and agencies are developing and operating emergency placement foster homes and facilities for children in care in different parts of the province. This report will provide an overview of the emergency placement system, as distinguished from other out of home placement systems in the province.

2. BACKGROUND AND CONTEXT

A national shortage of foster homes and other family-based placement homes has created a critical need for alternative emergency placement facilities for children in care. For almost 20 years now, the child and family services system has responded to this shortage by creating emergency shelters and using hotels to place children in care when no foster homes or other placement options were available. This outcome has been a concern to both administrators and service providers within the child and family services system and the focus of a public outcry against the use of hotel rooms as a place to care for children. In June 1999, the Office of the Children's Advocate, along with the Winnipeg Child and Family Services and the Department of Family Services and Housing, conducted a review of the use of hotels as emergency placements for children in care. The Hotel Review (unreleased) was completed in May 2000 and findings of the review confirmed that, "the child's best interests are not being served by admissions to hotels for emergency placement". Recommendations in the Review called for an end to the placement of children in care in hotels and other unregulated care situations. In response to the findings and the recommendations, the Winnipeg Child and Family Services proceeded to create additional emergency placement facilities (shelters) in an attempt to eliminate the use of hotel rooms. Although, the number of emergency facilities in Winnipeg increased considerably, this increase in bed space was not sufficiently adequate to completely eliminate hotel use. Children and youth continued to be placed in hotel rooms.

In response to the public concern about children living in hotel rooms, the Winnipeg Child and Family Services; Emergency Assessment Placement Department (EAPD)

continued to develop facilities to accommodate those children who were residing in hotel placements. The number of emergency shelters increased from 16 homes in 1998 to 72 homes by the end of the 2001 fiscal year. The development of the emergency shelter system was strictly in response to the number of children that required emergency placements. Initially, shelters were developed around licensed professional foster parents, who lived in shelter facilities, and with the assistance of respite staff, provided care to the children placed in the facility. However, as the demand for emergency placement resources for children increased, shelters were set up using child care support staff working 24-hour shifts, assisted by respite staff. Based on a model of live-in care providers, the emergency shelter system developed in accordance with regulations and standards for foster homes. However, as more shelters developed, the availability of live-in care providers decreased. Soon paid child care support staff, working shifts, were responsible for operating the shelters. With this change, the shelters could no longer be regarded as foster homes. With paid staff working shifts in the shelters, they were now considered residential facilities and would have to meet licensing and regulatory standards. The emergency shelter system was operating without policies and procedures and without compliance to existing licensing and regulatory standards. In the absence of licensing and compliance standards, questions began to surface about the quality of care children were receiving while in an emergency placement facility. These issues, along with the increasing costs associated with the emergency shelter system, prompted a call for a comprehensive review of the system. It took two years to complete the review of the operations of the shelter system in 2004 and resulted in 78 recommendations.

Defining Short-Term, Emergency Placement Resources

The term *emergency placement resources* refers to the vast number of placement facilities and foster homes that are used to accommodate children and youth who require an immediate placement due to entry into the care of the child and family services system or due to the sudden breakdown of a previous placement home or facility. Emergency placement resources differ from other placement resources by the urgency in which the placement is required and by the time frame that children and youth remain in these homes or facilities. They are meant to be short-term, and provide the opportunity to better assess the needs of a child or youth before either reunifying

them with family or moving them to an appropriate longer-term foster home or residential facility. Generally, emergency placement resources fall into the following categories:

- Emergency shelters that are shift-staffed
- Emergency four-bed foster homes that are shift-staffed or with a live-in professional foster parent
- External emergency shelters that are shift-staffed
- External emergency four-bed foster homes that are shift-staffed or with a live-in professional foster parent
- Foster homes that are designated as emergency foster homes
- Places of Safety in family residences or staff residences
- Places of Safety in hotels, motels or other facilities such as Women's Shelters.

According to the Child and Family Services Standards Manual, all emergency placement facilities that are shift-staffed must be licensed by the Residential Care Licensing Unit, while four-bed facilities with live-in foster parents and emergency foster homes are licensed by a respective child and family services agency. Places of safety (POS) in family or staff residences and in hotel rooms must be approved in accordance to the Child and Family Services Standards for Places of Safety.

Use of Hotels as Emergency Placements

The Office of the Children's Advocate's Hotel Review (unreleased 2000) focused on the Winnipeg Child and Family Services' practice of using hotel rooms for emergency placements of children and youth. The goals of that review were to identify gaps in service that contributed to ongoing hotel use, to identify minimum program standards required for emergency placements and to make recommendations regarding the use of hotels as resources for children and youth in need of an emergency placement.

The sanction for using hotels as placement resources for children and youth when there are no other options is provided in the Child and Family Services Program Standards Manual (1991). Section 411 sets the minimum service requirement standard for the management of hotels as places of safety. It reads;

1. *“The use of apartments or hotel/motel rooms occurs only where no other appropriate placement is available and is deemed to be in the best interests of the child.*
2. *Placement occurs only where there is an emergency and the child is moved within two weeks where possible. If placement extends beyond 14 days, an internal review is initiated.*
3. *A criminal record check, child abuse registry check and reference checks are done on any person hired or contracted to provide care for a child. Where an Agency contracts with another organization, commercial or non-profit, to provide place of safety services, the agency is aware of the hiring criteria and is satisfied these criteria meet the standards for service providers.*
4. *Management personnel in the agency (supervisor or higher) authorize the placement of any child into an apartment or hotel/motel room as a place of safety.*
5. *The child’s worker visits the child within two working days following placement.*
6. *If the apartment or hotel/motel room used as a place of safety is not located within the Agency’s catchment area, then the agency responsible for the area in which the apartment or room is located is notified within one working day following placement and sent a Place of Safety form. The Agency is notified when the child is moved.*
7. *Agencies submit the Place of Safety Monthly Report form to the director at the end of each month”.*

The use of hotels to care for children/youth is allowable under the Child and Family Services Act. The Act defines a place of safety as “any place” and provides authority to the Director to designate facilities as places of safety. The OCA was concerned that through the ambiguous definition of “any place”, the Act created a level of unregulated care for children with less protection than in any other placement resource.

Hotel Use in a Broader Context

Placing children in hotel rooms is not limited to the provincial experience in Manitoba, but occurs in many parts of the world in response to the wide shortage of foster and residential care bed spaces. On April 21, 2008, Andrew McGarry, a news

reporter with *The Australian* a newspaper in South Australia, reported on the results of a report released by the Commission on Children in State Care, which called for an end to the controversial practice of using hotels and motels as emergency accommodation for at-risk children in state care. Almost 200 teenagers and children nationwide (Australia) were reported sleeping in motels or caravan parks because of a shortage of foster families and space in institutions. According to the report, “while emergency accommodation, which involves expensive around-the-clock care, is meant to be a last resort and apply for a matter of days, it is routinely used for months”. [Time to stop dumping kids in hotels, B&Bs | The Australian](#)

On January 24, 2008 the *Dallas Morning News* reported that state children in care were sleeping in state offices and hotels in alarming numbers when protection workers cannot find a space in a foster home or a residential treatment facility. In one month, 160 children slept at least one night in a state office or a hotel room at an estimated cost of \$345 a day. [Foster care quick fix is adding up | Senator Eliot Shapleigh - Texas Senator District 29](#)

On February 13, 2008 a CBC news investigation has found that Health officials in St. John's were putting children in motels because of a critical shortage of foster families. “More than 700 children are now in Newfoundland and Labrador's foster care system or are waiting for a placement”, CBC reports. “However, a smaller number of families — more than 400 — are willing to take children in.” Eastern Health, the largest authority in the province, has been placing some children in motels and efficiency units and hiring home-support workers to look after them.

[CBC News](#)

On September 11, 2007 Paula Simon published an article in *The Edmonton Journal*. She quoted Rick Semel, the CEO of Edmonton and Area Child and Family Services, as saying, “hotels are a necessary ‘last resort’ until we find a way to deal with the shortage of foster families, it’s the best available alternative”. Semel reported that some apprehended children stay in hotels on an emergency basis only, for a few hours or days, until a family member or a foster home can be found to take care of them. Other times, children are “checked in” for weeks at a time.

Manitoba is not alone in turning to hotel use in order to provide a placement for children requiring emergency care.

Development of the Emergency Shelter System

The emergency shelter system developed simultaneous with hotel use to meet the emergency placement needs of children entering care or already in care but requiring another placement as a result of a placement breakdown. Due to insufficient emergency foster care beds and other residential care beds, hotels and emergency facilities provided a placement bed space when a child needed one in an emergency. As mentioned earlier, the emergency shelter system developed home-like facilities with four bed spaces operated by live-in foster parents who were able to accept children on a 24 hour basis and provide short-term care with the help of a respite worker, until the child/children can return home, move to live with extended family, a foster home or an alternative longer-term resource. The professional foster parent was licensed to provide this service and the home-like setting was considered to be the next best thing to children living in a foster home. As the shortage of bed spaces in the foster care system continued, more and more facilities were established. Accordingly, the number of facilities increased steadily over the years and in the absence of enough “professional foster parents” to operate emergency facilities, child care support staff working 24-hour shifts and assisted by respite workers were hired to staff facilities. The number of emergency facilities in Winnipeg grew rapidly and almost quadrupled in the three-year period from 1998 to 2001. The rapid development of emergency facilities to meet the demand of children in care requiring emergency placements occurred outside the provincial regulatory and licensing system as these facilities started as places of safety or licensed foster homes. Foster homes can be licensed by a child and family services agency. Shelter facilities were subject to criteria developed by the residential care-licensing Branch, a department of the Manitoba Family Services and Housing.

As a result, concerns about the emergency shelter system, known as the Emergency Assessment and Placement Department (EAPD) at the time, and operating over seventy emergency placement facilities in Winnipeg by 2001, were brought to the attention of the Minister of Family Services and Housing. In turn, the Minister asked the Office of the Children’s Advocate to complete a review on the operations of this system.

The Review of the Operation of the Winnipeg Child and Family Services Emergency Assessment Placement Department (EAPD) Shelter System (March 2004) was a comprehensive and concise review of the Winnipeg Child and Family Services' (EAPD) Shelter System. The purpose of the review was to document and assess the WCFS shelter system and make recommendations on the use of shelters to care for children and youth. With information collected and analyzed over a two year period, the Review described the shelter system's design, policies and procedures, analyzed how the shelter system fit into the continuum of services, described the children and youth who used the shelter system, identified the benefits, issues and pressures on the shelter system, provided a forum for the voices of children and youth in the shelter system to be heard and made recommendations to improve the quality of care to children living in the emergency placement system.

In the absence of a program model for the WCFS EAPD shelter system, and due to limited information on emergency shelters, the OCA developed a definition of an emergency shelter based on provincial standards, Professional Standards of Excellence (CWLA) and a literature review. A *Shelter* was defined as:

A licensed residential care facility that is community based and home-like for children and youth within the CFS system. It is responsive to an emergency/crisis situation that requires a safe and protective care alternative for a limited period of time. This is a developmentally appropriate group living environment that provides supervision, structure, support and programming which is child centred and delivered in a flexible manner to meet the needs of children and youth.

The OCA also recommended that shelter care operate in accordance to the following assumptions:

1. *Based upon "Best Interests".*
2. *It provides protective substitute care for the child.*
3. *Placement in shelter is of benefit to the child.*

4. *Provides basic necessities – food, shelter, clothing, medical, educational and recreational.*
5. *Staffed with qualified, competent, trained care providers*
6. *Provides basic assessment of child's needs.*
7. *Transitional to other care – foster, independent living, kinship, other residential care or home.*
8. *Time limited – 60 days.*
9. *Home setting is conducive to promoting healthy growth and development of the child.*
10. *Environment and program of shelter is conducive to ensuring connectedness to family and identified community.*
11. *Complies with minimum standards and regulations as set out in the CFS Act.*
12. *Shelters exist within programmatic boundaries, which define purpose, policy, procedures, stated goals, objectives and outcomes.*
13. *Program is accountable to an authority, community and child.*
14. *Community based which ensures access and linkages to schools, recreation, and resources.*
15. *Staff-child ratios are flexible and appropriate at all times to meet individual child, and group need and situation.*

The Residential Care Licensing Unit, a department of Family Services and Housing, is responsible for licensing all residential childcare facilities, including emergency

placement facilities for less than five children and youth. The Child Care Facilities Standards Manual outlines minimum staff qualifications, guidelines for staff functions including required areas of care and supervision, dietary/food services and domestic support/facility maintenance. The standards and regulations also state that all residential treatment facilities are required to have written statements of the program and services offered, including goals and objectives, and must meet zoning requirements and health and fire code regulations. When the OCA commenced with the review of the WCFS EAPD Shelter System, it was discovered that a number of emergency shelter facilities were operating without meeting licensing requirements for the number, ages and gender of the children in the facilities. The EAPD Shelters provided short-term emergency care to a wide range of children with different needs at the same time. Because this system responded to emergency placements needs, children of varying age levels were placed in facilities where bed space was available at the time emergency placement was needed. It was difficult to ensure bed space in age appropriate facilities when emergency placement was required. Due to continuous changes in the ages of children and youth requiring emergency placements, the OCA found that the EAPD facilities had difficulty in adhering to program requirements reflected in the standards. The OCA also found that a significant number of staff did not have the required training in First Aid and CPR or did not update their initial training after the expiry date. A three-year timeframe was provided to the agency to have all required staffing qualifications up to date.

3. METHODOLOGY

The purpose of the present review is to report on the progress of the previous OCA recommendations from the Hotel Review (2000) and the Shelter Review (2004), and to assess the current state of emergency placement resources in the province. The Review commenced in April 2007 and ended in September 2008. All data used in this report was obtained during or prior to this time line.

The first part of the Review focused on an analysis and progress report on the recommendations made in the two earlier reports by the Office of the Children's

Advocate on the state of the child and family services emergency placement system in Winnipeg. These reviews include:

- a). The Hotel Review, May 2000 (unreleased), inclusive of a report on the of care in hotel placements, titled, “Just Another Kid in Care”, and
- b). The Review of the Operation of the WCFS Emergency Assessment and Placement Department (EAPD) Shelter System, March 2004.

Update and Progress Report on the Previous Recommendations

Both reviews focused on emergency placement resources developed and used by the Winnipeg Child and Family Services. A total of 90 recommendations, made by the OCA in the above noted reports, were examined. Some of the recommendations were specific to Winnipeg Child and Family Services (WCFS) while others were directed to the Department of Family Services & Housing (DFSH). Since the Shelter Review (2004), responsibility for the WCFS has shifted from an independent Board of Directors, to the Department of Family Services and Housing.

Each recommendation was reviewed with the view of reporting any changes, the progress that has been made and the degree of implementation that has occurred to date.

Goals:

- To review progress in the implementation of the recommendations made in the OCA reports: *The Hotel Review, May 2000 (unreleased)*, inclusive of a report on the quality of care in hotel placements, titled, “Just Another Kid in Care”, and *The Review of the Operation of the WCFS Emergency Assessment Placement Department (EAPD) Shelter System, March 2004*.
- To identify and assess the impact of organizational and structural changes to the Child and Family Services system in Manitoba on the implementation of the above noted recommendations.

- To provide a comprehensive written report on the impact of changes, the progress to date and the state of implementation of the above noted recommendations.
- To make recommendations on the current state of progress in addressing and implementing the recommendations from the above mentioned OCA reviews.

Significant changes to the structure and organization of Child and Family Services in the province occurred in 2004/2005 when responsibility for child and family service cases was transferred to 25 agencies providing CFS services to culturally specific population groups in Manitoba. With the transfer of cases, the EAPD or EPR program, as it became known later, remained under the direction of WCFS. However, it located with the Child and Family All Nations Coordinated Response Network (ANCR), an agency of the Southern First Nations Authority. Ultimately, the plan for the EAPD/EPR program is that it will become part of the ANRC Agency. Careful consideration was given to how these changes may have impacted the recommendations that were made in 2000 and in 2004. As a result, the progress of implementing the OCA recommendations was analyzed in terms of whether the recommendation has been implemented in full with no further action necessary, whether there has been a level of progress but implementation has not yet been completed, whether the recommendation has been incorporated into work currently underway as a result of other recommendations or whether there has been no change to the recommendation or it has been rejected. Activities associated with this portion of the review included:

- Reviewing OCA reports and the DFSH Response and Action Plan to the Shelter System Review Report.
- Reviewing other reports and documents related to the Hotel Review of May 2000 and the Shelter Review of 2004.
- Reviewing minutes of meetings of the Standing Committee and other committees actively involved in activities associated with the recommendations
- In-person meetings with relevant DFSH management and staff
- Meetings with Executive Directors, or designates, of the four CFS Authorities and the Director of the Child Protection and Support Branch

- Meetings with management and staff of the WCFS Emergency Placement Department
- Other meetings, interviews, etc. resulting from information gathered from the above meetings, readings, etc.

The Current Emergency Placement System

The second part of the Review focused on examining and reporting on the current state of emergency placements for children and youth in the province of Manitoba. Although, the WCFS emergency placement resource unit (EPR) is the most developed emergency placement system in the province, aside from emergency foster care, other child and family services agencies in the province have developed or are in the process of developing emergency placement resources for their client population groups as well. This review examined the current operations of the WCFS EPR program and other programs and initiatives developed by other CFS Authorities and agencies to address short-term, emergency care for children and youth in the province of Manitoba. Consideration was given to such issues as:

- Governance, standards, program models, operational policies and procedures and organizational structures
- An examination of staff working in emergency placement facilities, their qualifications, training, supervision, and the expectations regarding communication, reporting and documentation.
- Admission/Discharge process.
- Quality of care for children/youth residing in emergency placements. This will involve a review of medical care, school attendance, administration of medication, behaviour management, recreational activities, programs within the emergency placement resource, etc.

Goals

- To review, examine and analyse the current state of Child and Family Service emergency placements for children and youth in the province of Manitoba
- To review the provincial mandate, policies, guidelines and standards that define and guide the organizational structure and operation of Child and Family Service emergency placements
- To hear from staff working in the EPR program in Winnipeg regarding issues that may affect the placement of children and youth in these facilities.
- To provide a description of the children and youth who currently use the emergency placement system in Winnipeg
- To provide an opportunity for children and youth in emergency placement facilities to tell their stories
- To provide a comprehensive written report, including recommendations, on the current state of emergency placement programs and services to children and youth in the care of Child and Family Service agencies and government departments in the province of Manitoba

The activities associated with this part of the review included:

1. An administrative review of emergency placement programs and services in the province including a review of policy, committee and departmental reports, minutes of meetings and other relevant documentation followed by interviews with key managers and staff. Interviews were based on pre-developed questions related to policy, operations and placement decisions affecting children and youth.
2. A Staff Survey, developed by the OCA in 2002, for the Shelter Review, was administered to a randomly selected group of EPR Shelter and Hotel staff. This

Staff Survey establishes a baseline allowing for a comparative analysis to occur between staff responses in 2003 and staff responses in 2008. At the same time, using the same data collection instrument reduces design and measurement bias.

3. In addition, particular attention was given to how children and youth enter an emergency placement by reviewing day-to-day admissions through the EPR placement desk for a six-month period of time.
4. An opportunity to hear the voices of children and youth placed in emergency shelters. Both the Hotel Review of 2000 and the Shelter Review 2004 used a standard interview survey to obtain the views of children and youth placed in hotel settings and in emergency shelters. The same Survey format was used to obtain the views and thoughts of children and youth currently in the EPR shelters in Winnipeg. Interviewing children and youth in the shelter system five years after the first survey has the benefit of allowing for a comparative analysis of the information and reducing design and measurement bias.
5. The voices of children and youth should not be interpreted through the words of an adult. Therefore, the second component of this review included direct interviews with children and youth in care residing in an EPR shelter. Marie Christian, Director of Voices: Manitoba's Youth in Care Network was contracted to administer the survey questionnaire in direct interviews with a randomly selected number of children and youth in care placed in EPR shelters in the time period from April to June, 2008.

4. THE HOTEL REVIEW (2000) UNRELEASED

Previous Findings and Recommendations

The Hotel Review (2000) specifically pertained to Winnipeg Child and Family Services' (WCFS) use of hotel rooms as emergency placements for children in care. The report was complicated by the unavailability of meaningful data, which prohibited a

more detailed analysis of hotel use. Hotel placements were entered into the Child and Family Services Information System (CFSIS) under the names of children in care. This made it difficult to collect data specific to hotel use as the system categorized hotel placements as “untracked facilities” and could not break down the data into reliable reports. Some information was retrieved from Child Maintenance accounting records and resulted in sufficient information to provide several findings that were shared with the WCFS. These findings were reported in the Children’s Advocate Annual Report, 2000-2001. They included the following:

- 2,553 individual children and youth were placed in hotels by WCFS between April 1, 1995 and Jan. 11, 2000
- Children and youth in care spent a total of 61,190 days in care in hotels between April 1, 1995 and January 11, 2000
- The Agency calculated that the 1999 per diem for the hotel placement averaged \$305 per child, yet the hotel placements offered almost no resources for treatment or care of a child
- Children under the age of 12, a majority of which were under the age of 5, were most likely to be placed in hotels. Most of these children were male.
- Older adolescents were the least likely to be placed in hotels. Adolescents generally remained there for shorter periods of time than those under the age of 12. Adolescents placed in hotels were predominately female.
- The average length of stay was 18.12 days per child
- Approximately 20% of children placed in hotels were re-admitted into hotels in that same year.
- Children re-admitted into hotels were re-admitted an average of 2.5 times in that same year. These children stayed an average of 40 days over the multiple

admissions and they accounted for 50-60% of the total days in hotel care that year

- Children who experienced multiple admissions during one year stood a greater chance of being re-admitted in subsequent years. These children accounted for approximately 14.5% of all hotel admissions tracked over the period reviewed
- It appeared that staff members caring for children and youth in hotels were not likely to be Agency staff. They were employees of private companies contracted by the Agency to provide the service in the hotels
- The Agency and Department (DFSH) were unable to access statistical data regarding the use of hotel placements given the technology available to them at the time.

In addition to these findings, the OCA submitted 5 recommendations to Winnipeg Child and Family Services. These recommendations were not publicly released. The WCFS responded to the recommendations on June 19, 2000. In a letter to the OCA, WCFS Management stated:

“We concur fully with the recommendation that we develop a better means of collecting child placement data relevant and pertinent to timely case and program planning. To date, we have been hampered in this regard by restrictions placed on access to appropriate software” and expected to develop a database and create an automated system to be operational September 2000.

“the data you (the OCA) have provided, together with some profile data that we (WCFS) have assembled, has already informed us with respect to further placement resource planning” and

“the Agency has developed an action plan designed both to reduce admissions to care and to decrease utilization of emergency placement resources, inclusive of hotels”.

Winnipeg Child and Family Services made a concerted effort to reduce admissions to hotels. As reported in the Children's Advocate Annual Report 2000-2001, "the Agency provided data showing a substantial downward trend in hotel placements". By the end of January 2001, a 64% reduction in hotel usage was reported. Although not totally eliminated, hotel placements were limited to sibling groups and high needs youth requiring one-on-one care and supervision.

In a second review on hotel usage, the OCA responded to community complaints about the quality of care to children and youth placed in hotel rooms. Fifteen out of the twenty-three children placed in two hotels used by WCFS were interviewed. The findings of this review included the following:

- Children as young as three years and as old as 17 were placed in hotels.
- There was no consistency in the way children were told that they were going into the hotel. Some were told by agency workers, others heard this from other adults. One child was dropped off by a foster parent. Only four children reported being greeted by hotel staff and feeling comfortable in their first few days.
- There was little or no programming for children and youth in hotel rooms.
- Basic necessities such as food, clothing and shelter were adequately provided.
- Once the child was placed in a hotel room, contact with their child and family services caseworker was limited.
- There was no consistency in discipline and behaviour management. Most children did not know what was expected of them in the hotel placement.
- Children in hotel rooms were not informed that they could call their caseworker if they had any complaints about their care.
- Most of the children were not aware of the case plan for them

- There were apparent and evident feelings of isolation and helplessness among the adolescents. They described being bored, unheard and isolated from their support systems.
- Eight of the children interviewed had been previously placed in a hotel.
- Qualifications of contract staff varied. Most indicated that they received a brief orientation by their employer.
- Many of the staff commented on the inappropriateness of hotel placements. They noticed deterioration in children's behaviour due to the lack of consistency, programming and boredom.

As a result of the findings, the OCA made seven recommendations to the WCFS. These included:

1. Activity money should be provided based on the age, needs and interests of a child.
2. Lunch money should be provided to older adolescents, when appropriate, to allow them to eat meals outside the hotel facilities.
3. Childcare staff should be assigned to a specific child as opposed to a room.
4. Qualified childcare workers should be assigned to work with high-risk children and youth.
5. The Agency (WCFS) should provide administrative supports, including regular on-site supervision of staff, regular staff meetings, and additional training.
6. As per standards, social workers should attend the hotels to meet their wards, return phone calls and involve children and youth in case planning.

7. Children placed should be informed of the Office of the Children's Advocate existence by Agency staff.

Findings and recommendations from the above hotel reviews pertained to hotel usage by the WCFS only and did not address hotel usage across the province for children requiring emergency placements. The OCA found that it was difficult to accumulate information on hotel placements in other parts of the province, as CFSIS information was not available in some geographic locations in the province, or was not utilized in tracking hotel placements. This was further complicated by the fact that hotel placements were listed under a category called "untracked facilities", which included other placement resources as well.

The data used for information and analysis in this review was obtained from the DFSH hotel placement tracking database, the WCFS Emergency Placement Resource (EPR) Systematic Tracking of Emergency Placements (STEP) database and the WCFS Child Maintenance System. All the historical information on hotel use was obtained from the WCFS STEP database as the DFSH only started to track children in hotel placements in 2005. This is by no means a comprehensive account of hotel usage by all child and family services agencies in the province. Some agencies make their own arrangements for hotel placements for children in their care. Although these arrangements must be reported to the DFSH, there are gaps in the information for the years prior to 2004/05.

Update on the Recommendations

It has been eight years since the OCA completed two reviews on the use of hotels as emergency placements for children in care and made recommendations to reduce and eliminate the use of hotels for child placements. Many of the concerns identified by the OCA, at that time, were related to the lack of standards that monitor the quality of care provided to children and youth in hotel placements, the use of purchased-service staff to care for children and youth with high needs and the lack of programming and scheduled routines and structures in hotel placements. During the review in 2000, the OCA found little information to guide the process of placing children in hotels rooms

and no tracking system for collecting information on who was admitted to a hotel, their needs and their length of stay. There was no system in place to address when and how hotels would be used for emergency placements, and most concerning, there were few policies that dealt with the quality of care for children placed in hotel rooms. Also concerning was the high cost of care for children in hotels. As the OCA reported in 2000, the per diem cost for a child was \$305 for each day that the child remained in the hotel placement.

The OCA completed a second review in 2000 on two hotels used by the WCFS for emergency placements for children and youth. This review primarily consisted of interviews with children residing in these hotels and resulted in several recommendations that were included in the Office of the Children's Advocate's Annual Report, 2000/2001. These recommendations pertained to the quality of care children were provided while in a hotel placement. To obtain a progress and status report on these recommendations, interviews were held with coordinators, supervisors and managers with the WCFS EPR unit. Questions on hotel use were asked during interviews with a selected group of shelter staff who had, at one time, worked as child care support workers with children in hotel placements. At this time, regular WCFS shelter staff do not work in hotels. If a hotel placement is required, staffing resources are purchased from private home care or health care organizations.

Although the initial Hotel Review (2000) was not released publicly by the OCA, some recommendations were made to the WCFS. Both the OCA and the WCFS concurred with the goal of eliminating the placement of children in hotels completely. A decline in hotel use was noted in the two years following the report, but hotel use picked up again in 2003/04 and rose steadily until the Child and Family Services Standing Committee introduced a strategy in November 2006, to reduce and eliminate the use of hotels as emergency placements for children in care.

Since the implementation of this strategy and the development of a Hotel Placement Standard, the placement of children/youth in hotel rooms has declined. As a result, most of the information below pertained to a period of time when hotel use was more frequent. To identify and update progress on the recommendations from the

previous reviews, the OCA recommendation will be restated and an update on progress and status will follow. The OCA recommended that:

- √ “Activity money should be provided based on the age, needs and interests of a child”.

Senior staff with the EPR unit advised that all children in emergency care, whether in a hotel or a shelter receive a standard weekly personal allowance set by the WCFS; children between the ages of 0 – 11 years receive \$5.00 a week and children from 12 – 17 years receive \$10 a week. Like children in shelter care, those in hotels can earn added money by participating in completing chores, homework, etc. Rates for personal allowances are not set in the provincial funding guidelines but are left to the discretion of agencies. Money for activities is allocated by the number of children in hotels, their ages and abilities. Generally activity money is distributed by the Coordinator from a budget maintained for that purpose. Activity funds are limited and therefore, activities are restricted to free and low cost events.

The OCA recommended that older adolescents in hotel placements should be provided with lunch money;

- √ “Lunch money should be provided to older adolescents, when appropriate to allow them to eat meals outside the hotel facilities”.

Senior staff advised that lunches are provided for children in hotel placements and that bagged lunches are made for children that attend school or participate in other day programs. The children that are not in a day program are provided lunches or given a bagged lunch if they request this. Additional money is not provided for older adolescents to eat lunch outside the hotel facility.

While conducting interviews with children residing in two specific hotel placements in Winnipeg in 2000, the OCA heard reports from children about being verbally threatened into compliance, subjected to physical restraints, and confined to hotel rooms by staff. Some children complained about being sworn at by staff. The

OCA reported that children placed in hotels demonstrated an apparent and overwhelming feeling of isolation and helplessness and recommended that:

- √ “Childcare staff should be assigned to a specific child as opposed to a room”.

Senior EPR staff advised that, currently, purchased service staff are primarily used to care for children in hotel placements due to the shortage of staff in EPR shelters. As there may be more than one child sharing a room, or a sibling group, it would not be feasible to have more than one child care support staff in the same room. At the same time, EPR staff advised that often children are placed in hotels with one-to-one child care support staff because of their high needs. Purchased service staff work 8-hour shifts, therefore, at least three child care providers are caring for a child in a full day. EPR Coordinators advised that they use the same purchased child care providers on a regular basis to try to ensure as much consistency for children in hotel placements as possible. Child care providers continue to be assigned to rooms instead of being assigned to a specific child, unless, the child requires one-on-one support and there are no other children occupying the hotel room. It doesn't appear that much has been done to alleviate the isolation and sense of helplessness reported in the previous review. Hotel placements remove youth from social interactions simply by the nature of the placements. If several children are in hotel placements, some staff make efforts to involve all the children in activities, however, as there is no structure or programming to guide this, social contact and interactions are really a “hit and miss” state of affairs.

In the review in 2000, the OCA noted that several children placed in hotels had very high needs, with at least two children requiring mental health services. It was recommended that”

- √ “Qualified childcare workers should be assigned to work with high risk children and youth.”

EPR unit coordinators advised that qualified child care staff are needed as much in shelter facilities as in hotel rooms. There is a shortage of qualified child care support staff available for employment and purchased service staff are used in both the shelters

and hotels to fill staffing needs. The use of purchased service child care staff is a necessity and, while there is concurrence, that this is not the best possible option for meeting the high needs of many children in hotel placements; it is also the current reality. Some children and youth with high needs may require the presence of more than one care provider. According to EPR coordinators and staff, double-staffed shifts are not unusual in hotels. For children requiring specialized medical care, the EPR unit purchases the services of Health Care Aides to provide the specialized care. Health Care Aides only focus on the medical or special care needs of the child and, therefore, work alongside a child care provider.

During the Hotel Review 2000, the OCA found that limited supervision and support was provided to staff working in the hotels and recommended that:

- √ “The Agency should provide administrative supports, including regular on-site supervision of staff, regular staff meetings and additional training.”

The WCFS responded to this recommendation by assigning all responsibility for coordinating and monitoring hotel placements to one hotel coordinator. This increased the amount of time supervisory staff can be available to child care staff/purchased service staff working in hotels and ensured some degree of consistency in the management of hotel placements. The hotel coordinator met weekly with staff working in hotels, responded to issues raised by child care staff, caseworkers, purchased service agencies and the children in hotel placements. The hotel coordinator continues to be a part of the EPR unit although hotel usage has decreased significantly in the past year.

In addition to finding concerns about the care provided to children in hotel placements, the OCA heard from the children and staff that caseworkers were rarely present in the hotels to meet with their children in care, respond to issues and develop case plans. One-quarter of the children interviewed by the OCA in 2000 reported that they had not seen their caseworker at all since being placed in the hotel. The OCA concluded that it appeared that the longer a child was placed in a hotel the less often the worker attended the hotel to see the child. As a result, it was recommended that:

- √ “As per standards, social workers should attend the hotels to meet their wards, return phone calls and involve children and youth in case planning”.

According to Child and Family Service Standards, caseworkers should minimally have one to one contact with a child in care in their place of residence on a monthly basis. The Place of Safety Standards, that regulate the placement of children in hotel rooms, state that a caseworker must visit the place of safety residence or facility two working days after the placement of a child.

EPR staff report that contact with the children in hotel placements, by their caseworkers, continues to be a concern. All report that there is no consistency to the amount of contact that caseworkers have with children in emergency placement facilities. Child Care Support Workers that participated in an interview for this review reported many concerns about the lack of involvement of caseworkers once a child is in a placement facility. Many reported that caseworkers were difficult to reach and did not promptly return telephone calls. Although, many staff had concerns about the contact with caseworkers, all indicated that some caseworkers spent an exceptional amount of time with children in emergency placements and were responsive to issues involving the children. It appears that the level of contact between children in care and their caseworkers varies considerably and appears to be dependent on the priority the caseworker gives to this activity. Child and Family Service Standards clearly outline the frequency of contact caseworkers should have with children in care. Not only are the reports by child care support staff about the inconsistencies in contact between children in care and caseworkers concerning, this issue requires further investigation to determine why compliance with standards is not consistent. Children in care should have regular contact with their caseworkers at all times. The caseworker is often the only connection children in care have with their families and their lives before entering care and the caseworker is highly influential in the outcomes for the children. If the caseworker is not having regular contact with a child in care, then the child is not involved in plans around his or her future. The child is in limbo, with no idea or control of what the future plans will be.

The final recommendation the OCA made to WCFS regarding the use of hotels as placement facilities for children was that;

- √ “Children placed should be informed of the Office of the Children’s Advocates existence by Agency staff”.

Staff reported that OCA brochures and posters were posted in some hotel rooms at one time, but due to children coming and going and hotel rooms changing, it was difficult to maintain this practice. At this time, staff report, that no material regarding the OCA is available to children placed in hotel rooms.

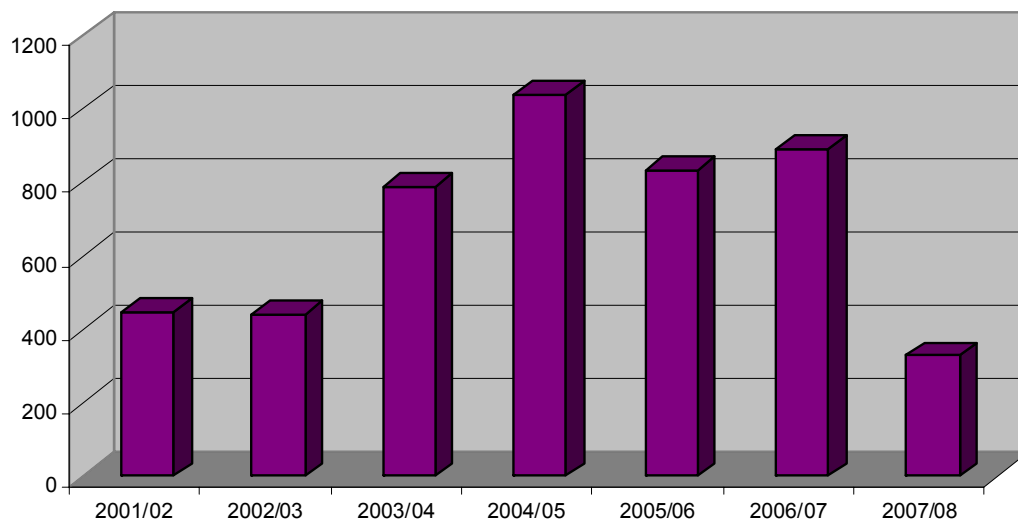
Several childcare support staff participating in an interview for this review reported that they worked in hotels prior to employment in the shelters. Most stated that caring for children in hotel rooms was a difficult task with overcrowded conditions, too much free time for children and limited resources available to engage in activities with the children. Several staff referred to the high needs of children in hotels and reported working with purchased service staff because two staff had to be present to care for children who were sex offenders or fire starters, and required 24 hour supervision. Staff reported that few children in hotel placements attended school or were involved in day programs. Financial limitations restricted opportunities to involve children in meaningful recreational activities and limited staff to taking children to inexpensive or free activities or events.

Hotel Usage - The Next Seven Years

In the Annual Report, 2000/2001, the OCA stated that WCFS reduced hotel usage significantly and by the end of that fiscal year showed only 29 children in hotels. This showed cause for optimism that there were alternatives to hotel placements and that the agency was well on its way to eliminating hotel use. Unfortunately, this trend did not continue and the next seven years saw a steady reliance on the use of hotels for emergency placements. The WCFS Emergency Placement Resource (EPR) unit uses a tracking system to collect information on the number of children placed in hotels. The Systematic Tracking of Emergency Placements (STEP) database is used to track all children in the emergency placement system, including children in hotels. According to

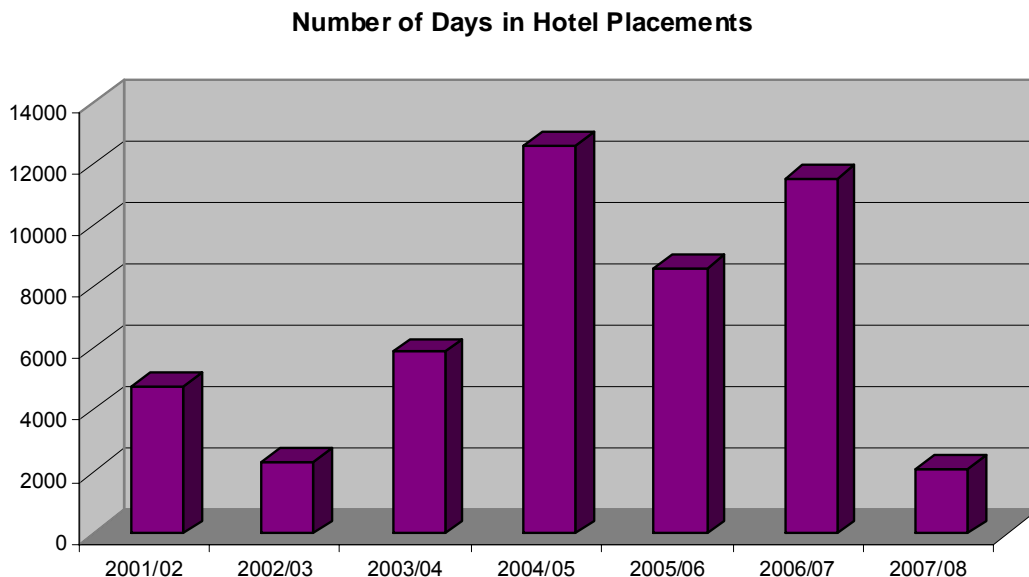
data obtained through the EPR STEP database and the WCFS Child Maintenance System, both the number of children and the number of days spent in hotel care continued to be significant over the years until a directive was issued by the Standing Committee in the fall of 2006, setting a date for all children to be removed from hotels. It should be noted that there is a discrepancy in the total number of days in hotel placements between the data from the EPR STEP database and the WCFS Child Maintenance System. While the STEP database shows that 57,203 days were used by children in hotel placements during the seven-year time period from 2000/01 to 2007/08, the Child Maintenance System shows the number of days spent in hotel placements for the same time period to be 53,729. This is a difference of 3,474 days. This discrepancy has been noted by the WCFS senior financial staff. For the purpose of this part of the review, the days in hotel placements reported by the Child Maintenance System will be used because this database provides the information that the cost of hotel placements are based on.

Number of Children in Hotel Placements



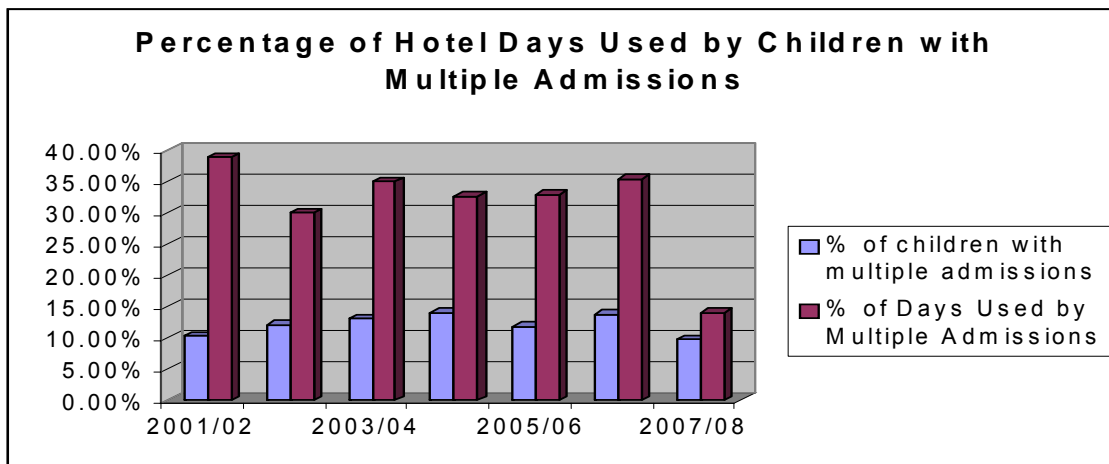
A total of 4806 children and youth were admitted to hotel placements by the EPR unit over the seven-year period between 2000/01 and 2007/08. These admissions totalled 53,729 days in hotel placements. The significant reduction in the number of children in hotels in 2007/08 can be attributed to the Hotel Reduction Strategy and the Hotel Placement Provincial Standard, which, effective August 1, 2007, called for the removal of all children from hotels. This strategy will be discussed later in this report.

The number of children admitted into hotels is not always reflected in the number of days spent in hotels. While some children stay in a hotel placement for a day or two, others may stay in hotels for several months at a time. For example, in 2001/02, 449 children were placed in hotels and spent 4,766 days in hotel care. While in 2002/03, 443 children spent only 2,344 days in hotel care. As a result, the number of days in care is a significant indicator of hotel usage. Children in the age category of 0 – 4 years made up 33% of the total number of admissions to hotels, but used only 22.6% of the total days in hotel placements, while adolescent youth in the age category of 12 – 18 years made up 38% of the admissions, but used 55.5% of the total days in hotel placements.



The low number of days care in a hotel placement for the 2007/08 fiscal year can again be attributed to the Hotel Reduction Strategy and the dedicated effort to ensure all children were moved from hotels by July 31, 2007.

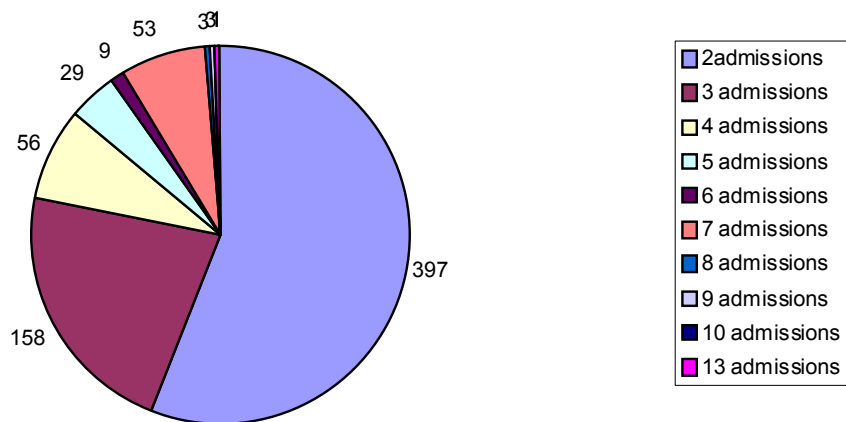
The high number of multiple admissions into hotel care was well documented in the first review of hotel use. The OCA found that approximately 20% of the children placed in hotels were readmitted into the hotel two or more times. These children make up a high percentage of the actual days care because they tend to stay in the hotel for a longer period of time. The current review found that 12% of the children placed in hotels were readmitted anywhere from 2 to 13 times. This 12% of children accounted for 30% of the total days in care in a hotel placement.



Over the years the number of children and youth with multiple admissions ranged from 10.5% in 2001/02, 13% in 2003/04, 11.8% in 2005/06 and 9.7% in 2007/08. While this number remained relatively constant, the number of days that the children with multiple admissions used in hotel placements was considerably higher. As reflected above, in 2001/02, the 10.5% of children with multiple admissions used 39% of the total number of hotel days in that year. In 2003/04, 13% of the children with multiple admissions used 35% of the total hotel days, in 2005/06, 11.8% of children with multiple admissions used 33% of the total hotel days and in 2007/08, 9.7% of children placed on more than one occasion in a hotel placement used 14% of the total hotel days. The data for the 2007/08 fiscal year reflects a time period of four months before all children were moved from hotel placements by the end of July 2007.

The number of times that children and youth were readmitted to hotels ranged from 2 to 13 times with the majority of children having two admissions. Those with two admissions made up 59% of the total days in hotel care by children with multiple admissions. Another 29% of children were admitted on three occasions, 9% of children were admitted on four occasions and 8% of children had five or more admissions to a hotel placement.

Multiple Admissions to Hotel Placement



The Children in Hotel Placements

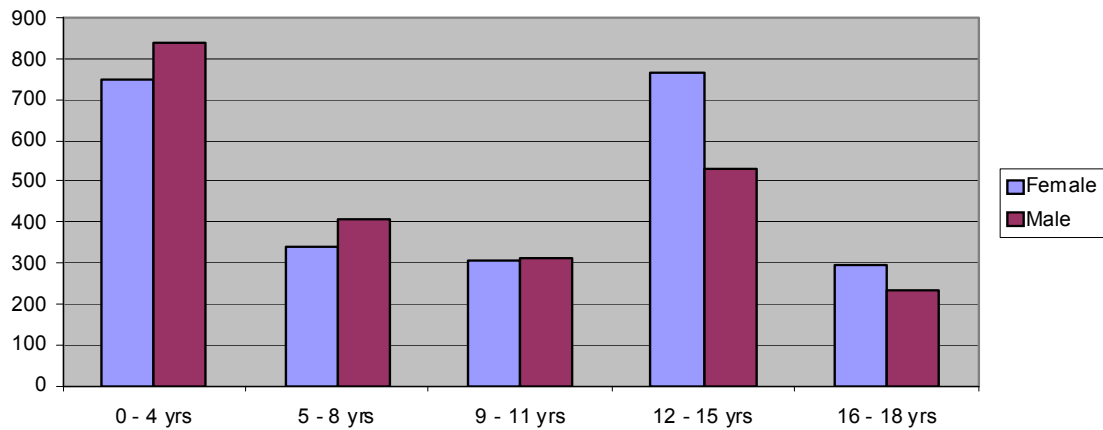
From the discussions with staff and managers working in the emergency shelter system, it appears that children and youth in hotel placements can be categorized in one of two situations; children/youth with special/high needs that preclude them from living with other children in foster or group care, or children that are part of larger (3 or more) sibling groups.

The children or youth in the first category usually have distinct behaviours that make them a threat to other children and, as a result, should not be placed in group facilities where other children may be at risk of harm. Many of the youth are violent, gang involved and/or dependent on substances. They make up much of the multiple admissions into hotels as they move from correctional facilities, crisis stabilization units and the child and family services system. Many of the youth in this category do not remain in placements, but frequently leave without permission (AWOL) until located by police services and returned to a correctional facility and discharged back to child and family service agencies. For the most part, these youth do not make use of treatment resources, may not be cooperative with casework plans and belong to a gang culture that discounts efforts to assist them in stabilizing their lives.

Admission to a hotel placement is considered a better option for sibling groups than separating them when they come into care, as most foster homes do not have the capacity to accommodate a large number of children at one time. In a hotel placement, the siblings can remain together until longer-term plans are made for them. This view is reasonable, as the trauma of being removed from their parental home would only intensify if children were also separated from their siblings. Once sibling groups are admitted into a hotel placement, the length of time that they remain in this setting is often dependent on the casework plan. If the plan is to return children to their parents or family members, the length of stay may be consistent with the amount of time a parent(s) requires to make the necessary changes to have the children returned. On the other hand, if the children will remain in care for a while, the onus is on the caseworker and the agency responsible for the children to locate a suitable alternative placement for the children. Staff working in the emergency placement unit report that the length of time children remain in either a hotel or shelter placement is highly attributed to the priority that the caseworker gives to moving the children and the availability of an appropriate longer-term resource. They report that some caseworkers are concerned about hotel placements and move quickly to find suitable alternatives while other caseworkers are less concerned about moving children promptly from hotel placements.

In the previous hotel review, the OCA found that children under the age of 12, a majority of who are under the age of 5, are most likely to be placed in hotels and that the gender of the majority of these children is male. Consistent with the previous review, the current review found that 62.5% of children placed in hotels were under the age of 12 years, and 33% of the children were under the age of 5. However the gender distribution was almost equal, with female children making up 51% of the total and male children 49% of the total number of children in hotel placements.

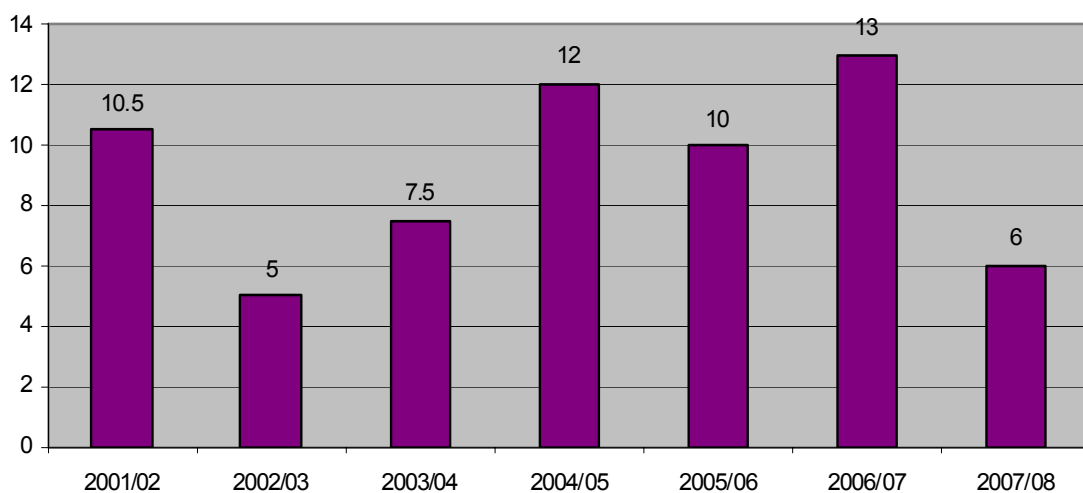
Children in Hotel Care by Gender and Age



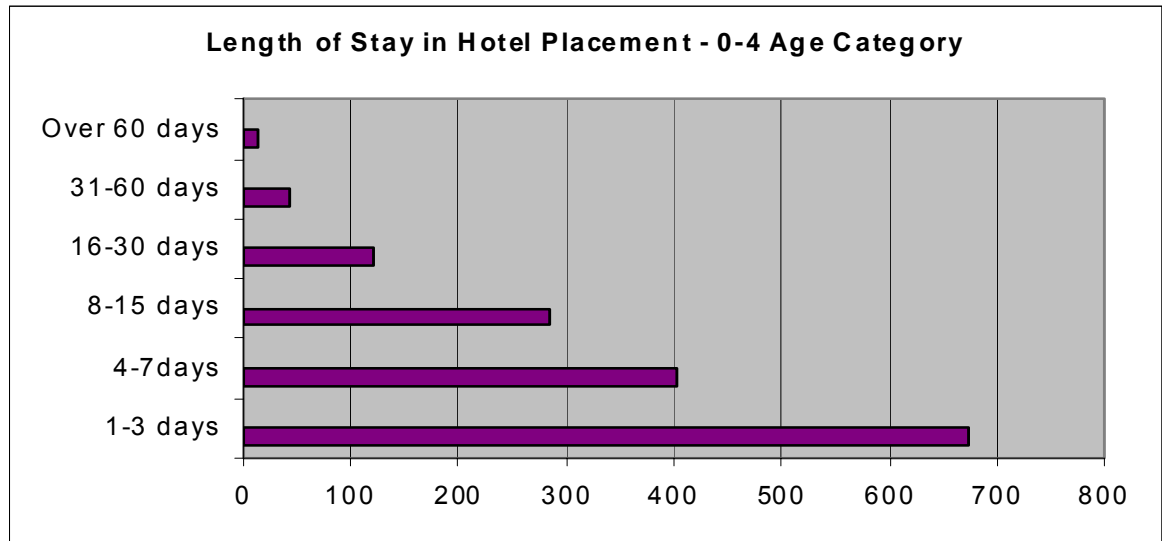
Average Length of Stay (Days)

The earlier Hotel Review (2000) found that children were staying an average of 18.12 days in hotel placements per admission. The number of days in hotel placements has been reduced by approximately 50%, with the average hotel stay being approximately 9 days.

Average Length of Stay in Hotel Placement



Most children enter a hotel placement for one or two days, then are moved to another placement. Yet, some children remain in hotel placements for much longer than three days. A number of children in this age category reside in hotel placements for a concerning length of time ranging from one week to a few months.



As indicated earlier, 33% of children placed in hotels at admission to the EPR emergency placement system were under the age of 5 years. In this age category, 44% of those children stayed in a hotel placement for 1 – 3 days, 26% stayed for 4 – 7 days, 18% for 8 – 15 days and 8% for 16 – 30 days. Another 4% of children stayed in a hotel placement for over 30 days while 1% remained for over 60 days. In this age category, five children under the age of 1 year had a combined total of 714 days in hotel placements. This amounts to 18% of the total length of hotel placements for children under the age of 1 year.

Children between the ages of 0 – 1 made up 50% of the total days in hotel placements for this age category. While these infants were part of sibling groups, it is difficult to comprehend infants and young children being cared in hotel rooms for long periods of time. Children in the age category of 0 – 4 years, who were in hotel placements for 30 days or more, were compared by Child and Family Service Authority. It is important to note that this data is limited to hotel placements arranged through the WCFS EPR unit and dates back to 2001/02. The First Nations and Metis Authorities did not assume responsibility for child and family service cases across the province until

2004/05. As a result, it is not surprising that from the available data, the length of stay for children in hotel placements is considerably higher for the General Authority. Furthermore, the following information does not reflect hotel placements arranged by child and family service agencies outside the WCFS emergency placement system.

Hotel Placements of 30 days or more by Authority

| | Southern Authority | Northern Authority | General Authority | Metis Authority |
|---------------------|-------------------------------|-------------------------------|------------------------------|------------------------|
| Age of Child | Total Days Use | Total Days Use | Total Days Use | Total Days Use |
| > 1 | 88 | 101 | 1395 | 44 |
| 1 | 79 | 99 | 508 | 43 |
| 2 | 82 | 32 | 166 | 43 |
| 3 | 73 | 372 | 129 | 43 |
| 4 | 36 | 0 | 120 | 0 |
| | 358 | 604 | 2318 | 173 |

A total of 63 admissions of children in the age category 0 – 5 years showed lengths of stay in a hotel placement exceeding 30 days. These children's stay totalled 3453 days of hotel use, which is 28.5% of the total days in hotel placements for children in this age category.

In the earlier review of the hotel system, the OCA found that adolescents were the least likely to be placed in hotels, and if placed in hotels, adolescents generally remained there for shorter periods of time than those under the age of 12. This finding was only partially substantiated in this review. While only 38% of all children/youth admitted to hotel placements were between the ages of 12 – 18 years, this age category was also responsible for 55.5% of the total number of days spent in hotel placements. More youth in this age category remained in hotel placements for longer periods of time than any other age group. A total of 259 admissions, or 14% of youth admitted to hotels remained in the placement for over 30 days with an average length of stay in a hotel placement being 63.6 days. A total of 48.8% of days spent in hotel placements involved

youth who stayed in the placement for 30 or more days with 15-year-old youth accounting for the longest number of days in hotel placements.



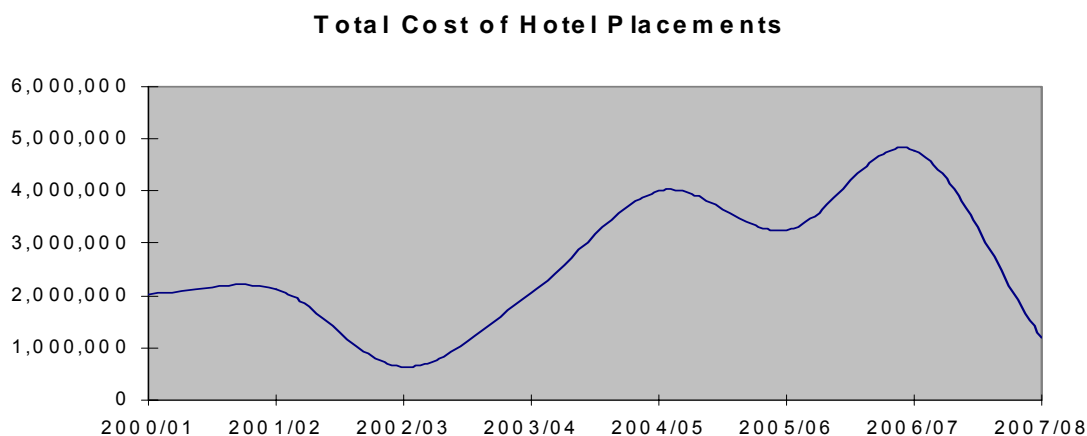
The Cost of Hotel Usage

The monetary costs attached to hotel placements are significant. During the first review of the hotel placement system in 1999, the OCA found that the per diem cost was \$305 per child for each day in a hotel placement. Over the years the per diem cost has risen along with the total costs associated with using hotel placements. The use of hotels to care for children needing emergency placements is not uncommon in many parts of the province by a number of child and family service agencies. The following costs reflect the use of hotels for placements of children, arranged through the WCFS Emergency Placement Unit, for WCFS until 2003/2004 and for all agencies providing child and family services in Winnipeg after the AJI-CWI case transfer process in 2004/05. The WCFS EPR system manages the costs of hotel placements arranged through the emergency placement system regardless of which agency is responsible for the child.

Total Cost of Hotel Placements Per Year

| | |
|-----------|-----------|
| 2000/2001 | 2,027,266 |
| 2001/2002 | 2,109,213 |
| 2002/2003 | 625,578 |
| 2003/2004 | 2,054,382 |
| 2004/2005 | 3,995,883 |
| 2005/2006 | 3,238,734 |
| 2006/2007 | 4,772,169 |
| 2007/2008 | 1,180,072 |

Costs associated with hotel use were predominantly around 2 million in 2000/01 and 2001/02. A significant drop in hotel use costs occurred in 2002/2003 when the total cost of hotel placements dropped to \$ 625,578. This reduction can likely be attributed to the release of the Office of the Children's Advocate's 2000/2001 Annual Report calling for an end to using hotels as emergency placements for children in care, and the increase in the number of emergency shelters developed by the WCFS EPR unit. In 2003/04, the cost of hotel use returned to the 2 million point and increased in the following three years until it reached 4.8 million in 2006/2007. In 2006, the CFS Standing Committee took action to reduce and eliminate the use of hotels by implementing policy and establishing action-driven teams to work on moving all children from hotels, developing additional emergency resources and working on a comprehensive foster home recruitment and retention strategy. This action resulted in a reduction in hotel usage costs to 1.2 million in 2007/2008.



Per Diem Cost

Through the AJI-CWI planning process, the EPR unit was designated to become part of the Winnipeg Intake system, now known as All-Nations Coordinated Response Agency (ANCR). Consistent with the mandate for ANCR, the EPR system would also have a coordinated responsibility for emergency placements of children from all child and family service agencies providing services in Winnipeg. As a result, with the case transfer process in 2004/2005; the costs of caring for children in hotel placements became the responsibility of the EPR program. These costs are inclusive of all expenses associated with a child's care in a hotel placement, including the hotel room cost and the cost of staff providing care to the child. Child and family service agencies caring for the child are responsible for basic child specific costs.

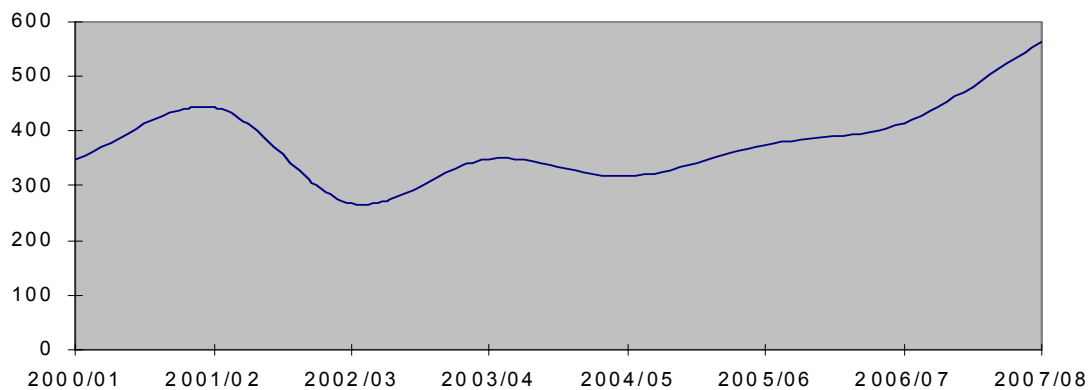
The *Child and Family Services Agencies Funding Guidelines (July 2005)* establish the criteria for agencies to use when determining costs related to children in care. This document does not provide a funding guideline for children in emergency hotel or shelter care, with the exception of discussing the process to bill the DFSH for children that are designated to have Level V needs. While hotel costs are included in the EPR budget, child specific costs are not and must be billed directly to the Child Maintenance Budget. Generally, the cost of caring for children is calculated on a per diem basis for each child. The following table reflects the cost of caring for one child for one day in a hotel placement over the years.

Per Diem Cost of Hotel Placements Per Child by Year

| | |
|-----------|-----------|
| 2000/2001 | \$ 347.13 |
| 2001/2002 | 442.55 |
| 2002/2003 | 266.88 |
| 2003/2004 | 348.44 |
| 2004/2005 | 316.88 |
| 2005/2006 | 374.46 |
| 2006/2007 | 414.14 |
| 2007/2008 | 561.67 |

Clearly, the cost of caring for children and youth in hotel placements is exceptionally high, and presents another good reason for action to reduce and eliminate the use of hotels as emergency placement resources for children in care.

Per Diem Cost of Hotel Placements



The Hotel Reduction Strategy

On November 23, 2006, the Child and Family Service Standing Committee announced the development and implementation of a hotel reduction strategy with the goal to eliminate hotel placements for children/youth in care, by July 31, 2007, except in exceptional circumstances. This followed an earlier announcement by the Minister of

Family Services and Housing to target 6.1 million dollars specifically for the development and retention of new foster homes in the province. Three teams, with representatives from each Authority, were developed to work on this task.

Team 1. The Hotel Reduction Team was established in the spring of 2007 to work within a 6-month time frame to identify, track and work with agencies to locate suitable placements for all children currently in hotel placements.

Team 2. The Resource Development Team was established to develop resources that would reduce the use of hotels as emergency placements for children in the long term.

Team 3. The Foster Care Recruitment and Retention Team was established to increase the number of existing foster care bed spaces in the province for children.

In addition, new hotel admissions would be subject to a protocol and procedures designed to reduce the number and length of admissions.

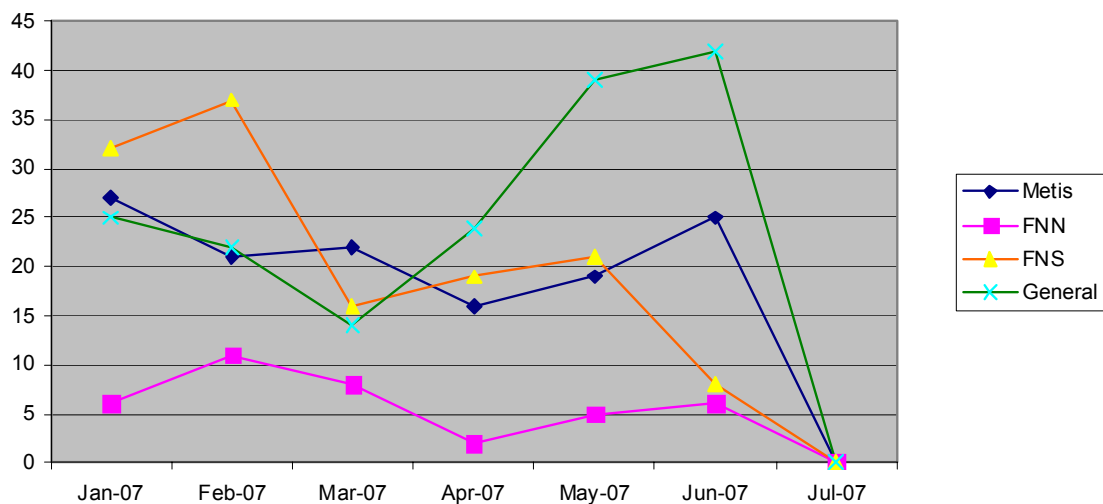
The Hotel Reduction Process

The hotel reduction team was made up of representatives from each Authority with each representative charged with the responsibility to work with the child and family service agencies responsible to it, to locate alternative placements for children and youth placed in hotels. According to data made available through the DFSH, a total of 66 children were in hotel placements at the end of January 2007. This number differs from numbers provided by Authorities. For example, in reports obtained from two Authorities; the General Authority reported 25 children in hotels in January while the DFSH listed the number at 14, similarly, the Metis Authority reported 27 children in hotels in January and the DFSH listed 14. It is a difficult process to obtain accumulative numbers for children in hotel placements because of the rapidly changing status of the children. Some children may be placed in a hotel, then moved the same day and return again in three days, therefore, the number of children in hotels may include multiple admissions resulting in the same child being counted twice. The DFSH is dependent on the information that is made available to them. The hotel reduction team tracked hotel

admissions on a daily basis showing the number of children entering and leaving hotel placements every day ensuring increased accuracy in the available data.

Between January and July 2007, the hotel reduction team worked to move children out of hotel placements across the province. In addition to the hotel placements, arranged by the EPR Placement Desk in Winnipeg, children were placed in hotels in other parts of the province, including central and northern communities. It was expected that a gradual reduction in hotel use would begin during this time and continue until no children were left in hotel placements. Hotel usage began declining with the exception of some increase during the months of May and June. By July 31, 2007 it was reported that no children were in hotel placements in the province.

Number of Children in Hotel Placements by Authority



Along with actively working to move children out of hotel placements, the Authorities issued directives to their agencies in July 2007, establishing the terms and conditions of hotel use in exceptional circumstances as outlined in the new provincial standard for hotel placements (Appendix I). This provincial standard, effective August 1, 2007, states that hotels are not to be used as placements for children except:

1. in the case of flood, fire, other natural disasters or community crisis that require the evacuation from the residence to ensure the safety of children, or

2. in the case of a public health issue that requires quarantine, restricted movement of affected individuals, or removal from an affected area, to prevent the spread of disease or other serious health conditions, or
3. in the case of sibling groups where there are 3 or more children and there is no other option available to place the children together.

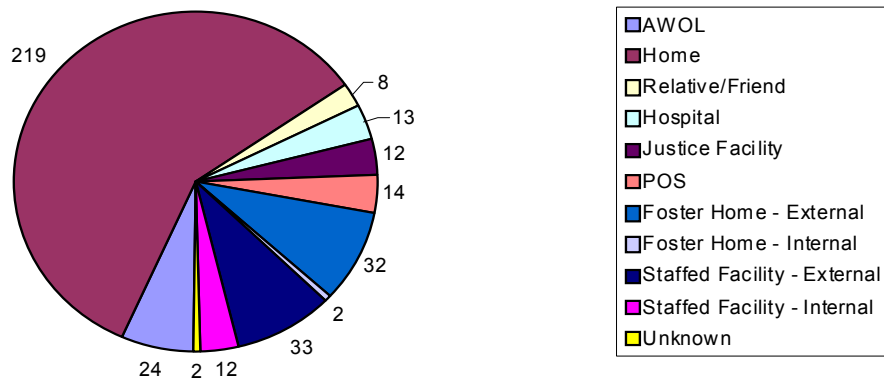
The CEO's from the four Authorities and the Acting Executive Director of the Child Protection Branch signed the provincial standard on hotel placements. It took effect on August 1, 2007 and was subject to a review within six months from the effective date. The standard was reviewed on Oct 3, 2007 and the policy was amended by removing the number of children in a sibling group. The original policy stated the sibling group included at least three children. It was thought that this restriction was not in keeping with the principle that siblings be placed together so the number in the group was removed. The hotel placement standard remains in effect at this time.

Where did the children go?

According to the DFSH database on hotel usage, approximately 370 children were moved from hotel placements between January and July 2007. The General Authority reported that over 50% of the children admitted to hotel placements by their agencies were previously in care. The Metis Authority reported that 66% of the children in hotel placements, in the care of MCFCS, were between the ages of 12 and 17 years. Twenty-four of the total number of children had been in a hotel placement for more than 30 days with one child showing over 90 days in a hotel placement and another showing 170 days. Eighteen children had multiple admissions; 16 of those children had two admissions, one child had three admissions and one child had four admissions. A total of 172 children in hotels were part of sibling groups. According to information obtained from the General Authority, agencies responsible to the General Authority had a total of 14 sibling groups in hotel placements; six sibling groups consisted of two members, six others consisted of three members, one consisted of four members and another of five members.

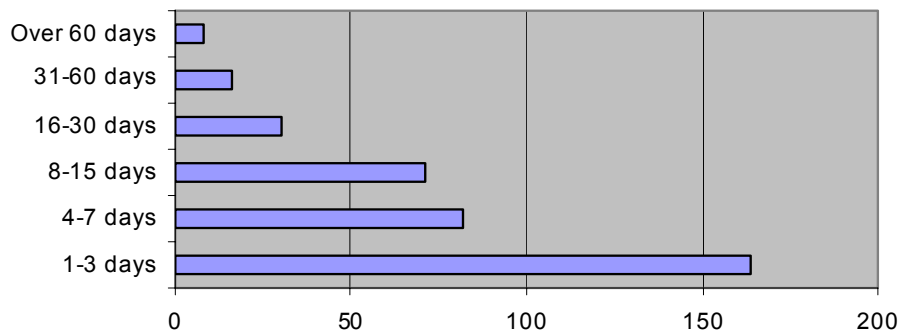
The majority of the children were admitted to a hotel placement directly from the community, from their home or after staying with a friend or relative. However, 25% of admissions were by children who were previously residing in a place of safety residence, a foster home or a staffed care facility.

Residence Prior to Admission to Hotel



The majority of children in hotel placements during this period of time (67%) stayed for less than seven days. Another 27% stayed for up to 30 days and 6% of the children stayed in a hotel placement for over 30 days.

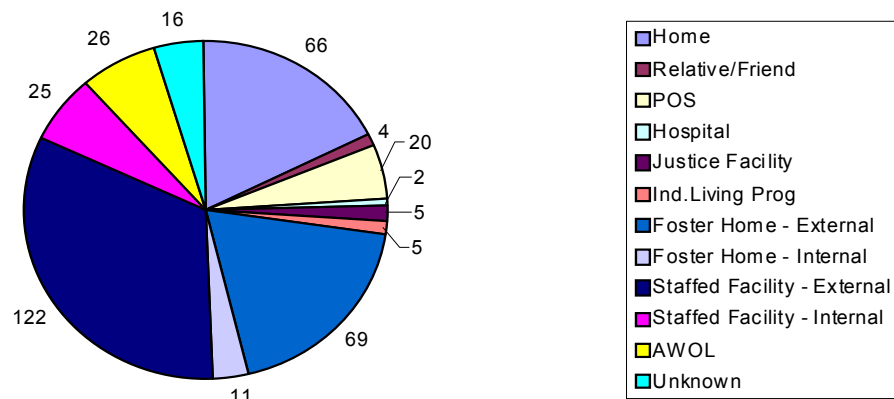
Length of Stay in Hotel Placement January - July 2007



With the announcement that all children will be moved from hotel placements by the end of July, came public concerns about the haste in moving the children and questions about where the children will be moved. Some of these concerns were brought to the attention of the OCA. Considering that hotel placements were a “last resort” because no other placement options were available, it is only reasonable to be concerned that moving children as a result of policy implementation may not take their best interests into consideration. According to data available from the DFSH, children and youth were moved from hotel placements as follows:

- 38% were moved to internal or external residential placement facilities.
- 21% were placed in foster homes.
- 20% were returned to their family or placed with a relative, friend, or independently in the community.
- 7% were placed in a Place of Safety (POS).
- 3% were admitted to a mental health or corrections facility.
- For 11% of the children and youth, it was difficult to determine their whereabouts as there was no data available.

Residence at Discharge from Hotel Placement



As a large number of youth with high needs were in hotel placements at the time of the hotel reduction strategy, the OCA was interested in the success of the youth who had been in hotel placements for over 30 days. Follow-up information on these youth was obtained from the Child and Family Services Information System (CFSIS) in May 2008, to determine their current whereabouts and their progress following discharge from a hotel placement during the hotel reduction strategy. A total of 24 youth had spent over 30 days in a hotel placement prior to being moved as a result of the Hotel Reduction Strategy. The CFSIS system contained no information on six of the youth and, therefore, no follow-up was possible. Five youth returned home and had no further admissions to care and four others were placed in successful placement resources where they currently remain. Nine youth went through a series of changes, placements and AWOL's after discharge from the hotel.

Youth #1 This 14 year old youth had two admissions to a hotel placement between January and July 2007. The first admission was a result of a placement breakdown in an external staffed residential facility. The youth remained in a hotel placement for 27 days before being moved to an external foster home. In less than a month the foster home placement broke down and the child was returned to a hotel where he stayed for 3 days before being moved to an emergency shelter. He stayed in the shelter for several months with, intermittent moves to the Crisis Stabilization Unit. In March 2008, this youth was moved to a foster home again, which did not last very long. Interestingly,

according to CFSIS data, this youth was placed in a hotel again as recently as this spring after the foster home breakdown.

Youth #2 This 16 year old youth had been in a hotel placement for 35 days after a foster home break down and was discharged to an external independent living program. Shortly afterwards, he was placed in a foster home, was found at the Youth Resource Centre on Mayfair, and returned to the foster home. He was discharged from care when he reached the age of majority in Oct 2007.

Youth #3 This 15 year old youth was in a hotel placement for 30 days after a placement in an external shift-staffed residential facility broke down. She was discharged from a hotel placement to the Manitoba Youth Centre (MYC). To date she has had 11 placement changes, including staying with a POS, staying at the MYS Youth Resource Centre on four occasions, two EPR Shelters, two other POS's, and an EPR Shelter again, until April 2008 when she left the shelter. No additional data was available.

Youth #4 This 14 year old youth had two admissions to a hotel placement totalling 30days. The first admission was short and the youth returned home where she remained for six weeks before returning to a hotel placement. She was discharged to Ndinawemaaganag Endaawad (Ndinawe) where she engaged in a pattern of running and returning to care. Between June 2007 and April 1st 2008, when she went AWOL, this youth went from Ndinawe to an emergency shelter to another emergency shelter to AWOL to Ndinawe to AWOL to an emergency shelter and AWOL again. According to CFSIS information, she remains AWOL.

Youth #5 This 16 year old youth had four admissions to a hotel between January and July 2007, staying a total of 197 days. He was placed in a hotel after a placement breakdown at an external shift-staff residential care facility. This youth was placed at the MYC from his last hotel placement. In Sept 2007, he was admitted to hospital and there is no further recording in his child in care file on CFSIS.

Youth #6 This 16 year old youth was admitted to a hotel placement due to a breakdown in the external shift-staff residential care facility she was living at. She

remained in the hotel placement for 35 days and was discharged to an external residential care facility where she remained until she reached the age of majority.

Youth #7 This youth was 14 years of age when he was placed in a hotel following discharge from the MYC. He remained in the hotel for approximately 30 days before being moved to an emergency shelter. Since then, this youth has had a series of moves, including several in the corrections system. Between Jan 2007 and the present, this youth has moved from an emergency shelter to AWOL to MYC to an emergency shelter where he stayed for 10 days to MYC to AWOL to MYC to the Agassiz Youth Centre to a foster home from where he went AWOL on three occasions. No further information was available on CFSIS.

Youth #8 This 15 year old youth had two admissions to a hotel, staying 3 days after the first admission and 43 days after the second admission. She was placed in a hotel after a placement breakdown at the external shift-staffed residential facility she was living in. At the end of July 2007, this youth was moved to an emergency shelter where she remained until placement in a foster home. This placement did not last long before she was admitted to MYC and re-admitted to a hotel in Feb. 2008. From the hotel she was moved to an emergency shelter and is back at the MYC.

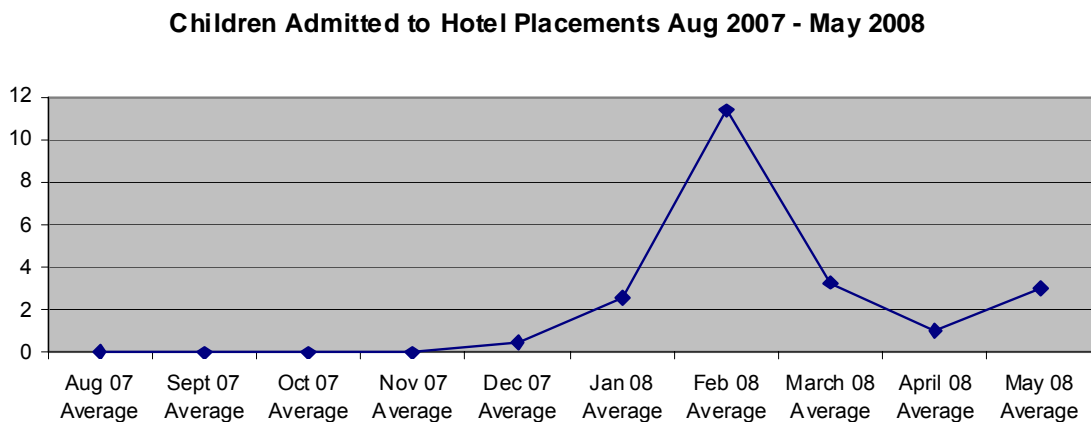
Youth #9 This 15 year old youth has multiple medical issues and was admitted to a hotel placement from the MYC. He remained in a hotel placement for 43 days and, at the end of July 2007, was moved to an emergency shelter and later to another emergency shelter until he was placed in a St. Amant Group Home where he remains to the present.

The hotel reduction strategy was effective in removing all children from hotel placements by July 31, 2007. Consistent with the recommendations made by the OCA several years ago, the use of hotels as placement facilities has been reduced and future hotel placements have become more regulated. According to the Hotel Placement Policy, youth such as those described above will no longer be placed in hotels. While residence in a hotel does not provide anything more for the youth than a place to stay, this may be the only thing the child and family services system can offer some youth. It may also be the only service that the youth will respond to. The work of the teams,

created under the hotel reduction strategy, includes the development of new emergency resources throughout the province and the recruitment and training of foster parents. This is an on-going process. It is unfortunate some youth had to move from hotel placements before resources, which could adequately meet their placement needs, were available. Several of the above mentioned youth have not fared well after being moved from a hotel placement. The lack of structure and limited intrusion into their lives, found in hotel placements, may be just what some youth need for a while. This need should have been identified prior to moving children from hotel placements and adequate resources developed to meet the needs of these children before they moved.

The Current State of Hotel Placements

According to data maintained by the DFSH, there were no children admitted into hotel placements for the remainder of 2007. In January 2008, some hotel admissions occurred and increased in the following month to an average of 11 children in hotel placements in February 2008. In March 2008, 3 children were in hotel placements each day. This decreased to one child each day in April 2008 and increased again in May 2008 to three children in hotel placements each day.



Staff with the DFSH report that most of the recent admissions to hotel placements include sibling groups. However, EPR staff indicate that in addition to placing sibling groups in hotels so they can remain together, the EPR unit has also admitted youth with high needs, such as violent or aggressive behaviour, into hotel

placements because of risks these children can present to other residents in shelters. Hotel admissions tend to be more closely monitored than before and children move out of hotels more quickly.

Final Thoughts

The use of hotels to place children/youth requiring an emergency placement has been a highly contentious issue since it became a practice in the mid 1980s. Initially, hotel placements were used to house traumatized youth with high-risk behaviours who may have been placed in a secure setting prior to the closing of Manitoba's Seven Oaks Centre in the early 1990s. The Seven Oaks Centre was a secure reception facility for high-risk youth. Later, after considerable controversy about separating sibling groups, a practice of placing larger sibling groups together in hotel placements evolved. These two groups of children largely make up the majority of children in hotel placements.

The Hotel Reduction Strategy was effective in removing all children from hotel placements by July 31, 2007 and introduced standards for the future use of hotels as placements for children in care. In addition, a collaborative resource development and foster home recruitment plan was developed to increase the number of emergency placement facilities and foster homes that would replace hotel placements. The plan was effective in keeping children out of hotels for several months. However, by February 2008, provincial statistics showed 11 children in hotel placements. Initially, most of the children were part of large sibling groups who could not be placed together anywhere else. Later, high needs youth were, once again, placed in hotels because of a lack of any other placement facility that would accommodate their needs.

The initiative taken to reduce hotel placements was necessary. However, the work in this area is not finished. The information regarding the children and youth in hotel placements is just a beginning as more work is necessary to ensure that other appropriate placement resources are available for the children and youth who would have been placed in hotels. Recently, in response to the lack of placement options, youth with high needs are beginning to reappear in hotel placements.

5. REVIEW OF THE OPERATION OF THE WINNIPEG CHILD AND FAMILY SERVICES EMERGENCY ASSESSMENT PLACEMENT DEPARTMENT (EAPD) SHELTER SYSTEM (2004)

The OCA Shelter Review (2004) provided a chronological history of the development of Winnipeg Child and Family Services' emergency placement system, previously known as the Emergency Assessment and Placement Department (EAPD). The name was later changed to the Emergency Placement Resource (EPR) unit. As the review clearly indicated, the emergency shelter system emerged in the early 1990's in response to the growing need for alternative accommodations for children and youth entering the child and family services system and for those children already in care, but requiring an emergency placement as a result of a placement breakdown. The system evolved in response to a need and, as a result, developed without the benefit of a structured organizational and operational plan. In the initial review of the EPR, the OCA found that the emergency shelter system was not operating in accordance with provincial licensing standards or a program plan that would provide an operational framework and direction for the system. In a comprehensive review of the operations of this system, the OCA made 78 recommendations that included a complete re-structuring of the emergency shelter system in Winnipeg.

A Review and Update on the Recommendations

Since the OCA presented its report on the operations of the Winnipeg Child and Family Services Emergency Assessment and Placement Department (EAPD) Shelter System in March 2004, the delivery of child and family services in the province of Manitoba has changed significantly. In 2003, *The Child and Family Services Authorities Act* transferred responsibility for child and family services in the province to four distinct Child and Family Service Authorities; the First Nations Northern Authority, the First Nations Southern Authority, the Metis Authority and the General Authority. In response, the delivery of child and family services in Winnipeg changed in 2005. At that time, through the *Authority Determination Process* (ADP), cases involving children and families were transferred to approximately 25 agencies and regional departments providing mandated child welfare services in the province. The ADP is a process that determines which Authorities will provide child and family services, based on the choice

of the family. With this transfer of responsibility, the WCFS EPR emergency shelter system began providing emergency placement services to children in care of the new agencies as well as WCFS and the newly-created Winnipeg Intake Agency, the All-Nations Coordinated Response Agency. In anticipation of changes to the child and family services delivery system, the OCA recommended that the newly created CFS Authorities take a leadership role in designing and implementing changes to achieve long-term improvements in the emergency care system. In the Shelter Review (2004), the following recommendation was made:

- √ The DFSH in conjunction with the Four Authorities review the information and demographic data provided in this report, and fully analyze the legislative (regulatory), the policy (service and fiscal) and resource (supportive, supple-mental and substitute care) planning implications as it relates to the evolving child and family services system.

The DFSH responded immediately to the Shelter Review (2004) report in a *RESPONSE AND ACTION PLAN to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, issued on April 7, 2004. The response and action plan indicated that "the findings and recommendations provide a blueprint for developing an emergency care system that has a clear direction and purpose within the broader context of all services intended to enhance the well-being of children". In response to the OCA report, the DFSH developed a comprehensive action plan with four main strategies.

1. Act immediately to create new emergency foster care resources specifically designed for children under the age of eight.
2. Immediately establish an Implementation Committee to address the Advocate's recommendations for future planning, system design and longer-term resource development.
3. Implement recommendations that will immediately have a positive impact on improving the quality of care in the shelter system.

4. Implement recommendations that will immediately strengthen the system oversight capacity.

The Assistant Deputy Minister of Child and Family Services and the Assistant Deputy Minister of Community Service Delivery were given the responsibility for ensuring that the four action plan strategies were implemented.

Developing New Emergency Care Resources

The first action plan strategy focused on developing new emergency care resources to reduce the need for children under the age of 8 to be placed in shift-staffed group facilities.

- Begin immediately to create 50 new emergency care foster beds specifically for children under the age of eight (*Response and Action Plan to the Shelter Review Report, April 2004*).

The action plan called for an immediate response to create 50 new emergency foster care beds specifically for children under the age of eight years. The four child and family services Authorities were given the responsibility for establishing criteria and recruitment plans with the expectation that 50 emergency foster care beds would be in place by the end of the 2004/2005 fiscal year. In February 2005, the DFSH announced that 50 new emergency care foster beds had been added to the provinces emergency care system. B & L Homes was selected to recruit, train and support foster parents for 35 new spaces and the Community Led Organizations United Together (CLOUT), a group of community-based organizations including Ma Mawi Wi Chi Itata Centre, Native Women's Transition Centre, Community Education Development Association (CEDA), Andrews Street Family Centre, North End Women's Centre, Ndinawemaaganag Endaawad, Rossbrook House and Wolseley Family Place, was selected to provide services for an additional 15 bed spaces. The new emergency foster beds were included in the emergency placement resources available through the WCFS EPR system and the EPR Emergency Placement Desk coordinated placements into these new foster homes. The number of emergency foster bed spaces has increased over the years. By

May 2008, B & L Homes had 85 emergency foster beds and 80 beds in family reunification foster homes and CLOUT had 16 emergency foster bed spaces.

A New Emergency Care System for Children

The second action plan strategy focused on the OCA recommendations to re-configure the existing residential care system. In the Shelter Review (2004), the OCA found that the current provincial care continuum was not reflective of a true continuum. It focused on care provided outside the home and did not include preventive services to assist families in caring for their children in order to prevent out of home placements. The OCA recommended that the current continuum of care be redeveloped to reflect a true continuum and include services aimed at preventing the need for out of home care. The recommendation included examples of what would constitute a true continuum of care.

- √ The provincial continuum of care be re-developed by the DFSH and the Four Authorities to reflect a true continuum and include preventive, supportive services, supplementary services and substitutional care services. Care of children and youth can be provided by the CFS system and or by the families of the children and youth, and as such, should include culturally appropriate resources that will support and augment the care of a child. Accessibility of services under the continuum of care should not be based solely on a child's care status, and should minimally include:

Supportive and Supplementary Services:

- Preventive services to support children and their families in the community.
- Supplementary services to support children in their families in the community.
- Family Reunification services to support children returning to their families from care.
- Therapeutic Daycare and Emergency and Respite Daycare

Out-of-Home Care Resources:

- Substitutional care services ranging from kinship care, adoptive care,

foster care including therapeutic foster care and family based care settings for siblings.

- Residential care including care settings specializing in variety of high needs service areas including FAS/FAE, drug/alcohol/solvent abuse programs, behaviorally challenging child and youth. Bail supervision homes for youth involved with the CFS system leaving correctional facilities on bail but unable to return to their home or previous care setting.
- Shelters (Emergency and Street shelters).
- Facilities (group or individual) for adolescent parents and their children
- Respite care (for parents, kinship, foster, adoptive homes).
- Independent living resources (youth ages 16-21).
- Specialized Care settings (family and group) appropriate for defined subgroups such as English as a second language; physically handicapped, visually impaired and hearing-impaired children and youth.

In accordance with the second action plan strategy, the Minister established the Shelter Review Implementation Committee (SRIC) in April 2004, to review the recommendations and develop an implementation plan.

- ❑ Immediately establish an Implementation Committee to act on the future planning and long-term recommendations in the Advocates report (*Response and Action Plan to the Shelter Review Report, April 2004*).

Comprised of three representatives from the DFSH, an associate professor from the University of Manitoba, and the Chief Executive Officers of each of the four Authorities, the SRIC was given the task of developing a blueprint for building a new system of emergency care for children “in a systematic and organized manner, using an evidence-based approach to planning”. (Response and Action Plan, April 2004).

In the Shelter Review (2004), the OCA was concerned that “resources were often built to accommodate crisis, without vision or a coordinated response” and called for a capacity to develop resources for youth and children in a systemic and planned fashion. It was recommended,

- √ That the DFSH develop, in conjunction with the Four Authorities, a Community Resource Development Office (CRDO) to be housed in the DFSH.
- √ It is further recommended that the CRDO complete a province-wide community needs assessment of the service providers to find out what resource and service needs are immediately required.

The OCA provided a list of tasks that the CRDO should focus on. These included:

- Develop residential care resources across the province, including emergency care facilities and treatment centres across departments and jurisdictions.
- Assist in the development of in-home support and community services resources to support children and youth in the community.
- Provide linkages with and between government departments and other public and private agencies and the Four Authorities to allow for cross-jurisdictional planning or resources.
- Assist in the development of neighbourhood-based services.

The plan of the Shelter Review Implementation Committee (SRIC) was to assume the responsibilities the OCA attached to the Community Resource Development Office (CRDO) in the interim and, through a process of evidence-based coordinated planning, determine the feasibility of the OCA recommendation to create the CRDO. To begin the process, the SRIC identified five steps that would serve as the terms of reference for gathering the information necessary to formulate a detailed evidence-based implementation plan within a one year time period. The plan included:

1. Complete a province-wide assessment of residential care needs for children.

2. Based on the results of the needs assessment, develop a proposed continuum of care and classification system for children's residential care.
3. Within the context of the proposed continuum of care, develop a vision statement and comprehensive program model for the role of emergency placement facilities and services.
4. Given the proposed program model, recommend standards and training strategy to ensure staff have the qualifications and competence to adequately meet the needs of children in emergency care.
5. Assess the feasibility of implementing the OCA recommendations regarding a centralized office to oversee future resource developments, reconfigure the provincial placement desk, external governance of placement resources for children and a strategy for foster parent recruitment.

Province-Wide Needs Assessment

To obtain an assessment of the residential care needs for children and youth, the SRIC requested a review of literature related to out of home care needs, a province-wide assessment of out of home care needs and a review of the collection of existing data within the DFSH on levels of care and rates paid for children in care.

a). The Literature Review

The First Nations Child and Family Caring Society of Canada was hired to complete a literature review of policy and resources pertaining to care needs. A comprehensive review, *Literature Review of Key Resources* (unpublished), was completed for the SRIC on out of home care needs of children. The review included an examination of demographic information and population trends, an overview of residential care in other jurisdictions across Canada, the recruitment and retention of

residential and child welfare workforce and contributing factors to out of home care for children.

According to *the Literature Review of Key Resources*, a review of population trends showed that Manitoba's population has gone through a boom, bust and echo cycle where a large portion of the population has been moving toward retirement age (boom) and their children (echo) are moving into post secondary education and the employment market. The "bust" population, or those born between 1967 and 1979, are beginning to have children. These children are known as the "millennium kids". They represent a declining portion of the overall population. However, although this trend is true for the general population, the trend for the Aboriginal population of Manitoba differs. The *Literature Review of Key Resources* found that Manitoba's Aboriginal population is considerably younger than the overall population and is growing at a much faster rate, "looking forward, by 2016 the Aboriginal population is expected to increase by 36% in the rural part of the province and more than double in Winnipeg".

At the same time, child in care statistics show that 81% of all the children in care in Manitoba are Aboriginal (CFSIS 2004). If this trend proves to be true, and the population of young Aboriginal children is increasing quickly, then the need to address an increase in the demand for appropriate placement resources cannot be ignored.

b. The Needs Assessment

Child and Family Service caseworkers across the province were asked to participate in a survey on out of home care needs of children. The DFSH Policy and Planning Branch reviewed the results from the survey. The Branch reported that there were 3, 472 placement spaces in Manitoba in 2005 and 66% of those spaces were in foster homes. The survey also attempted to determine the vacancy rates of various placement types and found that of the total available bed spaces, approximately 13% were vacant. If this information is accurate, it raised the question why children are staying in emergency shelters for long periods of time when vacant bed spaces are available in the system. There may be several reasons for this. Difficult to manage children may limit the number of children that foster parents can care for at one time, the special or high needs of a child may be beyond the capability of a foster parent, and beds may be unused because foster parents were not actively fostering at the time.

Child-specific surveys were completed on a sample of children in care to determine the level of funding required to meet the needs of children in care. Funding is tied to the assessed level of need ranging from Basic Maintenance (Level 1) through to Exceptional Circumstances (Level 5). Children's needs were assessed at the following levels.

Number of Children by Assessed Level of Funding

| Assessed Level | Number of Children | Percentage |
|-----------------------|--------------------|------------|
| Level 1 | 375 | 32.7% |
| Level 2 | 57 | 5% |
| Level 3 | 187 | 16.3% |
| Level 4 | 149 | 13% |
| Level 4+ (over range) | 120 | 10.5% |
| Level 5 | 55 | 4.8% |
| Missing data | 203 | 17.7% |
| Total | 1146 | 100% |

Although the majority of children were at Level 1, a high percentage (23.5%) were in Levels 4 and 4+ and 4.8% of the children were assessed at level 5.

c. The Database Review

Attempts to obtain relevant information from the CFSIS database were not successful. The Policy and Planning Branch found that the limitations of the database made analysis unfeasible and insufficient for a report. The review team had difficulty differentiating whether residential care facilities were being funded at the actual level of care that children were assessed at, or by the level of care the facilities can actually provide.

The Review team found that the average cost per day for a child assessed at Level 1 was \$25.27 in 2005, while the average daily cost of care for children assessed from Levels 2 through 5 was \$71.48 for that same year.

The information resulting from the above reviews and assessments was summarized and combined into a report, titled *Province-Wide Assessment of Out-of-Home Care Needs, Synthesis Report*, dated April 13, 2005. The Synthesis report was prepared by the DFSH Policy and Planning Branch and contained the following information that emerged from the assessments and reviews.

- The Manitoba Aboriginal population is increasing at a fast rate. It is predicted that the Aboriginal population in Winnipeg alone will double by 2016.
- Aboriginal children are over-represented in the out of home care caseload and that trend does not appear to be changing.
- A gap exists in relation to culturally appropriate services and programs, but that gap may be filled by changes implemented through AJI-CWI.
- Foster care placements are the most used placements in out of home care, yet anecdotal evidence suggests the supply of foster families is decreasing. An alternative model should be developed in the event the trend continues.
- Emergency needs (such as food, clothing, shelter) are commonly met, however, short-term needs (such as education, life skills and support services for families) are often unmet.
- A minority of children in care in the survey sample have unmet needs (9%). That is, they are not placed in a resource that is able to meet their needs.
- It was found that current and future service demands were highly associated with the age of the caseload. For example, as a child moves through the child welfare system, additional resources may be required to deal with emerging issues.

- Future service trends appear to revolve around specific needs and issues including:
 - culturally appropriate care
 - support services for families
 - education
 - life skills
 - drug/alcohol abuse
 - learning disabilities, and
 - criminal activity.

In addition to the above, the report contained two recommendations resulting from the research process. These recommendations aimed at correcting systems issues within the DFSH.

1. Issues with the CFSIS database must be resolved in order to provide meaningful analysis and valuable results. The research team encountered problems with the database resulting in a lack of information that could have contributed to the needs assessment.
2. Consistent level of care determinants must be used in order to ensure the assessed level of care and the actual level of care does not deviate. Assessment tools must be used consistently and the levelling information documented in the CFSIS database at all times.

Proposed Continuum of Care for Child and Family Services

Based on the information obtained from the literature review and the province-wide needs assessment, a definition of a continuum of care was suggested in the *Province-Wide Assessment of Out-of-Home Care Needs, Synthesis Report*, dated April 13, 2005 and presented to the SRIC. The working definition was comprised of the following principles:

- the continuum of care must use strategies targeted to “at risk” population groups and communities that are designed to strengthen their capacity to meet the protective and supportive needs of children, young people and their families.
- the continuum of care must include prevention and early intervention services that are designed to strengthen families and to protect young people.
- the continuum of care must include statutory intervention and ongoing support services designed to meet the protective, care and ongoing support needs of children and young people who have experienced significant harm or who are at risk of experiencing significant harm.
- The continuum of care should include a full range of services such as;
 - enhancing community capacity
 - in-home supports, and
 - out-of-home placements

At the time its mandate ended, the position of the SRIC was that the responsibility for developing and implementing an overall Child and Family Services continuum of care rested with the CFS Authorities, in cooperation with the Child Protection Branch. It was expected that, because of unique issues and service goals, different models for a continuum of care may emerge from different Authorities. The Synthesis Report became a resource to the Authorities to use in developing a continuum of care.

Responsibility for in-home and community support programs remains with child and family service agencies, with support from the Authorities. Family based preventative programs differ among agencies, however, all child and family service agencies provide some type of in-home support services to reduce the risk of children moving into out of home placements. Family preservation continues to be strongly reflected in the philosophy and principles of most child and family service agencies and family enhancement programs are in the process of being developed in many agencies. The development of Resource Centres in Winnipeg has increased the availability of

preventative services and programs for families that are willing to participate and access these programs.

The Differential Response Strategy

The responsibility for developing a continuum of care, including preventative services, rests with the four Authorities with the Standing Committee assuming a coordinating role for any joint development work among the Authorities. Some components of the continuum of care were delegated to sub-committees of the Standing Committee. The Changes for Children Initiative was given the responsibility for developing a province-wide Differential Response strategy. This strategy aims at providing a preventative and supportive response to families where child protection concerns are not imminent. A proposal has been submitted to Treasury Board for approval to implement the Differential Response strategy in all the Authorities. Plans are currently underway to test Differential Response in sites across the province. At this time some Authorities and agencies are actively involved in testing these strategies in their communities.

Classification System for Children's Residential Care

To determine whether children's needs were being met in out of home placements, the ability to evaluate the quality of care provided by caregivers was imperative. The OCA called for a coordinated and standardized system that can assess a foster home or care facility on several levels to ensure appropriate matching of the needs of a child to the most appropriate placement. A standardized classification system was recommended.

- √ The DFSH through the CDRO develop a standardized classification system for all out of home placement resources within the CFS system to evaluate type and quality of care provided amongst similar homes and facilities. The classification system would assist in assessing a child's service needs in relation to the current available resources, while simultaneously identifying gaps that exist.

The present classification system focuses on assessing the needs of a child according to five levels using a Child Assessment Format that has been developed by the DFSH for that purpose. The levels are summarized as follows:

Level 1

Basic care is required in the areas of food, health, boundaries, nurturance, sense of belonging, family involvement, socialization and school or day program.

Level 2

Providing basic care in the above areas requires that the care provider increase the level of care, assistance, support, guidance and supervision to the child in order to meet their needs.

Level 3

Behaviour and personal conflicts require more tolerance, understanding and control on the part of the care provider. Extra involvement is required to address behaviour issues and provide coordination of activities, school programs and social opportunities.

Level 4

More program planning is required to meet the individual needs of the child for school involvement, mental health, unmet emotional needs and control and structure. A great deal of encouragement and support is required by the care provider to assist the child in adapting to their environment.

Level 5

Children at this level are determined to be a danger to themselves and others due to the severity of their emotional state. They may be unable to handle the demands of daily living and school attendance requiring individual treatment planning and programming. Treatment is focused on improving the child's capacity to manage their environment by building insights, increasing self-awareness, and achieving personal control.

The level that a child is assessed at does not necessarily mean that the child will be placed in a foster home or care facility that is able to provide care at that same level. A good example of this is placement in an EPR shelter facility. The level of care that a

child needs is not a relevant factor in the decision to locate an emergency placement. Children with different levels of care needs are placed in the same facilities as children that have just entered care and those children that are not levelled to determine need. It was this issue, combined with the absence of a standard special rate assessment process that concerned the OCA and resulted in the recommendation that all resource facilities be assessed in accordance with a standardized classification system. This would ensure that all placement resources are classified at the level of care they can provide and allow for the appropriate matching of children's needs to the facility that can properly meet these needs.

According to the *Detailed Implementation Plan* (June 2005) presented by the SRIC, three approaches were being used to match resources to child needs at one of the five levels.

1. Levels are based on the needs of children and youth, using a formalized scoring system with predetermined criteria. This approach is primarily used to generate a special rate payment to foster parents.
2. Levels are based on the needs of children and youth, but instead of a scoring system, there is a companion instrument that matches a child's need to a predetermined funding model. This approach is used primarily with a funding model for residential care facilities.
3. Levels are based on categories of funding levels. This approach is a tool for tracking special rate expenditures and is used primarily as a financial analysis tool.

The SRIC found that the three approaches were not used in a highly integrated and systematic manner. The first two approaches showed some consistency of levels but allowed for considerable subjectivity in decision-making because the criteria were not strictly defined. The CFSIS data review did not provide conclusive information that could be used for planning. Information was not entered on CFSIS for one-quarter of the children in the child-specific sample. The SRIC noted that more consistent use of CFSIS would be required if it is to be used to provide meaningful data for planning purposes.

When the SRIC completed its term in June 2005, the findings and recommendations were presented to the Standing Committee. Responsibility for continued work on the review recommendations regarding the classification system remained with the Standing Committee. A project proposal was developed by Standing Committee to identify standardized processes and approaches to the setting of special rates and, subsequently, linking any new processes and approaches to the larger funding model. A survey of the current practices in place by agencies for setting special rates was completed and, based on the results of the survey, the Standing Committee has started working on redesigning the special rate determination and funding process.

A Vision Statement for a New Emergency Placement System

Cautioning that the responsibility for developing a vision statement, that guides an emergency placement system, should be complimentary to a broader vision for the redevelopment of child and family services, the SRIC proposed a draft vision statement for a child and family services emergency placement service. The Shelter Review Implementation Committee submitted this draft to the Standing Committee in their final report.

“The Emergency and Short-Term Care System provides a safe and supportive temporary environment during the time it takes to develop longer-term strategies to strengthen the family and provide ongoing protection of children and youth.”

A review of reports and documents related to reconfiguring the emergency placement system shows no further reference to the above vision statement. Neither has this vision statement been adopted by the current emergency shelter system.

Cost of Care: A Realistic Program Model

The OCA recommended a formal program model, to ensure an organized and structured approach to service delivery, for the new emergency placement system. Recognizing that the changes to the CFS system, as a result of the AJI-CWI process, will necessitate the distribution of resources currently part of the residential care system,

the OCA proposed a series of recommendations that would guide in creating a realistic budget based on actual cost, days care and projected needs within a programmatic structure. The recommendations included the following:

- √ The DFSH immediately request Internal Audit (IA) to complete a financial management practice review of WCFS, now a branch of the DFSH. From this starting point, the DFSH, in consultation with IA, develop a realistic budgetary process that will take into consideration the actual costs, current and expected needs of the agency's service system.
- √ The DFSH in consultation with IA analyzes current shelter system expenditures and itemizes and documents each cost element.
- √ Following establishment of the budgetary process, the DFSH in conjunction with WCFS, identify the operational issues of emergency care service delivery and develop a realistic funding formula for the current shelter system.
- √ Following the resolution of the budgetary process and the establishment of a realistic budget, the DFSH, in conjunction with the Four Authorities, identify the operational issues and create a program model for emergency residential care.
- √ That the DFSH adopt control and responsibility of the current shelter system until the aforementioned recommendations of cost of care have been completed.

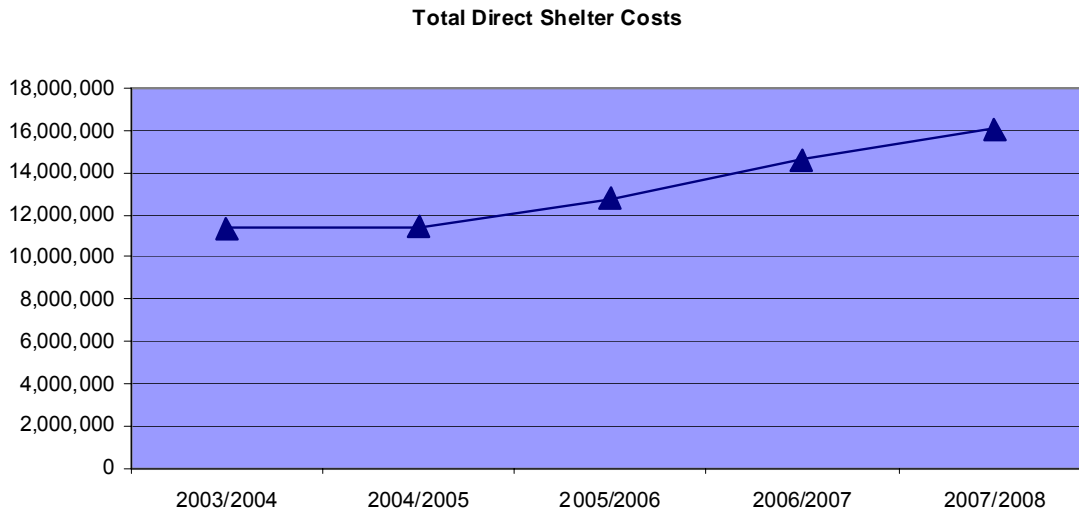
According to the *Detailed Implementation Plan* (2005), the Internal Audit Unit of Manitoba Finance conducted and completed a financial statement audit of the WCFS EPR unit in March 2005. This information was included in the review of the entire system of funding child and family services in Manitoba as a result of the implementation of the AJI-CWI. The DFSH, along with the four Authorities, were participating in developing a comprehensive funding model at that time and all financial arrangements

pertaining to an emergency shelter system became part of the overall funding discussions.

The OCA recommended that a realistic funding model for the EPR program should accurately reflect the actual costs of the emergency shelter system. The EPR program operates without a clearly established budgetary framework and funds appear to follow the growth and development of the program. As staff report, funding always seems to materialize when new emergency shelters are needed. It was noted in the initial review of the emergency placement system, and clearly reflected in the OCA Shelter Review report (2004); the emergency placement system in Winnipeg operates without a precise program or funding model. Funding models are generally connected to policies that measure performance and outcomes. The absence of goals and program objectives permits the flexibility that is inherent in the operations of the EPR emergency shelter system.

The funding process for the WCFS EPR shelters has not changed much since the OCA completed the initial shelter review in 2004. Direct shelter costs include salaries and benefits, building maintenance and care costs. Child-specific costs are related to the care needs of children and include initial clothing, activities outside the shelters, therapy, and medical needs. The latter are the responsibility of the agency caring for the child placed in an emergency shelter. The budget for the EPR emergency shelter system does not contain additional funding for the development of new shelters or improvements to existing shelters. Staff report that the costs of developing new shelters are picked up by the DFSH, "We've never had any problems with them, when we need more bed spaces, we develop shelters and the expenditures are always covered by the province".

The total direct service costs of the EPR shelter system continue to show a steady increase every year.



These costs do not include child specific expenditures. Since 2005/2006, the EPR shelter system has provided emergency care for children from all agencies providing child and family services in Winnipeg. Each agency is responsible for the child specific costs of children in their care.

The Standing Committee and the DFSH continue to work on the process of establishing a comprehensive funding model for child and family services in the province. While the work has been completed in some areas, it is just underway in others. In the meantime, the EPR continues to be funded by the DFSH as the transition to the Southern Authority Network of Care, as part of the ANCR agency proceeds. While some discussions are in place regarding the transfer, they are very much in the early stages at this time.

Staff Qualifications

The OCA recommended that care standards for emergency facilities reflect hiring qualified and competent staff with at least a two-year child care diploma and experience in behaviour management, crisis intervention and prevention, counselling and recreation and supervision of children/youth. The Child Care Facility Standards Manual contains the following standard for staff qualifications.

1. The following qualifications shall be considered the criteria for staff competency. All staff shall demonstrate a level of skill in each area which is consistent with the needs of their position, job function and responsibilities. Staff responsible for the care, supervision or safety of residents shall minimally meet the following qualifications:
 - a). language, writing and comprehension skills at a level necessary for effective communication and the maintenance of required written records;
 - b). been provided with an orientation to licensing legislation, regulations and Standards, facility policies, procedures, routines and responsibilities, conducted by the licensee;
 - c). provided a Criminal Record Check dated within three months prior to commencing work (refer to Appendix B);
 - d). provided a Child Abuse Registry check dated within three months of commencing employment (refer to Appendix C);
 - e). Certification in First Aid and CPR which meets the requirements of the Canadian Red Cross, Emergency First Aid Course;
 - f). consents to the release of information about their previous employment or volunteer work;
 - g). provides character references; and
 - h). is an adult who is medically, physically and emotionally able to do the required work.

The standard does not provide any guidelines on the level of education that a person hired to work in a residential facility must have. It does not provide enough parameters for ensuring staff are qualified to care for children. Although, the standard attempts to ensure that staff hired to work with children in facilities do not present a risk

to them, it does little to guide in the hiring of qualified staff that are able to meet the needs of children placed in residential facilities.

The WCFS EPR hiring policy requires that applicants for the position of Child Care Support Workers have a minimum of one-year post secondary education in courses pertaining to the care, supervision and development of child/youth, plus a minimum of one-year experience working with children in a care provider role. The educational qualifications and related experience in the sample of EPR child care support workers, who participated in an interview, reflects the following level of education and previous experience before being hired by the WCFS EPR unit.

Educational Qualifications of Child Care Support Workers

| | Number | Percentage |
|---------------------------------------|--------|------------|
| | | |
| Less than Grade 12 | 2 | 17% |
| Grade 12 | 4 | 33% |
| College diploma | 4 | 33% |
| Education degree from another country | 2 | 17% |
| | | 100% |

One-third of the child care support workers had completed high school and another one-third had a college diploma. A smaller percentage of the workers had less than a Grade 12 level of education and an equal percentage reported a university degree from another country.

Related Experience of Child Care Support Workers Prior to Hiring by EPR unit

| | Number | Percentage |
|--|--------|------------|
| | | |
| Raising own children | 3 | 25% |
| Day Care Centre < 2yrs | 2 | 17% |
| Day Care Centre > 2 yrs | 3 | 25% |
| Work with youth in a community setting < 3 yrs | 3 | 25% |
| Work with youth in a group home> 4 yrs | 1 | 8% |
| | | 100% |

One half of the child care support workers had a post secondary diploma or degree after completing high school in an area related to working with children and youth. Four child care support workers had a diploma from RRCC in Early Childhood Education, Youth Care Practitioner program or Family Counselling. Two other child care support workers had related university degrees from another country. The majority of the support workers had previous experience ranging from less than 2 years to more than four years in settings where they would be caring for and interacting with children.

Staff Competencies

In the Shelter Review (2004), the OCA reported on the lack of an overall professional development strategy for staff working in the emergency shelter system. EPR staff were not provided with sufficient professional development supports to assist them in achieving standards of care especially when working with high needs youth. Training was recommended for supervisory staff, direct care shelter staff and purchased service staff.

- √ The Agency ensures that all their permanent/casual shelter staff receive Competency Based Training (CBT) for child care support workers employed in the shelter system.
- √ Prior to the Agency employing purchased service agencies to provide child care in the shelter system, the Agency ensure that all purchased service staff have successfully completed CBT training. Such training should be made available to these outside agencies; however, the costs of the training should be absorbed by the purchased service agency.
- √ The Agency ensure that all shelter coordinators and staff, including purchased service staff are certified in Non Violent Crisis Intervention (NVCi) skills. Further all staff should be re-certified yearly.

In 2000, a competency-based training program for residential child care workers was introduced in the province. The *Child and Youth Care Workers Core-Competency*

Training is a 30-day in-service training program for child and youth care workers. This training program, available at no cost to mandated child welfare agency staff, consists of three “tiers” of training with competencies critical to residential child and youth care workers. Nine specific training modules, relevant to work with children and youth in residential settings is offered. When the SRIC reviewed the recommendations related to training strategies, it reported that CBT may not be a practical or cost effective option to implement for EPR staff. Rather, it was suggested that training for shelter staff become the responsibility of the Committee reviewing changes to the Joint Intake Response Unit (JIRU). At the time, the plan was to transfer operational responsibilities for the EPR unit from the WCFS Branch to the JIRU (now ANCR). With this consideration, the SRIC did not make any further recommendations about a staff training strategy.

The EPR program has established mandatory training in Non-Violent Crisis Intervention. All shelter staff are expected to have completed this training by March 2008. On going training in Effective Communication is available to staff. Plans were in place for training in Infectious Diseases and Documentation but, for unknown reasons, the workshops were cancelled. First Aid and CPR training is mandatory and must be renewed on a regular basis. The EPR unit has developed a tracking system and informs staff when their certification is nearing the expiry date.

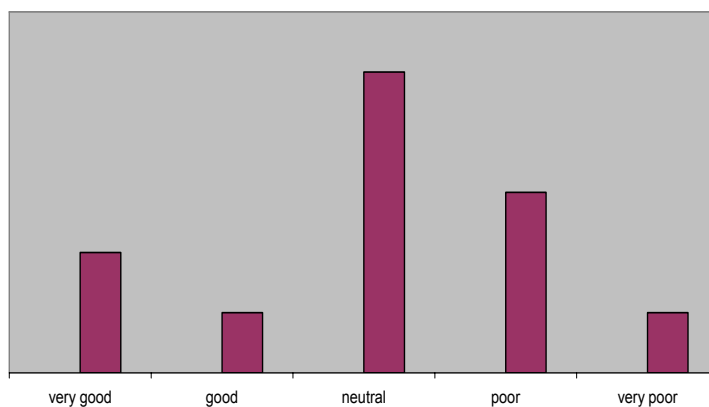
In addition, the Training Coordinator with the General Authority has developed a strategy that includes training for EPR staff in Applied Suicide Intervention Skills Training (ASIST) and “Safe Talk”, a workshop on communication strategies with children and youth. The Training Coordinator also facilitates the Non-Violent Crisis Intervention Training program.

Shelter staff participating in an interview for this review were asked what type of orientation and training they received at the time of being hired for the position and concurrently. All the shelter staff reported having an orientation to the emergency shelter system when hired. The orientation minimally consisted of a half day in-office information session outlining policies, procedures and practices. Some staff reported reading the Home Manual as part of the orientation process. In addition, three-quarters of the staff reported on the job training by working with an experienced staff person before they were assigned to a shift. Staff were asked if they received any training while employed in the shelter system. All the staff interviewed participated in Non-

Violent Crisis Intervention training and many attended an agency-sponsored workshop on Effective Communication. Very few staff participated in any other training events. Several reasons were provided for this. Most staff reported that they were not compensated for attending training events and would lose wages. Some staff stated that attending training events was not encouraged by the agency and there was little notification of training opportunities. A couple of staff, however, thought that notification of upcoming training events was regularly faxed to the shelters. None of the shelter staff interviewed attended the Child and Youth Care Workers Core-Competency Training, with one exception where a shelter staff reported attending this training when she was employed by another residential care facility. Shelter staff were asked if they felt they needed additional training. With the exception of one person, all shelter staff reported needing additional training. They cited the high needs of many children and youth that are in emergency shelters and suggested training in behaviour management, gang cultures, alcohol/drug involvement, dealing with emotional issues of children entering care, working with children who have specialized medical needs, cultural diversity, teamwork and documentation skills.

Shelter staff were asked to rate their response to the question,

How would you rate the training opportunities provided to you?



The majority of shelter staff wanted to remain neutral in their response to this question. Several responded that they were not provided with sufficient opportunities for training by the agency. On the other hand, a number of staff responded that training opportunities were good and very good.

On the topic of training needs and qualifications for the job, staff were asked if they strongly agreed, agreed, were neutral, disagreed or strongly disagreed with the following statements.

I possess the necessary skills to do this job.

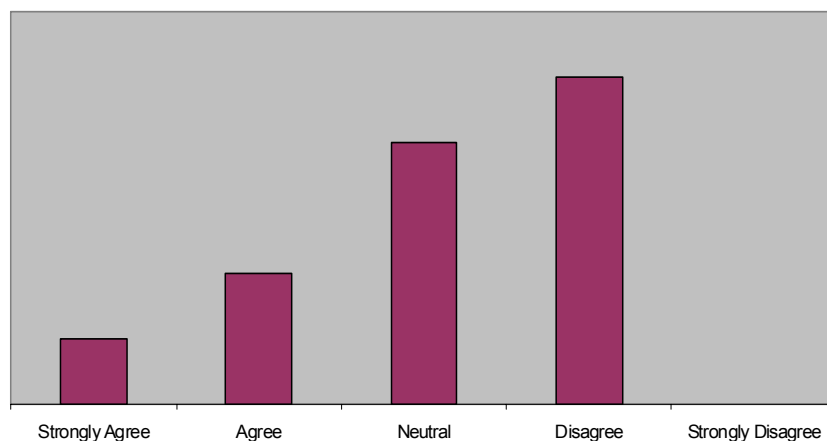
All the staff either agreed or strongly agreed with this statement.

I am expected to use my own knowledge/judgement to do the job.

Again, all the staff either agreed or strongly agreed with this statement.

Staff possess adequate job knowledge and skill in the Shelter

Although shelter staff report that they possess the necessary skills to do the job, they also report that they have to rely on their own knowledge and judgement in the work that they do. To have this knowledge, staff have to keep up with trends and issues related to the needs of children and youth. When asked if, in their opinion, other shelter staff had the skills and qualifications to work in the shelter system, interview participants were not as forthcoming. The majority reported that they did not feel that shelter staff have adequate job knowledge and skill. These are important factors in support of on-going comprehensive training that would provide knowledge and skill required to deal with the numerous issues associated with the vulnerable and high risk children and youth they work with.



The lack of training provided to shelter staff was a reoccurring issue in the Shelter Review (2004). In addition to recommending competency based training for shelter staff, the OCA proposed that competency-based training be linked to the regulations governing emergency shelter facilities and entrenched in the operations of the shelter system.

- √ Successful completion of Competency Based Training become part of the licensing process of an emergency shelter with respect to staffing qualifications as is First Aid and Non-Violent Crisis Intervention Training.
- √ DFSH build into the funding formula of the EPR system, current and future, training dollars to ensure agencies can provide CBT to their staff.
- √ The DFSH review the CBT in order to ascertain if training can be provided through a combination of in class and computer-assisted training. Individual computer assisted training can offset the cost of shift coverage and will be less disruptive to the shelter system.

The SRIC concluded that CBT should not be a licensing requirement, but stated that professional development plans should be developed for each staff member as part of standard human resource management practices. Funding for training programs for EPR staff was not discussed in the Detailed Implementation Plan (June 2005) but reference was made to the overall training strategies that will have to be developed as part of the AJI-CWI implementation process.

Training for shelter staff has been a lengthy and contentious issue between staff and WCFS management. Through their bargaining unit, shelter staff proposed wording in the collective agreement obligating the DFSH to provide competency based training to all support workers who wished to participate in this training. During bargaining unit negotiations in 2006, agreement was reached to establish a Joint Training Committee with representatives from the bargaining unit and WCFS management. The Committee's mandate was to examine overall training needs, evaluate training programs, propose mechanisms for ensuring equal access to training and submit plans for improving skills. At the time of this report, the Joint Training Committee is still working on developing its terms of reference and reviewing the mandatory training

needs. Discussions regarding competency-based training for child and youth care workers have started but are not near a decision-making stage. One of the issues that is paramount in these discussions is coverage for child care support workers to allow them to attend the competency based training program. Costs for replacement staff are not included in the budget. The Committee has yet to put a training plan in place.

Competency based training provides the essential knowledge to support the performance of skills in many relevant areas such as gang involvement, sexual exploitation, substance and drug misuse, etc. Shelter staff deal with children and youth entrenched in these situations on a daily basis and should have the skills to effectively assist youth in addressing and overcoming barriers and obstacles to a healthier and more productive life. WCFS senior staff advise that CBT is available to shelter staff on a voluntary basis. While the Branch is not in a position to pay staff to attend the training program, costs associated with pre-approved participation in any relevant training program will be reimbursed.

At the time of this review, four Shelter Coordinators have completed the Supervisory Training module offered by the Competency Based Training Centre in full and the remaining Coordinators are in the process of completing the training. Two new Coordinators have been hired recently and they have not yet completed the competency based training for supervisors.

Several staff reported that the lack of knowledge and skill in working with children and youth was more pronounced when it involved purchased service staff and has resulted in physical altercations between staff and youth. This information was confirmed by staff with both the Licensing Branch and the PAI unit, who reported that investigations of incidents related to inappropriate behaviour management attempts and physical and emotional abuse involving purchased service staff were more common than investigations involving regular shelter staff.

In the *Detailed Implementation Report* (June 2005), the SRIC reported that it was impractical to require purchased service providers to incur the costs related to competency based training for their staff who may or may not have continuous employment in the child and family service emergency placement system. The SRIC considered the idea of workshops for purchased service staff. In conclusion, the

Committee suggested that “JIRU (now ANCR) will take responsibility for ensuring that any training requirements, whether through CBT (Competency Based Training) or other methods, are detailed in service purchase agreements” with external service providers.

According to WCFS supervisory staff, all purchased service staff must be trained in Non-Violent Crisis Intervention skills and have First Aid and CPR certification prior to working in emergency shelters. This expectation is the responsibility of the purchased service providers who have to provide evidence that their staff have completed the above. External service provider agencies arrange Non-Violent Crisis Intervention training to their staff. However, checks do not occur to determine whether the staff are getting re-certified annually as recommended. Once the training conditions are met, the purchased service staff are maintained on a master list for work in the shelter system. Generally, shelter coordinators address training needs of purchased service staff by advising the private service provider organizations of limitations noted in the performance of these staff. They will either identify gaps in knowledge or skill to the service provider agency to be addressed or recommend that a staff person no longer be sent to work in the shelter system. Shelter coordinators report good cooperation and compliance by the external service provider organizations. However, with this in mind, coordinators continue to be concerned that a number of purchased service staff lack the capacity to learn the skills required to adequately work with high needs youth largely due to personal limitations such as language skills, lack of education and/or lack of motivation. They report that many purchased service staff resort to using methods of behaviour management that are familiar to them, including such inappropriate methods as sending children to their room without food. In general, shelter coordinators are concerned about the on-going reliance on purchased service staff to support the emergency shelter system.

Like First Aid and CPR training, Non-Violent Crisis Intervention training is mandatory for all shelter staff and those interviewed had participated in the training. This program, developed by the Crisis Prevention Institute teaches staff to respond effectively to warning signs that someone is beginning to lose control and addresses how staff can deal with their own stress, anxieties and emotions when confronted with challenging situations.

In addition to recommendations regarding staff training, the OCA made an additional recommendation on the coordination of purchased service staff.

- √ The Agency coordinate the use of purchased service staff through one central management position until the use of purchased services can be phased out entirely.

In the existing system, shelter coordinators are assigned five to six shelters where they are responsible for several aspects of managing and maintaining these shelters including on site inspections, overseeing budgetary issues, requesting variances, addressing special requests, arranging case conferences and scheduling, supporting and supervising staff. This model requires that a coordinator is responsible for all aspects related to the shelters assigned to them. This includes supervisory responsibilities for the staff that work in these shelters, including permanent, casual and purchased service staff. The management model has certain limitations, in that casual and purchased service staff in particular, are accountable to a number of coordinators if they work in more than one shelter. It is not unusual for casual and purchased service staff to work in a number of different shelters because they provide coverage for regular staff who are unable to work and to fill gaps in staffing where needed. Hence, casual and purchased service staff do not have one supervisory person to whom they are accountable but report to the coordinators of the shelters they work in. If they work in three shelters in one week, they may be reporting to three coordinators. This was raised as a concern by casual shelter staff who participated in an interview for this review. The staff reported that, although they consulted with the specific shelter coordinators on issues related to that shelter, they were not sure who to talk to when issues were personal or personnel related. One casual shelter staff did not know who he reported to.

This supervisory model similarly impacts purchased service staff who report directly to the coordinator responsible for the shelter they are working in. Any issues or concerns regarding the performance of purchased service staff is documented and a letter is sent to the purchased service provider organization with either suggestions on how to address these issues or concerns, or with a recommendation that this staff person no longer be sent to work in the shelters. In turn, the purchased service provider must report in writing what corrective actions were taken to address the issues or

concerns with the staff. EPR staff report that a file is kept on purchased service staff and these letters are placed in the file.

A Centralized Office to Oversee Future Resource Development

The OCA recommended the establishment of a Community Resource Development Office (CRDO) to work with the CFS Authorities and the DFSH to coordinate activities related to developing a new emergency resource system in the province. The CRDO would be comprised of representatives from each Authority and the DFSH and work to develop residential care resources and assist in the development of in-home support programs, community resources and resources for children in care. In addition, the CRDO would provide linkages with and among government departments, public and private agencies and the CFS Authorities to allow for intersectoral planning of resources and assist in the development of neighbourhood-based services.

The SRIC was charged with the responsibility of assessing the feasibility of this new office and embarked on an evidence-based study of population trends, the needs of children and families and nation-wide emergency placement alternatives. Through this process, the Committee had significant information on which to develop strategies for resource development and coordination. It determined that the development of a centralized office for community development was not a feasible option at the time. When its mandate ended in June 2005, the SRIC proposed that the Standing Committee assume the responsibilities and tasks associated with the CRDO. Hence, the recommendations of the Shelter Review (2004) were given to the Standing Committee for implementation.

The Office of the Standing Committee was created in 2003 under the *Child and Family Services Authorities Act*. This Committee became an executive forum for facilitating system-wide development, coordination of resources and for promoting cooperation and collaboration within government systems and with community organizations. The Standing Committee was comprised of the Chief Executive Directors of the four Authorities and the DFSH with a second representative from the Metis CFS Authority.

The Office of the Standing Committee

The Standing Committee had been working on activities related to the restructuring of the child and family services system in Manitoba when, in June 2005, the term of the Shelter Review Implementation Committee ended and responsibility for any further review and implementation of the Shelter Review recommendations was transferred to the Standing Committee. Shortly after the Standing Committee assumed responsibility for these recommendations, a total of five external reviews were completed on the child and family services system, containing 296 recommendations (Changes for Children Implementation Team Progress Report, April 2007). In response to this, the Minister of Family Services and Housing and First Nations and Metis political leadership, announced the *Changes for Children: Strengthening the Commitment to Child Welfare* Initiative in October 2006. The Changes for Children initiative provided a comprehensive framework for action to change the child and family services delivery system. Seven major theme areas were identified and an Implementation Committee established to develop an action plan for change.

The recommendations from the Shelter Review (2004) were not specifically included in the responsibilities of the *Changes for Children* initiative, although some of the recommendations were incorporated in the Implementation Committee work plan because they had a common theme to recommendations from other external reviews. Other recommendations were referred to the Alternative Care Sub-Committee, a Committee of the Standing Committee for follow-up. Furthermore, the plan to move the EPR unit to the All-Nations Coordinated Response (ANCR) Unit diverted the responsibility for restructuring the EPR system to the Joint Planning Committee for JIRU/ANCR.

Alternative Care Sub-Committee

The Alternative Care Sub-Committee is a resource to the Standing Committee on issues related to alternative care options for children. In addition to identifying and responding to these issues, the Committee is responsible for research and service delivery strategies related to alternative care. The primary focus of the Committee at this time is to strengthen the foster care system.

For the most part, it appears that progress on implementing the Shelter Review (2004) recommendations related to structural and governance issues slowed considerably after the work of the SRIC ended in June 2005. As the recommendations were forwarded to other committees, who were well entrenched in work related to their terms of reference, some components from the recommendations were absorbed into the committee work and others were not.

Governance of Placement Resources

In the Shelter Review (2004) the OCA suggested that the DFSH assume responsibility for the emergency shelter system until financial issues can be reconciled and that the future operations of the system rest outside the mandated child and family services system.

- √ The coordination and development of any future shelter system serving primarily the City of Winnipeg should rest outside the mandated child and family service system. Governance over the shelter system should come from a non-mandated child welfare agency or authority. The system needs a buffer between those who are placing children and youth, those who are providing care and those responsible for licensing and regulating care. It is a clear conflict for the regulatory bodies and or authorities to license, regulate and provide care. The choice of which system should be brought into overseeing the development of the shelter system in partnership with the DFSH and the Four Authorities is a decision better made as the AJI-CWI process unfolds.

The SRIC proposed that responsibility for managing the emergency shelter system in Winnipeg should be transferred to JIRU/ANCR, which was scheduled to begin independent operations in October 2005. JIRU/ANCR would be managed by the Southern Authority of Care Network and, as a result, would be an independent body from the DFSH. Planning for the implementation of JIRU/ANCR took almost 2 years to complete. The agency did not “go live” as an independent agency under the management of the Southern Authority of Care Network until February 2007. Several

sources reported that the EPR unit was not discussed during the planning process for ANCR. Only recently have discussions started focusing on the transfer of the EPR unit to ANCR.

The Provincial Placement Desk

The Provincial Placement Desk is located with the DFSH and is responsible for the placement of children/youth into one of 31 residential facilities across Manitoba, core funded by the DFSH. Twenty-three of these facilities are licensed for Level 4 children, 7 are licensed for Level 5 children and 1 is licensed Level 3 and is an independent living group home for 17-year-old males. In the province most child caring residential facilities are categorized through a level of care system. This system indicates the level of a child's needs and the care provided by the facility. *The Child Caring Facilities Licensing and Standards Manual* describes the levels as follows:

Level 3

To be eligible for a Level 3 placement, the child's behaviour and personal conflicts require more tolerance, understanding and control than could be reasonably handled in a family setting.

Level 4

These children cannot regularly handle the demands of regular school programs. They are demanding on other children and adults and consequently experience many crises in daily living and exhibit many signs of disturbance.

Level 5

These children are frequently a danger to themselves or others due to the severity of their emotional disturbance.

In the Shelter Review (2004), the OCA recommended that a centralized office be established for developing and regulating placement resources across the province and suggested a reconfiguration of the Provincial Placement Desk to better coordinate between WCFS, residential care providers, and between government departments. At the time, the OCA heard concerns from caseworkers that they rarely were asked to present case information to the Provincial Placement Desk and didn't feel their

assessments were given full consideration at the Desk. Workers from northern and rural areas spoke of either not understanding the role of the Provincial Placement Desk or not having any success in securing a placement. Long waiting lists were reported in residential care facilities, communication from the Desk was minimal and workers felt that they had little control over where a child/youth will be placed. The OCA also heard that caseworkers were not aware of available bed openings in residential care facilities. As a result, the OCA made the following recommendations pertaining to the Provincial Placement Desk:

- √ The DFSH in conjunction with the Four Authorities redesign the Provincial Placement Desk. A single Desk, managed and co-ordinated through the DFSH should be created. The Desk should incorporate a multi-disciplinary membership inclusive of the;
 - Four Authorities
 - DFSH
 - CFS agency through rotating membership
 - Child Mental Health
 - Residential care through rotating membership
 - Youth Justice
 - Children's Special Services
 - Education
 - Community

The Desk should allow for additional case-specific members whose expertise can assist in the overall planning for a child to be brought in as needed.

- √ Social work staff who are applying for a residential care admission should whenever possible present in person to the Desk as well as provide written assessment material. Whenever possible, the Desk should travel to rural and northern areas. If this is not economically feasible then all efforts should be made to ensure that agencies are provided the funds to allow their social work staff to travel to make presentations to the Desk or present to the Desk through alternative communication technology (ie. Telephone conference, video conference).

- √ All admissions and discharges from residential care should be under the authority of the Desk. As part of their coordinating role, the DFSH should immediately begin tracking all residential care breakdowns. Such information should be shared annually with the Four Authorities as well as with the residential care system.
- √ The DFSH post, through a secure site, accessible only to CFS agency staff, all residential care bed openings. This site needs to be kept up to date and include a description of the residential care facility and program offered. Such information will assist line staff in better planning for their children and youth.

The DFSH, in the *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, dated April 7, 2004, indicated that action would be taken to,

- Expand the membership of the Provincial Placement desk so the composition is more multi-disciplinary in nature.

At this time, the Provincial Placement Desk is staffed by one Specialist responsible for collecting referral information, arranging case conferences, assigning referrals to vacant bed spaces in residential facilities, managing referrals on the waiting list, responding to complaints and concerns from both the child and family services system and the residential care facilities, providing child specific consultations to both systems, attending meetings of residential care facilities and child and family service agencies, attending meetings of the EPR STEP Committee, maintaining data and managing an information and communication system that advises child and family service agencies of bed space vacancies in residential care facilities. The restructuring of the child and family services system in the province increased the number of child and family service agencies requiring, at one point or another, a placement for a child or youth in a residential treatment facility.

Referrals for a placement in a residential treatment facility are accepted from child and family service agencies in the province on a specific form that is sent to the

Provincial Placement Specialist. Once the referral is screened and appears acceptable, a case conference should follow where a treatment plan is developed for the child/youth that includes an appropriate placement and a case plan with treatment goals and interventions. Historically, a committee was in place to review all referrals to residential treatment facilities. As a result, case conferences were held prior to a placement in most situations. This is no longer the process. More recently, as referrals from rural and northern child and family service agencies increase, case conferences become time consuming and economically impractical. Case specific discussions occur over the telephone and, in order to expedite the placement process in the most efficient and convenient manner, the provincial placement specialist, after considering all available information, makes the placement decisions.

With the loss of the Placement Committee, the child and family service system also lost the benefit of support and assistance in case planning for a group of children and youth with high needs, by a team of child and family service experts. This resource is even more critical in view of recent reports from caseworkers suggesting that some residential treatment facilities are reluctant to accept children who are suicidal and/or very aggressive, or if accepted, these children or youth may be subject to early or unplanned discharges. There is an expectation that children and youth are accepted into residential facilities, regardless of their behavioural issues or emotional well-being, if the facility offers a treatment program that can assist the child/youth. After all, treatment facilities are in place to provide treatment for these issues. DFSH staff report that meetings are in the process of being arranged with Directors of residential child caring facilities to discuss this issue and create a forum for representatives from residential care facilities and the department to collectively discuss the increasingly difficult issues that children in care are presenting with. Placement breakdowns in residential child care facilities are also a concern for the DFSH. All unplanned discharges must be reported to the Provincial Placement Desk, in accordance with the licensing standards. The Provincial Placement Specialist may, in turn, request a meeting to discuss the reasons for the breakdown. Staff with the DFSH report that the issue of unplanned discharges is not one-sided, but, as often as children are being prematurely discharged from facilities, caseworkers are pulling children out of residential placement facilities for reasons such as that the child does not want to be there, or refuses to go to the facility.

The provincial placement desk is responsible for tracking placement information including admissions and discharges. With this comes responsibility for addressing issues related to accepting difficult to manage children and youth and dealing with unplanned discharges. However, the capacity to track information related to placement breakdowns is not currently available. The existing database either does not have this capacity or no attention has been given to creating a system capacity to track residential care breakdowns.

A positive step toward planning for children and youth in emergency care is the connection that has been established between the provincial placement desk and the EPR unit through the Short Term Emergency Placement (STEP) Committee. This committee, established by the WCFS Branch, reviews all children residing in EPR shelters and emergency foster homes over 30 days. Participation by the provincial placement Specialist on this committee enables some long-term planning for children and youth in emergency shelters through matching the needs of these children/youth and the available treatment bed spaces. Because children and youth from most child and family service agencies are placed in the EPR system, the STEP Committee offers the benefit of case planning to caseworkers from all child and family service agencies using the EPR emergency placement system in Winnipeg.

One of the functions of the provincial placement desk is to make staff from child and family service agencies aware of the provincially managed residential treatment facilities and report on bed space vacancies so children/youth requiring a placement in a treatment facility are matched to existing facilities when a bed space becomes available. The Provincial Placement Specialist maintains linkages with Placement Desks and Resource Programs in all Authorities and many agencies. Depending on the size and structure of the agency, these connections are stronger with some agencies and not as strong with others. Smaller child and family service agencies do not have specific staff dedicated to the placement of children and youth, and, therefore, it is more complicated to ensure a consistent communication strategy. The large number of child and family service agencies, each structurally different to some degree, has challenged the present communication system. The process, inclusive of weekly e-mail messages to Authorities and some Agency Placement Desks and fax information to other agencies advising of bed space vacancies, is highly dependent on other individuals for distribution. As a

result, it cannot be assured that information on residential bed space vacancies is reaching caseworkers in the child and family services system in a consistent manner. This means that some children and youth may have an opportunity for a therapeutic residential placement and some may not. The OCA, in the Shelter Review (2004), reported on the inefficiency of the communication system well before the increase in the number of child and family service agencies in the province. The increase in the number of agencies only compounds the communication concerns. The OCA recommended that the DFSH post, through a secure site, accessible only to CFS agency staff, all residential treatment bed vacancies. This site would also contain a description of the residential care facility and program offered. At the time of this review, no action has been taken to change the communication system used by the DFSH to inform caseworkers of vacancies in residential treatment facilities.

A Strategy for Foster Parent Recruitment

For several years now, the growth of the EPR system has been attributed to the shortage of foster homes for children in care. The initial OCA review of the EPR shelter system reported of a foster home crisis in the province. Foster homes are a resource for the many children in EPR emergency placements so children can move from emergency placements to stable, long-term foster homes. Although the OCA did not review the foster care system, a report by Judge Linda Giesbrecht, completed following the death of a child in care identified several issues with that foster care system.

“Rates paid to foster parents should reflect the value of the work that is being done. Barriers to recruiting foster parents in all parts of Manitoba need to be addressed. Foster parents need to be adequately supported. It is recommended that the Director of Family Services establish a committee including representatives from foster parents, the Office of the Children’s Advocate and other stakeholders in the system to examine and address the following issues;

- The payment of fees to all foster parents based on the needs of the child and the ability of the foster parent to meet these needs,
- The obstacles that exist in the system to recruitment of foster homes, in particular, Aboriginal foster homes.

- The need to provide appropriate supports to foster parents including respite and clinical support to meet the needs of the child.
- The need to provide appropriate training to foster parents to enable them to meet the needs of the children in care.” (Manitoba Justice 2003)

Considering the linkage between the emergency shelter system and foster care, the OCA made the following recommendations for improving and strengthening the foster care system:

- √ That the DFSH and the four Authorities implement the above noted recommendations of Judge Linda Giesbrecht.
- √ The DFSH and the Four Authorities work cooperatively with the Manitoba Foster Family Network to develop a province-wide strategy to address the recruitment, support and retention of foster families.
- √ The DFSH provide the Four Authorities with the financial support to develop one province-wide system to track foster home breakdown. This information will be of assistance to the Authorities to evaluate the needs of children and youth in foster care; evaluate the needs of foster care providers and assist in determining what barriers (case and systemic) contribute to the breakdown of foster care placements from a regional and provincial perspective. This information should be shared annually with the Manitoba Foster Family Network.
- √ That the DFSH support the endeavours of the Manitoba Foster Family Network to complete research determining what supports are needed to retain and support foster care resources. The results of their research should be shared among all Four Authorities.
- √ Emergency foster care for children be developed in conjunction with the Four Authorities and existing community agencies who already provide foster care programming to the CFS system. The DFSH will need to review its current foster care system utilizing the standardized classification system

of the Community Resource Development Office (CRDO) to ensure consistency in the level of care provided, and that any emergency foster care system complies with Foster Care Regulations and Standards.

The Manitoba Family Services and Housing *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT* (April 2004), indicated that the Child Protection Branch will take the following actions to address foster care breakdowns;

- Meet with the Manitoba Foster Family Network to explore ways of supporting research into foster care breakdown, which appears to be a factor contributing to shelter usage.

The SRIC completed its work on the recommendations of the shelter review in June 2005 with several suggestions for strengthening the provincial foster care system. The Committee recommended actions and activities in several areas discussed in the review and these activities were assigned to other committees to assume.

The responsibility for addressing Judge Linda Giesbrecht's recommendations was given to the Alternative Care Sub-Committee to include in its work to examine and address key issues in the foster care system. The Committee is currently working on the following activities related to the foster care system.

- Standardization of emergency rates for foster care.
- Standardization of special rates for foster care.
- The recruitment and development of new foster homes
- The development of a funding strategy to strengthen foster care
- Developing a foster parent training program
- Review of foster care standards

The SRIC reported that tracking foster home breakdown was not possible due to the inconsistency in the data that is entered on CFSIS. Although the CFSIS system had the capacity to track movement of children in and out of foster homes, the lack of consistent data could not produce meaningful information. Concerns about CFSIS have been raised on numerous occasions. The *Strengthen the Commitment: An External Review*

of the Child Welfare System (Sept 2006) reported that agencies are not using CFSIS for a number of reasons. Some communities do not have the technological capacity to allow its use, others do not have the necessary equipment to run the system or have developed their own systems. Most concerning was the fact that CFSIS lacks significant amounts of information and, therefore, is incapable of producing accurate and meaningful data that would be useful in service delivery planning. Recently, the Standing Committee announced a plan for incremental improvement to the CFSIS and prioritized a number of projects for immediate attention. In the DECEMBER 2007 STATUS REPORT by the Child and Family Services Standing Committee on Changes for Children, prioritized improvements to CFSIS were developed with some already underway. The first phase of incremental enhancements began in July 2007 and included:

- Repairs to ensure that Prior Contact Check (PCC) in the Intake Module and CFSIS produce the same results, and
- The introduction of a new feature in the Prior Contact Check to ensure accurate results are properly displayed and duplications reduced.

Other improvements include:

- Province-wide access to all CFSIS cases by designated roles or positions,
- Province-wide access to all intakes on the IM for designated workers,
- Reduced navigation to case recordings to a single click solution,
- New security levels including restricted access to some information,
- Advanced notice of expiring foster home licenses,
- Recording of medical information for children in care,
- The creation of a 'flag' to identify children in care with high risk medical needs, and
- Automatic transfer of household information from the Intake Module to CFSIS.

Progress is reported in solving current connectivity problems experienced by some agency offices when trying to utilize Child and Family Services Applications and Authorities are continuing the process of entering all open cases, federal and provincial, into CFSIS. While improvements to the CFSIS system are underway, DFSH staff

continue to report that, although data on foster placements is available through the CFSIS, the accuracy of this data continues to be questionable.

As noted in the Dec 2007 status report, the Standing Committee reviewed the standardization of special rates and a proposal was developed to identify standardized processes and approaches to the setting of special rates. A survey of current agency practices in place for setting special rates was completed and a process is underway for the redesign of special rate determination. Any further action in this will be linked to the larger funding model currently in the planning process. At this time, many child and family service agencies use their own child assessment forms to determine the level of service a child requires. Although this creates a system of inconsistencies, a standardized child assessment form must provide for cost differences in geographic locations of the province.

In October 2006, a province wide foster home recruitment strategy was announced, with an investment of \$6.1 million to improve the foster care system in the province. This included a province-wide foster care recruitment strategy, an increase of 23% in foster care rates over two years, and standardized foster parent training and support.

Shortly thereafter, in November 2006, the “Circle of Care”; a province wide foster family recruitment campaign was launched by the Child and Family Services Authorities and the DFSH. The goal was to develop 300 new foster bed spaces in the province in the next year. In October 2007, the recruitment campaign was hailed as a success when it was announced that 500 new bed spaces were added to the provincial foster care system. As of May 2008, informal reports suggest that almost 900 new foster bed spaces have been created in the province through this campaign.

Foster parents in the province received a 10% foster care rate increase in January 2007 and another 10% rate increase in January 2008. In addition, funds were increased for recreational supports for children in care. As of January 2008, the basic rate paid to foster parents is \$21.57 with an additional \$2.36 for child specific use, for a total of \$23.93 a day.

Another \$200,000 has been allocated through the Changes for Children Initiative to develop a competency-based training manual for foster parents. A committee consisting of representatives from the Authorities, the Manitoba Foster Family Network (MFFN) and the Joint Training Unit, with foster parent representation, has been established to develop this training module.

Improving the Quality of Care in the Shelter System

The third strategy presented by the DFSH *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, involved the implementation of the recommendations that would have an "immediate and positive impact on improving the quality of care for children placed in emergency, short-term care";

- ❑ Not use 24 hour shifts in any new shelter that is opened and continue to reduce and eventually eliminate 24 hours shifts in the existing shelter system
- ❑ Increase the availability of supervision across all shifts in the shelter system
- ❑ Ensure shelter staff have regular access to updates and other information routinely available to other staff in the Branch, and
- ❑ Ensure staff in the shelters inform children of their rights and provide children with information about the Office of the Children's Advocate and the Manitoba Youth in Care Network.

When the OCA conducted the initial review of the shelter system, most shelter staff were working 12 hour shifts and several staff were working 24 hour shifts as guaranteed to them under the terms of their collective agreement. Although there were some exceptions, permanently employed shelter staffs were guaranteed a specific number of hours of work. With the expiration of the collective agreement in 2004, an arbitration process resulted in the elimination of the 24-hour shifts. The only exceptions were the On-Call Dispatch staff; which includes two staff and two substitute staff, who

continue to work 24-hour shifts from their homes, on a rotating basis. Most staff still work 12-hour shifts, although 8-hour shifts have been implemented in some shelters. For the majority of the permanent EPR staff that participated in an interview, the reduction from a 12-hour shift to an 8-hour shift was a big concern. Staff cited that this will change the staff configuration in shelters and increase the number of staff children in shelter care will have to interact with. This will increase inconsistencies in maintaining schedules and routines and create additional problems in communication and structure, particularly in shelters with infants and younger children. Other staff presented concerns that the current compliment of shelter staff is not sufficient as it is and the reduction of hours will only create the need for more staff to cover shifts, resulting in more frequent use of purchased service staff.

Coordination and Supervision Responsibilities

The OCA made several recommendations to improve the current shelter system. With regards to the coordination and supervision of the shelter program and staffing in the EPR unit, the OCA recommended that,

- √ The Agency should assign a position specifically responsible for coordination and operation of the shelter program. One possible way of achieving this is to remove from the current project manager all responsibility for the implementation of the consolidation plan and reassign to this position the responsibility for coordination and operation. The DFSH continue to support the program through the continued provision of a seconded staff person who should work under the project manager to coordinate the shelter program.
- √ The Agency ensure supervisory responsibility of all shelter coordinators be designated to the newly created position responsible for the coordination of the shelter program

Through this designated position, the OCA recommended that:

- √ The Agency ensures that all shelter staff has access to supervisory staff across all shifts, as has been implemented within the agency after hours unit.
- √ The Agency ensures that the shelter coordinators directly supervise all purchased service staff.
- √ The Agency ensures all shelters have monthly team meetings.
- √ The Agency undertakes regular site inspections and ensures all shelters meet licensing requirements.
- √ The Agency ensures that all shelter staff has on-site access to the agency's internal computer information communication system. This would not include access to the case files but access to email and general agency information for staff.

As indicated previously, the AJI-CWI planning and implementation process transferred responsibility for the EPR program to the Winnipeg-based Joint Intake Response Unit (JIRU) as part of the Intake services to the city of Winnipeg. As a result, the EPR unit relocated to be in near proximity to JIRU. At the same time, an implementation committee was working on a process to transfer responsibility for JIRU, now known as the All Nations Coordinated Response (ANCR) unit, to the Southern Child and Family Services Authority. Because JIRU was in transition, the EPR unit remained under the direction of the WCFS Branch.

At the time that the AJI-CWI planning process was reviewing the transfer of resources from the Winnipeg Child and Family Services to other Authorities, the organizational structure and staffing composition of the EPR unit consisted of one program manager and five Shelter Coordinator positions, along with more than 200 permanent and casual shelter staff, who were members of the Canadian Union of Public Employees (CUPE) Local 2153. The EPR unit operated 51 emergency shelters in 2003, with bed spaces for more than 130 children.

At the same time, the WCFS was working on a Consolidation Plan for the EPR unit that consisted of a review and amalgamation of shelters to meet licensing requirements and addressing system gaps that the OCA noted during the review process. To assist with these tasks, in the fall of 2003, the DFHS seconded a senior staff from the department to the position of Specialist/Consultant to the EPR system. This position was to assist with implementing some of the required changes as identified by the OCA.

While the Joint Management Committee for JIRU worked on the details of developing a service delivery model for the city-wide Intake service, the EPR unit maintained “business as usual”. The demand for emergency beds continued as the responsibility for children and families was transferred to as many as 19 different agencies providing service delivery in the city of Winnipeg. As these agencies were starting out with limited placement resources, the EPR system became an integral resource for the emergency placement needs of children entering care or moving as a result of a placement breakdown. In 2005, the DFHS created 50 emergency foster beds and assigned responsibility for coordinating emergency placements into these foster homes to the EPR unit. In addition, several other urgent issues required attention; the bargaining unit representing staff wanted confirmation of its existence in the new structure for JIRU, the Collective Agreement was approaching its expiry date, and several outstanding staff grievances had to be addressed. WCFS Branch and the CUPE bargaining unit began a lengthy process of negotiations that ended with an arbitration award in 2006. With the added responsibility for emergency foster beds, meeting licensing requirements and involvement in bargaining unit negotiations, little time was available for staff-related responsibilities. The increase in shelter beds and emergency foster care beds required additional coordinators to manage the increased workload. The WCFS responded to this need by taking a staff position from another program and assigning the staff to an acting supervisory position with the EPR unit. The supervisor provided direct supervision to coordinators responsible for the 51 shelters and 50 emergency foster beds in the EPR system. By 2005, for a period of time, the shelters were licensed and a number of other changes, recommended by the OCA, were implemented. Once the implementation work was completed, the seconded position assumed supervisory responsibilities for some of the shelter coordinators. As the number of shelter coordinator positions increased, both the seconded position and the

re-assigned WCFS staff position assumed supervision to fourteen Shelter Coordinators, a Placement Coordinator/Foster Care Worker and one administrative assistant. The Program Manager's responsibility includes the overall coordination and operations of the EPR system.

The EPR unit operates an On Call Dispatch Service to ensure that 24-hour support and assistance is available to all shelter staff. Two experienced full time child care support staff work from their homes in rotating 24-hour shifts in this position. The rotation involves working five 24-hour shifts during week 1 and two 24-hour shifts during week 2. Both these employees, as well as two substitute on-call staff, are members of the CUPE bargaining unit. On Call Dispatch staff are responsible for basic scheduling of replacement staff if a scheduled staff reports sick or is unable to work, addressing requests after hours for emergency repairs to equipment or a window replacement, assigning a second staff to a shift if the staff on duty is having difficulty with a child and providing support in the form of consultations with staff working after hours. On-Call Dispatch staff track the number of calls they receive and record the number of staff that have to be replaced while on shift and the number of staff that are added to assist staff working a shift. These are tracked on a weekly basis.

| | Number of Requests | Number of Staff Replacements or Additions | Total |
|---------------------|--------------------|---|-------|
| April 21 – April 28 | 248 | 58 | 306 |
| April 28 – May 5 | 301 | 71 | 372 |
| May 6 – May 11 | 272 | 58 | 330 |
| May 12 – May 19 | 258 | 55 | 313 |

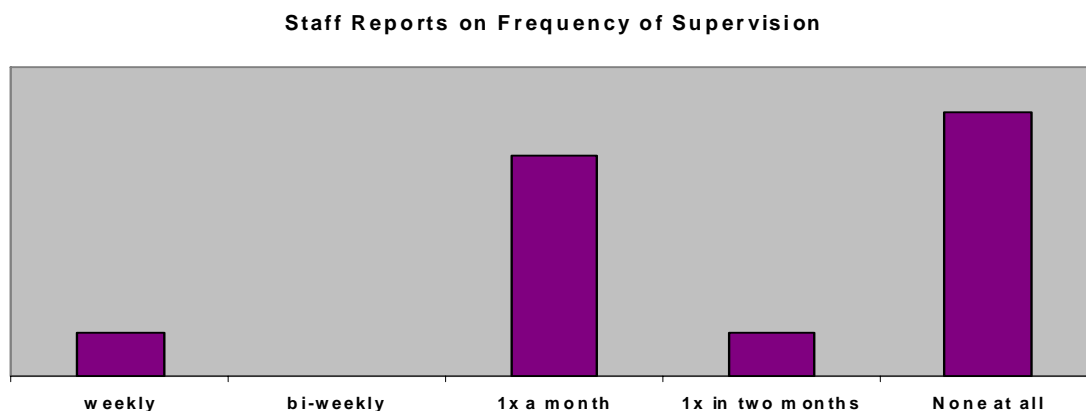
In a four-week period, 1,321 requests for service or staff replacement were made to the On-Call Dispatch Services by staff working in EPR shelters after regular working hours. Of these calls, 242 were requests for replacement staff or additional child care staff.

To ensure 24-hour supervisory support to the EPR system, both the program manager and the two supervisors provide after-hours coverage through 7 day rotating

shifts. The managers are on call to the After Hours Services Unit and provide approval for children requiring emergency placements after work hours.

Shelter Coordinators are responsible for providing supervision to approximately 25 – 30 permanent and casual staff working in the EPR shelters that they each manage. A management model, where shelter coordinators are assigned specific shelters and are responsible for all aspects of operations in those shelters is used. This includes supervisory responsibility for permanent and casual shelter staff and on-site supervision for purchased service staff. Most staff supervision occurs through monthly team meetings, informal contact when the coordinator visits a shelter and through either arranged meetings or by telephone when either shelter staff or the coordinator has an issue or concern to discuss. Coordinators advise that the frequency of supervision provided to shelter staff can be scheduled, formal, informal or as needed. Each coordinator determines the frequency and method of providing supervision to shelter staff. Most coordinators attempt to have monthly team meetings with the staff working in the shelters they are responsible for. These meetings are not mandatory and occur during the day, making it more difficult for night shift and casual employees to attend. Most coordinators work during the day, although recently at least one coordinator has been working at least one evening a week. Several coordinators indicated that due to their workload demands, monthly meetings do not always occur.

Although supervision is readily available and accessible to some shelter staff, it is much less available to others. Staff, participating in an interview for this review, were asked how frequently they receive supervision. The frequency was reported as follows:



The frequency of supervision is highly associated with the time of day staff work and whether the staff are assigned to one shelter or work in several shelters. Staff who work a regular day shift in one shelter reported at least monthly supervision. Some reported receiving supervision on a weekly basis because coordinators attend at shelters at least once a week. Staff who worked a night shift reported receiving supervision once a month, through attendance at a monthly team meeting. While some staff, who work night shifts, attend the monthly meetings, others indicate that they don't participate in these. Casual staff, working in different shelters, were the least likely to have access to supervision. Most reported that they received no supervision at all. Casual staff working days in a shelter may have some contact with the coordinator in the home, while those working night shifts did not. At least one staff person who was a casual staff did not know who he would contact if he needed supervision.

Staff reported that coordinators worked daytime hours and were not available to those staff working night shifts. If night shift staff had issues or concerns to discuss, they had to wait until the next day to contact the coordinator. Some reported that this necessitated that they work during their off time. Most staff reported attending monthly team meetings usually held in a location outside the office or the shelter. Two staff stated that they attend team meetings in local restaurants. It is not mandatory for shelter staff to attend the monthly meetings and most staff reported poor attendance at these meetings.

In general, staff reported good working relationships with coordinators. All coordinators were seen as knowledgeable, supportive and accessible. Some staff reported that their coordinator was at the shelter at least twice a week while others stated that they rarely saw a coordinator in their shelter. Again, staff working day shifts had more contact with coordinators while those working night shifts rarely saw the coordinator. However, whether a coordinator was frequently at the shelter or not, staff reported that they can access the coordinators when they needed to speak to them providing it was during daytime hours. Casual staff working in several different shelters reported dealing with a number of different coordinators. These staff were less likely to comment favourable on having access to a coordinator when needed. In fact, there appeared to be some confusion for casual staff working in more than one shelter about who to go to when they needed to discuss issues. Although they were clear that issues

involving the shelter they were working at should be brought to the attention of the coordinator for that shelter, they were less clear on who they would go to on a more personal or personnel related matter.

Shelter Coordinators are required to perform on-site inspections of shelters for compliance with licensing regulations. Using a prescribed checklist, site inspections occur routinely on a monthly basis. Once these are completed they are posted in the shelter. The Health and Safety Committee, a joint staff/management committee, also reviews the checklists at their meetings to determine whether safety-related concerns are occurring. While health and safety issues are identified through regular site inspections, both staff and coordinators reported that repairs to shelters are not addressed in a timely way, particularly if the shelter is owned by Manitoba Housing. A large number of EPR shelters were developed in vacant Manitoba Housing units over the last few years as a result of an arrangement within the DFSH to use vacant units for this purpose. Although the initial plan was that Manitoba Housing renovates the unit prior to the placement of children in these homes, this did not always occur. While some units were renovated, the urgent need for bed space resulted in children placed in some shelters before they can be repaired or renovated. The state of disrepair in several units make them ineligible for licensing by the Provincial Licensing Branch, yet children continue to live in these homes. Staff report that maintenance and repairs to units managed by Manitoba Housing are not being addressed. A coordinator described the state of a Manitoba Housing unit, currently used as a shelter for children, as deplorable with holes in the walls, broken floor tiles and outdated, irreparable fixtures. In addition, many Manitoba Housing units are located in areas of Winnipeg that are now considered unsafe due to the rash of violence and gang activity in those areas. Youth walking to and from their shelters have been threatened and robbed.

In the *Detailed Implementation Report*, the SRIC reported that a review of the cost of providing access to email services at all EPR shelters was undertaken. The costs were determined to be prohibitive and email access was not provided. The EPR program uses facsimile machines, currently installed in all shelters, as the primary source of communication of formal material. Frequently, however, coordinators take material out to the shelters or share information during team meetings. Weekly EPR unit team meetings including management and coordinator staff provide a forum for

discussion and decision-making. This forum also considers how information will be shared with shelter staff. Previously, shelter staff have raised concerns that they were not receiving information related to the AJI-CWI developments and, as a result, supervisors have become more diligent in ensuring Branch information is promptly shared with shelter staff. Shelters do not have computers, as a general rule, and staff do not have access to email services or the department Intranet.

Advocacy and Support for Children and Youth

During the initial Shelter Review the OCA heard that children and youth in the EPR system lacked an awareness of the OCA and of Voices; the network for children in care. The OCA advised that it is the responsibility of agencies and staff to inform children about their rights to advocacy and support services. As a result, it was recommended that:

- √ The DFSH ensure that all children and youth in care of a child and family service agency and who are able to understand are made aware of the OCA and that they can request a review of the circumstances through the OCA. This cannot occur on a one-time-only basis but requires a standard directing agencies to inform children and youth of the existence of the OCA.
- √ The DFSH ensure that all child and family service agencies, residential care facilities, treatment centres, foster homes and emergency shelters are provided with rights information, as prepared and authorized by the OCA.
- √ The DFSH ensure that all youth (ages 14 – 18) in care of a child and family services agency are made aware of the existence of Voices; Manitoba's Youth in Care Network.
- √ The DFSH ensure that all child and family service agencies and regional offices, foster homes, residential care and treatment centres and emergency shelters are provided information about Voices prepared and authorized by Voices; Manitoba's Youth in Care Network.

In June 2005, in response to the recommendations of the OCA, the SRIC reported that Authorities have committed to reviewing the current practices among their agencies for informing children and youth about the OCA and Voices, and developing a communication strategy in this regard. Enhanced communication has been a central theme that emerged from several reviews pertaining to the child and family service system in the last few years. Recommendations from these reviews have been delegated to the *Changes for Children Initiative*, and provide the framework for a comprehensive review and restructuring of the existing child and family services system in the province. In response to recommendations for enhanced communication between systems, a Communications Sub-Committee was created to ensure that ongoing communication strategies are in place in all sectors of the province's child and family service delivery system.

The work-plan of the Communications Sub-Committee is broad in scope at this time and does not reflect specific communication strategies such as informing children of their right to services from the OCA or support and assistance through Voices. Neither is this specifically addressed in the *Changes for Children* website or in other formal public communication involving the Standing Committee or the Child and Family Service Authorities. References to the rights of children in care are reflected in the websites of both the OCA and Voices; the Child in Care Network.

The Child and Family Services Residential Care Licensing and Standards Manual contains a section that addresses children's rights. In particular, the section reads, "The child care facility should develop and maintain a client's rights policy that supports and protects the fundamental human, constitutional and statutory rights of all children in care. Since an effective grievance procedure is an important safety precaution within child care settings, staff must ensure that all residents are aware of the facility's grievance procedure including access to the director and the Children's Advocate." The WCFS EPR Home Manual contains a page clearly outlining 19 rights of children including, "the right to be informed of the Office of the Children's Advocate, Youth in Care Network, EPR Resolution Process", etc.

Staff that participated in an interview for this review were asked several questions related to the rights of children. All staff responded that children in the EPR shelters are

told their rights and explained the grievance process. They all reported that this information is provided to children and youth at admission to the shelter by the staff on duty on the time. When asked what children and youth are told regarding the grievance process, most staff reported that they were told to call their caseworkers if they were unhappy or upset about something in the shelter. Some staff reported advising children to call their caseworker or the Office of the Children's Advocate. Very few staff referred to the formal resolution process that is outlined in the EPR Home Manual. The Manual states that shelter staff are responsible for making the child aware of the EPR resolution process at the time of placement in the shelter facility. The process has several steps:

- Children are encouraged to bring an issue to the attention of the person, (child or support worker) directly involved in an attempt to reach satisfactory resolution.
- If more involvement is needed, the child may "request to express concerns to any or all of the following to achieve satisfactory resolution;
 - The child's staff, or any other staff
 - The coordinator of the home
 - The child's social worker
 - The supervisor of the coordinators
 - The program manager
 - The CEO of WCFS
 - The CEO of the Placing Authority
 - The Director of the Child Protection Branch, or
- The child may request to contact the OCA. A shelter support worker should be available to assist the child in this process.
- The shelter support worker will advise the child of the availability of legal counsel through Legal Aid should the issue remain unresolved.
- Where a child or his/her family considers the child's placement in the EPR system as inappropriate, they may contact the child's social worker, that worker's supervisor, the program manager, or CEO of the placing Agency and request that the placement be reviewed."

The EPR resolution process was not mentioned during interviews with staff. After reviewing the process, it is quite understandable why it would not stand out in the minds of shelter staff. The process is too vague and includes too many possibilities. Furthermore, children should not be directed to bring concerns about staff or other

residents to their attention. Depending on the nature of the concern, this can be risky. At the same time, relationships between children in care and shelter staff are based on an imbalance of power and, as a result, it is not a fair request that children bring issues involving staff to their attention without the benefit of some support. The list of people that a child can contact with concerns or complaints is too broad and doesn't provide any direction on how that contact should be made. The process indicates that a shelter worker should be available to assist a child contacting the OCA, while no such assistance is suggested for a child wanting to voice a concern or complaint in any other manner. Having a grievance process is a requirement of all licensed child care facilities. While the EPR resolution process is an attempt to meet this standard, it should be reviewed and developed so it can become a viable resource for staff in assisting children in shelter care to uphold their rights and follow a meaningful process to address issues that are concerning to them and to reach a realistic solution.

All shelter staff participating in an interview were familiar with the OCA and advised that shelters have information on the OCA posted in central areas with a telephone number that children can call. On the other hand, all staff reported that youth in care in EPR shelters are not told about Voices; Manitoba's Youth in Care Network (Voices) and a large number of staff were not aware of Voices. Posters from the Office of the Children's Advocate were visibly located in all the shelter locations that were visited in the course of this review. However, there was no reference to Voices in any of the shelters for youth.

Human Resource Administration

In the Shelter Review (2004) the OCA recommended changes to the WCFS Human Resource administration to include shelter system staff.

- √ The Agency expands their human resource program to support the shelter system. All personnel files should be housed in the HR program and be maintained in a manner consistent with current departmental standards.
- √ The Agency, in conjunction with the DFHS, develops administrative HR standards, policies and procedures consistent with departmental standards.

- √ All shelter coordinators be provided with regular HR training about the current collective agreement and performance evaluations.
- √ All shelter coordinators and permanent/casual shelter staff receive yearly performance evaluations.

Two Human Resource positions were added to the WCFS Human Resource department in 2004; a Labour Relations/Compensation Coordinator and a Staffing and Employment Equity Coordinator. Both positions provide support to EPR staff. The WCFS management reviewed the Advocate's recommendation to physically store and maintain all EPR shelter personnel files within the Human Resources department and decided that this was not feasible as Shelter Coordinators required regular access to the personnel files. As a result, shelter staff personnel files remain with the EPR program. However, WCFS developed a policy to ensure that these files are maintained in a proper and secure manner. The policy, *Management of Personnel Files of EAPD Support Staff Policy*, dated April 15, 2005, pertained to the safety and securing of personnel files and to file maintenance. This policy was shared with coordinators in an EPR unit meeting on April 20, 2005.

In response to the OCA recommendation, coordinators were provided with some training in managing under the collective agreement in 2005. Since that time, several coordinators have left their positions and another round of training is needed for the new coordinators. The Labour Relations/Compensation Coordinator with WCFS acts as a consultant to shelter coordinators and managers on issues related to the collective agreement.

Performance reviews on all staff should be completed annually. Coordinators report being behind in completing performance reviews on shelter staff. They advise that workload demands tend to push this task to the background.

Improving the Current Shelter System

The OCA made several recommendations to improve the current WCFS shelter system. In order to assist the WCFS Branch in developing a program model for its current emergency placement system, the OCA recommended that the services of an independent residential care expert be retained to assist in the developing of the program model.

- √ The Agency obtains the assistance of independent residential care expert(s) to create and document a program model for their current shelter program.

At the time the SRIC issued its final report, it was thought that the WCFS EPR unit would become part of the Joint Intake Response Unit (JIRU), now known as the All Nations Coordinated Response Unit (ANCR), when the unit begins operations on October 1, 2005. The initial plan called for JIRU to provide the intake, after-hours services and emergency placement functions for all CFS agencies operating in Winnipeg. Because the Joint Management Group for JIRU had retained an independent contractor to work on developing a program model for JIRU, the SRIC suggested that a program model for the emergency placement department would be a task for that Committee. Once JIRU began operations, the WCFS Branch would no longer have responsibility for this program.

The transfer of the EPR unit to the responsibility of JIRU (now ANCR) did not proceed as planned. WCFS was in the midst of negotiations with the bargaining unit representing the EPR Shelter staff. The negotiations had stalled and the matter was referred to arbitration. The arbitration process took almost a year to resolve and by the time a decision was made by the arbitrator, the term of the collective agreement had expired and negotiations started again on a new collective agreement. As negotiations between the CUPE Bargaining Unit and the DFSH involving the EPR shelter workforce continue, the EPR unit remains a part of the WCFS Branch, although it is providing emergency placement services to all CFS agencies providing child and family services in the city of Winnipeg.

Standards of Care for Children in Emergency Placement Facilities

1. School Attendance

In the initial Shelter Review, the OCA found that almost one-third of children and youth placed in an emergency shelter did not attend school. While most attended school before coming into care, school enrolment dropped once children entered the shelter system. To address this concern the OCA recommended that:

- √ The Agency, in conjunction with the DFSH, develop the position of Educational Specialist to act as a liaison between the education system and the emergency care program. The Educational Specialist should have a background in education and policy administration in order to assist with transitioning children in schools, to support children during this transition, and to assist with the development of educational planning and funding applications where necessary.

The poor educational outcomes for children and youth in care have been raised as a serious concern in previous reports by the OCA and through advocacy groups for youth in care. There is sufficient evidence at a national level that youth in care are far behind their non-care counterparts in the area of education and employability. According to the National Youth in Care Network (NYICN), getting a high school education when youth are in care is difficult. Going on to college or university seems almost impossible for most youth in care. Over the past few years, the NYICN has been increasingly concerned with the alarmingly high numbers of youth in care who do not complete their high school education. The little available research data on this subject suggests that youth in care fall below educational achievement standards for youth in the general population. Rutman et al (2005) found that only 41% of 19-year-old youth who had been in care completed high school. The national average is approximately 71% for that age group. Reily, T. (2003) reported that 50% of youth left care without a high school degree and were generally unprepared to be competitive in a workforce that requires a high school diploma for most jobs. The OCA report, *Strengthening Our Youth: Their Journey to Competence and Independence. A Report on Youth Leaving Manitoba's Child Welfare System* (November 2006) reported that less than 5% of youth in permanent care go into post secondary education studies and less than 10% of youth

in permanent care graduate from high school. The report strongly encouraged reducing school moves due to placement changes and supporting youth in care to complete high school.

The lack of reference to educational needs of children in care in departmental policies is very noticeable. The Child Care Facilities Licensing and Standards Manual has one standard that relates to education of children in care and it reads, “The licensee ensures the child is involved in appropriate day programs. The care provider and/or agency develop and maintain a positive relationship with day program authorities. The licensee advises the agency of meetings concerning a child with schools or employers”. It is quite alarming that a place where children receive the skills and tools to function as independent adults for the rest of their lives is merely a day program. This undermines the value and worth of education as a critical component in the overall development of children in care. School attendance and participation should be encouraged and supported. Like the Child Care Facilities Licensing and Standards Manual, the EPR Home Manual does not have a policy dealing with children in emergency shelter care and school involvement.

In the *Detailed Implementation Plan* (June 2005), the SRIC left the recommendation to develop an Educational Specialist position to the Joint Management Group of JIRU/ANCR. At the time of this review senior staff with WCFS advised that discussions between the Joint Management Group of JIRU and the EPR program management did not include the above recommendation. At this time there is no Educational Specialist associated with the emergency shelter system and no discussions pertaining to this recommendation are in place.

In general, shelter staff report that all efforts are made to ensure that children in shelter care attend school. Shelter staff provide the liaison role with the school. Staff that participated in an interview advised that they weren’t aware of an education policy for EPR but knew that the expectation was that all children eligible to attend school should be attending. When a child enters an EPR shelter, all efforts are made to keep the child in the school they attended prior to coming into the shelter system. Transportation is provided by staff, emergency shelter support drivers or by taxi services. Approximately half the children are able to attend their former schools while

the remaining children are registered at schools located near the shelter where the child is placed. The responsibility for registering children in schools is shared with the caseworker. Most of the shelter staff expressed concern about the length of time it takes caseworkers to complete processes to register a child in school following admission to a shelter facility. According to staff, some children are not registered for weeks. One staff reported that a child waited for two months before the caseworker registered the child for school. Another staff, who worked in the hotel system, reported that children living in hotels do not go to school for months. Several staff stated that they have to “push” the caseworkers to register children.

Once children are attending school, most staff reported making efforts to help the child stay in school by encouraging attendance, assisting with homework, and maintaining contact with the school. The degree of involvement with a school varies. Some staff have limited contact with the school while others have daily contact. Some walk children to school. One staff person advised that he actually sat in a classroom with a youth to assist him in adapting to school. In general, staff felt that the teamwork between schools and the shelters could be improved. They cited that children who demonstrate behaviour problems in schools are suspended too quickly and too frequently. Once this happens, the caseworker needs to be involved to reinstate the child in school or locate another school program for the child. Again, shelter staff report that this leaves the child/youth without attending school for weeks at a time and too much free time with nothing to do.

The position of Educational Specialist was not created. All school liaison functions continue to be the responsibility of shelter staff and the caseworker for the child/youth.

2. Special Care Needs

Children and youth entering the emergency placement system present with a variety of physical, emotional, mental and cognitive needs. Fuchs, Burnside, Marchenski and Mudry (2005) reviewed children in care for determinants of a disability. They found that one out of three children in care in Manitoba in 2004 had at least one disability within a range of six different types of disabilities, which included:

| | |
|---------------------------|-------|
| → Intellectual disability | 75.1% |
| → Mental conditions | 55.6% |
| → Medical disability | 22.4% |
| → Physical disability | 17.5% |
| → Learning disability | 6.1% |
| → Sensory disability | 4.8% |

Many children had multiple disabilities and 17% had diagnosed or suspected FASD.

With this in mind, there is no doubt that at least some of the children that enter the emergency placement system have at least one or more disabilities that may impact their adjustment, adaptation and behaviour. In the previous shelter review, the OCA found that children with special needs made up a large component of the children in emergency care. The needs of some children were too excessive to be managed in a foster care system and this accounted for one of the reasons that children with special needs stayed in the EPR system for longer periods of time. The resources available to provide long-term care to children with disabilities are limited. These children require enhanced care and supervision to meet their needs. Some require frequent medical appointments, while many others are on medication. In the Shelter Review (2004) the OCA recommended that:

- √ The Agency, in conjunction with the DFSH, develops the position of Health Specialist to act as liaison between the emergency care program and the public and mental health system. This position would be in addition to their current health care coordinator. The Health Specialist should have a background in public health in order to support shelter staff in providing health intervention to children with specific medical care needs. The Health Specialist should also be responsible for the provision of training in health prevention for issues such as communicable diseases.

The Child Care Facilities Licensing and Standards Manual contains minimum standards for health and safety and a comprehensive Medication Policy. The section on health and safety requires that residential care facilities have information pertaining to medical, dental and optical treatment on children placed in the facility. It also calls for

medical check-ups to be arranged within 30 days of placement if medical information on the child is not current. Health records must be kept for each child. The Medication includes standards in administering and storing medication, documenting when medication is provided and reporting any medication errors. Staff working in child caring facilities, including the EPR shelter system, are expected to administer medication to children. The EPR Home Manual contains a lengthy section providing information and guidelines to staff on addressing medical issues and administering medication to children. This information is consistent with the Licensing and Standards Manual and provides information and direction on medical issues in excess of what is provided in the Standards Manual.

In the *Detailed Implementation Plan* (June 2005), the SRIC left the recommendation to develop a Health Specialist position to the care of the Joint Management Group of JIRU. At the time of this review senior staff with WCFS advised that discussions between the Joint Management Group of JIRU and the EPR program management did not include the above recommendation. At this time there is no Health Specialist associated with the emergency shelter system and no discussions pertaining to this recommendation are in place. However, the WCFS Branch employed a Nurse for many years. With the transfer of staff positions to the four Authorities, the Nurse was transferred to ANCR. The primary responsibility of the Nurse has been to participate in the weekly Medical Clinic and track medical information on children in care under the age of 6 years. The services of the Nurse are used frequently by EPR staff to consult on medical situations, contact doctors regarding interpretations of reports and provide some staff training.

The shelter staff that participated in an interview were aware of the EPR unit's Medication and Health policy. They reported that medical and dental appointments are arranged for all children within 30 days of their admission to the shelter system. Children who get injured while in the shelter system or appear ill receive medical attention immediately. A strong focus on the medical needs of children in the shelter system was clearly a priority for the staff that were interviewed. At the same time, staff shared concerns that they were not always provided with medical information on children at the time of admission to the shelter. Some staff indicated that caseworkers either did not know the medical information or were not present when a child was admitted. The

majority of shelter staff indicated that Drivers brought children to shelters for admission and the Drivers did not have any information on the child. Staff reported trying to locate caseworkers to obtain information on children admitted to shelters. This was often a long and frustrating process as many caseworkers are not available when called and did not promptly respond to voice mail messages. One staff recalled that a child went without life supporting medication for a week before it was discovered that the child required this medication. The other issue that concerned many of the shelter staff was the amount of medication errors that occurred primarily when purchased service staff were working. Shelter staff reported that some purchased service staff either did not take the time to read instructions or did not understand the instructions left in the communication log. As a result, medication was not administered properly or, in some situations, at all. This fact is supported by the findings from Incident Reports. A total of 168 medication errors were reported in a time period of less than 4 years. Licensing Branch staff, who read all Incident Reports, stated that most of these occurred when purchased staff were working.

Strengthening the System Oversight Capacity

The fourth Action Plan Strategy proposed by the DFSH, in response to the Shelter Review Report (2004), focused on improvements in the way quality of care is monitored and the development of program standards specific to emergency placement facilities. One of the concerns cited in the Shelter Review (2004) was that the quality of services to children in all residential child care facilities may be threatened without adequate staff to monitor and ensure compliance with the DFSH Licensing Standards and Regulations. The OCA recommended that;

- √ The DFSH add one additional position to the licensing program and further ensure annual reviews are completed of all residential care programs in Manitoba.
- √ The DFSH licensing program review all requests for variances in the shelter program, and complete a site inspection and review of the needs of each child in the shelter prior to issuing the variance. Further the

DFSH should give consideration to expanding this recommendation to include all residential care.

- √ The DFSH require that all variances issued should be posted in the facility.

The DFSH, in the *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, dated April 7, 2004, agreed to immediately act to:

- Add one more staff position to the Licensing Unit.

The Residential Facility Licensing Unit

The DFSH Residential Facility Licensing Unit is responsible for assessing, licensing, regulating and monitoring all residential child caring facilities, including the EPR emergency shelters. During the course of the initial shelter review, it became evident that the department was not adequately resourced to respond to the workload. Of particular concern was the fact that regular annual reviews of residential care facilities were not occurring as required. At the time of the initial Shelter Review (2004), one staff person was employed to license, approve variances, monitor, review and support the residential care facilities in the province. The OCA clearly thought that one staff was not enough to provide this range of service adequately and recommended that the DFSH hire another person for the licensing branch. A second Licensing Specialist was added in November 2004 and a manager of licensing position was added to the unit in June 2008. The Licensing Specialists are responsible for ensuring that all residential care facilities operate in accordance with regulatory standards, review and license new facilities, perform annual reviews on existing facilities, monitor the operations of facilities, respond to complaints and provide support.

All child care facilities other than foster homes must be approved and licensed by the DFSH after demonstrating compliance with standards in:

1. legislation, regulations and bylaws as to building construction (Building Code) and zoning,
2. legislation, regulations and bylaws respecting fire safety and health, and
3. sanitation, natural and artificial lighting, heating, plumbing, ventilation, water supply, sewage disposal and food handling.

Since 1999, all shift-staffed EPR Shelters have been included in regulations and standards pertaining to residential child care facilities in the province. These regulations govern the conditions for licensing, variances, compliance, suspension and appeal, as well as set minimum staffing qualifications. The Child Care Facilities Standards Manual provides the minimum standards for staffing, record-keeping, incident reporting, personnel policies and procedures, disciplinary practices, complaints, food, health and safety, and operations.

Regulating and Monitoring the Emergency Care System

Currently the Provincial Licensing Branch is responsible for 135 residential care facilities and, at the time of this review, another 20 facilities were in the process of being licensed. With an additional staff person in the Licensing Branch, annual reviews of all residential care facilities should be completed. However, the development of additional Shelters by the WCFS EPR unit and by some of the Authorities and Agencies in the province has increased the workload of the two staff in the Licensing Branch significantly. The increase in residential facilities across the province has also increased the number of special investigations that are required. As a result, a third Licensing Specialist position has been approved.

Since the hotel reduction policy was implemented in July 2007, the number of WCFS EPR emergency shelters has increased in order to keep up with the large number of children requiring emergency placements. Without having the option of placing children in hotel rooms as before, the EPR unit is opening more and more shelters to accommodate the children referred for emergency placement. In many situations, the need for bed space is urgent and, in response, EPR shelters are set up as

quickly as possible and without the approval of the Licensing Branch. These shelters operate as a Place of Safety (POS) until the Licensing Branch is able to arrange an inspection and review the facility for compliance with zoning by-laws and public health regulations. A POS is defined in *The Child and Family Services Act* as “any place used for the emergency temporary care and protection of a child as may be required under the Act”. The Child and Family Services Place of Safety Standards state that “agencies are authorized to designate and use the following types of places of safety:

- residences of agency's own staff;
- apartments or hotel/motel rooms;
- residences of relatives or friends of the child or his family;
- family residences; and
- women's shelters.”

Establishing emergency facilities under the Place of Safety (POS) regulations allows for a quick response to urgent placement needs for children in care. However, these facilities are developed outside the provincial regulatory system and are not subject to the requirements set out in the Child Care Facility Standards Manual. The system responsible for ensuring the quality of care to children is being by-passed. This issue was one of the primary concerns of the OCA during the initial review of the operations of the WCFS EPR shelter system. Without a regulatory system in place, quality care to children can be compromised.

The EPR system, on the other hand, is governed to a large degree by the demand for emergency placement beds. It is not the role of this program to question why children are coming into care, this system has evolved on the premise that it is the “last resort” for children that require an emergency placement and its primary goal is to come up with bed spaces when they are needed. In order to accomplish this, the EPR system will take all necessary steps to achieve the end result, a bed space for a child in need. Unintentionally, as regulatory efforts are imposed on the emergency shelter system, that system responds by using more creative means to achieve its goals. Without considering the implications, the current provincial regulatory system and the emergency placement system are working at odds with each other. There was good reason that the OCA, in the initial review of the shelter system, referred to the unique status and position of the EPR system and recommended a governance and operational structure specific

to that system. The EPR system operates from a response to demand position. As one manager stated, “a sibling group of three was coming into care and we had to set up a home in a weekend”. Operating with a sense of urgency, emergency shelters have difficulty meeting licensing standards and procedures that were developed to apply to non-emergency residential facilities. The result is a “catch up” situation where emergency shelters are established first and then work is completed to meet the licensing criteria.

The Hotel Placement Policy has contributed to the urgency of locating emergency placements for children and, as a result, intensified the need for opening shelters under the Place of Safety regulations. Hotel placements offered the benefit of time to locate or create suitable placements for children. Now, bed spaces have to be located or created immediately in an existing system where the majority of bed spaces are full most of the time. Furthermore, the needs of children referred to the EPR system are significant and modifications to existing shelters may be required to adapt them to the child’s needs. Some children cannot be residing with other children because of the risk they may pose to others or to themselves if not constantly supervised. EPR shelter staff described a child who was recently admitted into a shelter. The shelter had to be emptied to accommodate him. This 7 year old came into care after he broke his mother’s nose during a violent episode leading the parents to conclude that they were no longer able to care for him. In addition to frequent aggressive and destructive outbursts toward people and property, this child does not sleep most of the night, participates in non-stop eating and hoarding food and, most concerning, engages in self mutilating behaviours such as cutting the skin between his fingers and toes and attempting to pull his toe nails off using implements, or in the absence of these, using his teeth. This child requires 24-hour supervision with two staff in place during the evening hours. Another example included a 17-year-old youth who was refused admission to an external emergency resource in Winnipeg because he had assaulted a staff person. When this youth was discharged from the Manitoba Youth Centre (MYC), the EPR unit was asked to locate a bed space for him. This child was not only a risk to staff but also to other residents, yet there was no other resource in the city where he could be placed.

Existing facility licensing standards do not apply to the unique needs of emergency care facilities. Adaptations or contravention to the existing standards are not uncommon

as emergency placement facilities struggle to respond to the needs of the children and youth that they provide care to in keeping with guidelines that were developed for a very different system. Standards that are relevant to emergency placement facilities are essential.

Purchased Service Staff

The increase in the number of emergency shelters that the EPR program operates combined with the difficulty in hiring sufficient staff to fill all shift positions has necessitated the use of purchased service staff from independent health care and home care organizations. This is not new and purchased service staff have supplemented regular staff positions in the emergency shelter system since its development. Senior staff with the DFSH estimate that approximately 40% of emergency shelter workers are purchased service staff. They report that it is most often when purchased service staff are working that licensing regulations get breeched. Both the DFSH Licensing Branch and the Provincial Abuse Investigators unit reported that a significant number of the investigations of the EPR shelter system included purchased service staff. Reasons for this are related to the lack of knowledge of the emergency shelter system, their roles and responsibilities, the needs of the children in these facilities and a basic lack of training in minimum standards for caring for children and managing challenging behaviours.

The concerns raised by the DFSH were echoed by the WCFS EPR shelter staff who reported that a large number of purchased service staff work in the EPR shelter system on a regular basis. Staff participating in an interview were asked if they agreed or disagreed with the statement, "Agency staff, when paired with contract staff, work as a team". 92% of the participants disagreed with the statement. The most frequently noted concerns were that purchased service staff did not know how to communicate with the children and youth or respond effectively to them. Some staff indicated concerns that many purchased service staff were unable to communicate adequately because of poor language skills. They reported that purchased service staff lack the knowledge and training to effectively deal with child management issues. They tend to resort to intimidation tactics or inappropriate responses that only set a child up for a confrontation. Other shelter staff indicated that some purchased service staff they worked with did not know how to cook food that children would eat while others simply refused to do

housework. In general, regular shelter staff indicated that working with purchased service staff only made their work more difficult. Comments such as “contract staff have different attitudes toward the job. They are just there to make money”; “It’s like having another child. They have to be told what to do and corrected in things that they do.”; “It’s like a ‘crap shoot’, sometimes you get someone who knows what they are doing, most of the time you don’t.”; were heard.

The EPR Shelter Coordinators are equally concerned about the large number of purchased service staff working in shelters that are not properly trained to deal with children who present with behavioural challenges. Coordinators reported dealing with purchased service staff who used restraint inappropriately or punitive disciplinary techniques. As Coordinators do not directly provide supervision to purchased service staff, therefore, misdemeanours are dealt with through the organization that employs them. Concerns about inappropriate conduct by purchased service staff are documented and reported to the coordinator from the private organization. If the conduct is a result of a lack of training or understanding the system, recommendations are made to the organization. Some of the more recent recommendations made to private service organizations focused on increasing knowledge about the role of staff working in the EPR shelters, including familiarity with the EPR Home Manual and additional training in areas that pertain to working with special needs and high risk children and youth. Purchased service staff who make serious errors or exercise poor judgement that may present a risk to children are not used in the future. A letter is sent to the organization that employs them stating that this person can no longer be placed to work in an EPR Shelter.

Variance Orders

Operating licenses issued to residential care facilities include, among other conditions, the designated number of children, and the ages and gender of the children, who may be placed in the facility. In order to change these conditions, a request for a variance must be submitted to the DFSH Licensing Branch. The variance request must contain information on the nature and reason for the variance and the anticipated length of time the variance is being requested. EPR Shelters are licensed for children in several age categories; 0 – 5; 0 – 8; 0 – 11; 8 – 12; 9 – 15; 9 – 17; and 12 – 17. The license also designates a gender category that includes either male, female or coed.

However, when a child outside the age group or gender that the facility is licensed for needs to utilize a bed space when there are no other beds available, variance requests are needed. The OCA recommended that the DFSH Licensing Branch review all requests for variances in the emergency shelter program, and complete a site inspection and review each child's needs in the shelter prior to issuing the variance. The Child Care Facilities Standards Manual requires that requests for variances be submitted in writing and states that written approval for the variance will follow. According to senior staff with the EPR unit, the emergency nature of the shelter system requires a quick response to a variance request in order to accommodate the needs of children. An example was provided of a sibling group aged 3, 5 and 12 years. Three beds were available in a shelter but only two of the children can be placed in that shelter according to its licensing conditions. In order to place the third sibling, a variance was required. A delay in obtaining this variance would mean that the siblings couldn't remain together. The response and turn around time for approvals of variances appears to be quick and by telephone for a verbal approval, followed up with a faxed written request. Variance requests after working hours are approved by a DFSH staff or the EPR Program Manager as designated by the DFSH Child Protection Branch. Once a variance has been issued it is sent by fax to the Shelter and it has to be posted. Generally variances are approved for no longer than a week. Senior staff with both the WCFS Branch and the DFSH concur that the present system cannot accommodate the delay that would occur as a result of a site inspection and needs review. The emergency nature of the shelter system requires a fast response in order to meet the needs of children requiring emergency placements.

Incident /Reports

Incident reports are completed by child care support staff each time an incident occurs in a residential care facility. The Child Care Facilities Licensing and Standards Manual defines an Incident as:

- Any serious licensing Standards violation including all incidents of abuse (physical, verbal, emotional, psychological, financial), medication errors, medication or chemical abuse.

- All fire incidents.
- All incidents resulting from defective physical structures.
- Any emergency situation which involves a child in care and police intervention (excluding unplanned absences, unless of a serious nature).
- Any emergency situation which involves public health or medical intervention.
- The death of a resident.
- Any situation in which a care provider or other adult in the facility is charged under the Criminal Code of Canada.

When an incident as defined above occurs, licensing standards require that a verbal report is provided within 24 hours and a written Incident Report Form completed by the staff person involved within five days. All Incident Report Forms are sent to the Licensing Branch for review and follow-up action. Staff with the Licensing Branch report that they receive approximately 5000 incident reports a year. Every incident report is read and follow-up actions determined. It was estimated that less than 10% of the incident reports require further follow-up. Most of them are information only. Follow-up actions may result in referrals to other DFSH departments, the Provincial Abuse Investigator or letters may be sent to the facility regarding necessary corrective actions and requests for follow-up.

The WCFS EPR Home Manual contains a section on Incident Reports which states “any time there is a situation which goes beyond the expected day to day occurrence in residential care, an Incident Report Form must be completed”. In addition to the situations identified in the Standards Manual, the EPR Home Manual includes two other situations where an Incident Report must be completed:

- Any time a child is in a physical altercation.
- Any situation in which a child is physically restrained.

The EPR Home Manual provides detailed descriptions of incident types, guidelines for staff on completing the Incident Report and procedures for submitting the report form. The shelter staff involved in the incident must complete an incident report. The completed report is copied to the EPR Coordinator and a copy is placed in the child's file. Coordinators review the incident reports and determine what follow-up action is necessary. They also forward the information to the agency responsible for the child and the Licensing Branch. All incident reports are reviewed by an EPR supervisor who may or may not be involved in coordinating an action plan to deal with the incident.

Incident reports provide a mechanism to track issues and identify patterns that occur in child care residential facilities, as well as ensuring that licensing requirements are met. According to Licensing Branch staff, compliance with incident reporting within the EPR program is well established. In fact, there is almost an over reporting where incident reports are completed on issues that are not in licensing regulations. Entering the data from incident reports into the Licensing Branch database continues to be a concern in that the department does not have permanent administrative staff assigned to data entry and the upkeep of the database. Furthermore, the database is outdated and limited in the reports it can generate. Although the Licensing Branch was able to compile some data at the request of this writer, they also advised that the existing database was out-of-date and questioned the accuracy of some of the information that was available. The database was not able to generate reports where meaningful outcome analysis was possible.

In the Shelter Review (2004), the OCA recommended that:

- √ The Agency develops the capacity to track internal incident reports and ensures that all required reports are forwarded to the DSFH.

The WCFS EPR unit has attempted to track data from incident reports in their database but was so far behind at the time of this review that meaningful data was not available.

In addition, the OCA recommended that:

- √ The DFSA and Agency examine the PAI reports and the incident

reports to determine if patterns exist that contribute to poor child management practices, and take corrective action.

The Licensing Branch was able to provide some data on the number of incident reports that were received from the WCFS EPR shelters in a four year time period, Jan 2004 to December 2007, specific to missing person reports, use of isolation, use of physical restraint, assaults/aggression by children, assaults/aggression by staff against children, and medication errors. Unfortunately, only limited information was available and the accuracy of some of the information was questionable. In view of this, the information is used in this report to show trends and patterns in reporting issues. No information was available on outcomes. Furthermore, only EPR emergency shelters that are licensed by the DFSH Licensing Branch are required to submit incident reports. Those shelters operating under the Place of Safety designation are not required to submit Incident Reports directly to the DFSH Licensing Branch.

Incident Report Trends –
WCFS Emergency Placement Resources Unit 2004 – 2007

| | |
|--|------|
| Number of missing person reports | 1059 |
| Reported incidents of isolating a child | 13 |
| Number of physical restraint incidents | 50 |
| Number of incidents involving assault/aggression by children | 2772 |
| Number of incidents involving assault/aggression by a staff person | 75 |
| Number of incidents involving medication errors | 168 |

According to the Licensing Branch, the EPR unit has been compliant in submitting incident reports. Restraints were over-reported by the EPR, in that the Licensing Regulations and Standards only require that restraints resulting in an injury are reported via incident report forms. Reported incidents resulting in physical injury are always referred to the PAI unit for review and/or investigation.

Number of missing person reports

When a child leaves a shelter without permission or does not return to the shelter at curfew time, an incident report on the missing child is required. Approximately 26% of all reported incidents involved a missing child report. Incident Reports showed that 78% of the EPR shelters filed missing person reports in the four-year period from Jan 2004 to Dec 2007. An average of 28 missing person reports were made per shelter. Most shelters (18) reported a missing person on less than 10 occasions; Twelve (12) shelters reported a missing person on more than 10 occasions but less than 50 occasions; Eight (8) shelters reported a missing person on more than 50 occasions, three reported a missing person on more than 75 occasions and one Shelter reported a missing person on 155 occasions. According to this information, 21% of the EPR shelters submitted 63% of the missing person incident reports. All of the shelters that submitted missing person reports on more than 50 occasions were licensed as placements for youth in the 12 – 15 or the 12 – 17 age category.

Reported incidents of isolating a child

None of the EPR Shelters have Director approved isolation rooms. Incident Report Forms are meant for facilities that have Director approved isolation rooms. However, occasionally EPR staff misunderstand the incident report form and report when they send children to their bedroom. Between March 9, 2004 and January 14, 2007, 13 reported incidents of isolating a child were submitted by EPR staff.

Number of physical restraint incidents

Between March 2004 and Dec 2007, the Licensing Branch received 50 incident reports of staff using physical restraint on a child. Although the Licensing Regulations and Standards only require that restraints resulting in injury be reported, the WCFS EPR unit asks that an incident report be completed within 24 hours whenever a physical restraint is used on a child.

Number of incidents involving assault/aggression

Physical assaults and aggression are behaviours that must be reported to the Licensing Branch. Of all the reported incidents, 69% involved an assault or aggression including children. Although there are several categories under this incident type, it was possible to divide the data into two separate parts:

i). Assault/Aggression – children’s behaviour

This category refers to an assault or aggression by one resident toward another resident or toward a staff person. Between Jan 2004 and Dec 2007, 2772 incidents of assault/aggression by children were reported.

ii). Assault/Aggression – by staff against children

An assault or aggressive behaviour by a staff person toward a child accounted for 75 incident reports between Jan 2004 and Dec 2007. Whenever an incident report involves an assault or aggressive behaviour by a staff toward a child, an investigation follows. During this time frame 60 physical abuse allegations, 13 emotional abuse allegations and 2 sexual abuse allegations were investigated.

Number of incidents involving medication errors

Although the database is limited in the scope of information that can be generated regarding this incident type, Licensing Branch staff reported their observations that the frequency of medication errors increased when purchased service staff were working. Between March 2004 and Jan 2007, 168 medication error incidents were reported.

The capability of the Managed Care database, used to track information from Incident Reports, is concerning to say the least. Accountability and compliance standards should allow little room for discretion in ensuring that incidents breaching the regulatory system for child care facilities are adequately identified, analyzed and corrected. Such information is imperative in order to change and augment resources to address system issues that could contribute to on-going incidents. Although the current database has the capacity to track incidents, it cannot produce a qualitative report that makes analysis possible. Without this capability and the commitment of staff to enter

data and maintain the system, the benefits of the information available through the incident reports are lost.

Program Standards for Emergency Care Facilities

In the initial review of the WCFS emergency shelter system, the OCA was concerned that not enough attention was being given to ensure that emergency care facilities were complying with Licensing Standards and Regulations. As an example of this, the OCA noted the absence of a program model, including a mission statement and specified goals that identify objectives and intended outcomes for the operation of the WCFS EPR shelter system. Those were required criteria for residential child caring facilities. Yet, they were notably absent in the EPR program. Although, specific program standards for emergency facilities did not exist, they were expected to comply with the regulations and standards developed for long term residential care facilities. The OCA was concerned that the residential care facility standards did not provide for the unique nature of emergency care shelters, and as a result, emergency facilities were not adequately monitored for compliance with several critical factors that ensure quality of care for children and youth.

Following the initial review of the WCFS shelter system, the OCA had the following recommendations:

- √ The DFSH will develop care standards and licensing regulations specifically for emergency shelter care that reflect the CWLA assumptions including:
 - No child or youth shall remain in a shelter setting for longer than 30 days. This time line is renewable for one additional 30-day period to allow for continued assessments. No child or youth shall remain longer than 60 days.
 - All shelters shall provide structured programming within a given program outline (ie. recreational, life-skills, cultural programming).

- Functional assessments shall be completed which can be used to assist in care planning and transition to the new placements.
- Each shelter will be age appropriate and have a routine and set rules that will promote healthy life and development.
- Provisions of competent and regular emergency medical/dental care with attention provided to special medical needs.
- Employment of qualified and competent staff with at least a two year child care diploma and experience in behaviour management, crisis intervention and prevention, counselling and recreation and supervision of children/youth.

The DFSH, in the *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, dated April 7, 2004, endorsed the recommendation that specific program standards need to be developed for emergency care placements rather than applying the broader residential care standards, that may not completely address the unique environment in the shelter system. The DFSH advised that immediate action will follow to:

- √ Begin developing program standards specific to emergency placement resources.

The Child Care Facilities Licensing and Standards Manual, revised November 2004, defines a child care facility as “a foster home, a group home, a treatment centre, or any other place designated in the regulations as a child care facility”. The Child Care Facilities Regulations include a definition of a “temporary shelter” which “means a facility where residential care and supervision, support programs and referral services are provided to children on a short-term basis”. Neither the regulations nor the standards mention emergency placement facilities. A review of the Child Care Facilities Licensing and Standards Manual shows no reference to the unique status of the WCFS EPR shelters. EPR shelters continue to comply with the standards set out for residential child care facilities. No program standards or licensing regulations have been developed specifically for emergency shelters. As a result, regulatory standards are absent for

many issues that are unique to emergency shelters such as the length of time for stay in an emergency child care facility, programming, child assessments and rules and routines. Senior staff with the WCFS Branch reported that efforts are made to comply with the OCA recommendation that children's stay in an emergency shelter should be limited to 30 days, and, if necessary renewed for another 30 days up to a maximum of 60 days. But no reference to this was found in any written information on the EPR emergency placement system. This is only a verbal guide.

The Standards Manual sets a minimum requirement that "the child care facility has written statements of the program and services offered, the goals and objectives of the program, and makes them accessible as defined in Section 28(2)" (of the Regulations). The Standards Manual also states that child care facilities should consider including therapeutic recreational activities within the objectives of a resident's treatment plan. The WCFS EPR system does not have a written mission statement or a description of programs and services. The objectives of the service are set out in the referral information that is sent out to Agencies but not included in information available to staff. These objectives relate more to referrals to the emergency shelter system than to the shelter program. Concerned about the lack of a program model which sets the direction for service delivery, the OCA recommended that the existing EPR structure can be strengthened in the interim by having a policy and procedure manual for staff to work with. It was recommended that:

- √ The Agency develops a policies and procedures manual reflective of Child Care Facilities Licensing standards, regulations and Child Welfare League of America's best practice standards.

The WCFS developed the EPR Home Manual in June 2005. With input from staff working in the shelter system, this Manual contains policies and procedures for EPR facilities and provides step-by-step guidelines and information on dealing with a variety of incidents and behaviours while working in an EPR Shelter. The Manual is well written, organized and includes references to the Child Care Facility Standards when applicable. An entire section of the Home Manual is devoted to recreational programming. The opening in this section reads, "Child Care Support Workers in consult with their co-ordinator, should plan a program of recreational experiences that

give children opportunities to find pleasure, experience success, and gain confidence. Recreational objectives should be included in each child's service plan". This section discusses types of recreational activities and provides examples of activities that staff can engage in with children and youth. There is no reference to any other programming in either the Standards Manual or the EPR Home Manual.

Almost all the child care support workers who participated in an interview for the purpose of this review indicated that no formal programs were available for children and youth residing in the shelters. Many stated that the shelter they work in has scheduled times allocated for recreational activities while others stated that decisions to participate in recreational activities are randomly made by the staff on duty. Recreational activities usually occur on the weekend. Several staff commented that they would like to see more structured programs for the children and youth but were not able to say whose responsibility it is to arrange these programs. Similarly, shelter coordinators shared a concern that day programs were not available for many children residing in shelters. If the child is not in a school program during the day, there is nothing for the child to do. Community day programs are rarely available during the school year and are "hit and miss" during the summer months. Both shelter staff and coordinators indicated that the children and youth residing in emergency shelters have too much time with nothing to do.

The role of assessments in emergency shelters is not a well-understood concept. Although staff are expected to do an assessment of a child at admission and throughout the placement, and record the information in the Child's Log as indicated in the EPR Home Manual, there is no training or guidelines for staff on how this should be done. The Child Care Facility Standards Manual does not include a standard on conducting an assessment on a child in a residential facility, however, an Appendix F, titled "Treatment Planning Process" is attached to the Standards for Child Care Facilities. The Treatment Planning Process includes a section on conducting a needs assessment. Its direction is vague. For example, the article states that "the best way to gather the information about a family's and a youth's strengths is to chat informally with them". It identifies several areas of functioning in which strengths can be explored and needs identified. However, it recommends a process of "informal discussion with family and youth, assessments that were previously completed, observation, referral from the placing agency and use of structured interviews with the family and youth". A "Strengths/Needs Assessment

Guideline” is included in the Appendix that focuses primarily on strengths and relationships. Although this is important, there is clearly an absence of an assessment format that identifies a child’s functional needs for the purpose of short and long term planning. The EPR department does not use this assessment guideline in its shelters. The EPR Home Manual contains an entire section on documentation. It begins with the opening that “documentation should be a factual recording of exactly what the staff heard and saw. The words of the children should be used, the exact behaviours witnessed should be recorded and interpretations should be kept to a minimum”. The EPR department recommends the ABC Model for observing and describing behaviours and actions and developing reasonable assumptions about these. The model involves breaking down observations into three separate components; A – Antecedents, representing the events, conditions and environment stimuli present before a behaviour or event occurs; B – Behaviour, observation of what is said or done by the individual; and C – Consequences, the results, outcomes or impact of a behaviour on others, self, environment, etc.

Emergency shelter staff were asked what their role was in assessing children residing in shelters. Most of the staff were not clear on the role, but the majority concurred that they were not required to do assessments. They did, however, indicate that they had to document behaviours and concerns in the child’s log on a regular and consistent manner. Some indicated that they verbally shared serious concerns about a child’s behaviour or emotional state with their coordinator or the child’s caseworker. Several staff stated that assessments are required in preparation for Individual Case Planning Conferences, but all staff stated that these rarely occur. In general, shelter staff are not doing assessments on children in shelter care, do not feel they are trained to do assessments and do not understand the purpose of these. Conducting child assessments should not be viewed in the same terms as documenting child behaviours, medical needs, marks and bruises and general appearance and conduct. The latter are required and appear to be done on a consistent basis. All staff interviewed were well aware of this requirement and reported regular recording in the child’s file.

Functional assessments are recommended by the CWLA as a means of assessing how a child functions within the larger environment and adapts to that environment. Primarily through observation, staff can assess a youth’s degree of

strength and impairment in day-to-day functioning. A variety of functional assessment rating scales are available and can be adapted to children and youth in emergency facilities. Using functional assessment techniques will assist staff and caseworkers to understand a child's challenging behaviour and identify specific communicative messages underlying that behaviour. This information is useful in developing a positive behaviour support plan designed to not only reduce occurrences of challenging behaviour but also to enhance a child's ability to learn and participate in home, school and other community environments.

. The EPR Home Manual contains a section for staff on daily routines in the shelters. It clearly lays out a daily schedule including meal times, nap times for younger children, times for staff and child activities, baths and preparation for bed. Similarly, guidelines are available for medical and dental care, emergency medical situations and giving medication to children. These guidelines reflect the standards set out in the Child Care Facility Standards Manual.

Placement of Children – Age, Gender and Bed Capacity

The OCA recommended age, gender and bed capacity standards for emergency care facilities.

- √ It is recommended that no children ages 0 to 7 years of age are placed in any emergency group care facility,
- √ All other group care shelter facilities shall be licensed based upon gender specific age categories,
 - Primary School age (8 - 10) up to a maximum bed capacity of four beds.
 - Pre-adolescents (11 – 13) up to a maximum bed capacity of four beds
 - Mid-adolescents (14 – 16) up to a maximum bed capacity of six beds
 - Late adolescent (16 – 18) up to a maximum bed capacity of six beds.

- ✓ Youth varying in ages and of opposite gender shall not be placed together. Under no circumstances shall licensing variance be provided which mixes the age groups and gender.

The OCA included the following exceptions to the above recommendation: Children ages 0 – 7 will not be placed in a group care setting except in these instances where,

- the child has exceptional needs documented by a specialized evaluation, and there is evidence that the facility can meet those needs
- placement of a child 0 to 7 would avoid separation of a sibling group if the sibling group were placed together in one shelter. The CEO of a CFS agency and the Director of the organization in charge of the group shelter must approve such exceptions
- shelters designed to house children in these exceptional circumstances shall be licensed to a maximum of six beds.

The DFSH responded to the OCA recommendations by creating 50 new emergency foster beds in Winnipeg in 2005. These beds were intended only for the placement of children under the age of 8, with exceptions provided for sibling groups in order to keep the children together. The SRIC recommended that the OCA recommendations be used by the CFS Authorities as guidelines within a “flexible approach for making placement decisions” (*Detailed Implementation Plan, June 2005*).

Although an addition of 50 foster home bed spaces to the existing emergency shelter system was a good attempt to reduce the number of children under the age of 8 placed in shift-staffed group resources, this was not sufficient. A review of the ages of children entering the emergency placement system, obtained from the WCFS STEP database, showed that almost one-half of all children admitted to the EPR emergency placement system were under the age of 8 years.

Age Category of Children Admitted to EPR Shelter System

| | 0 – 7 years | | 8 – 18 years | |
|-------------|-----------------|------------|-----------------|------------|
| | No. of Children | Percentage | No. of Children | Percentage |
| 2004 - 2005 | 396 | 50.7% | 385 | 49.3% |
| 2005 - 2006 | 335 | 49.7% | 338 | 50.3% |
| 2006 - 2007 | 314 | 47.2% | 350 | 52.8% |
| 2007 – 2008 | 436 | 45.0% | 534 | 55.0% |

Consistently over the last four years, children under the age of 8 made up almost one-half of all admissions to the emergency shelter system. The number of children under the age of 8 years entering the emergency placement system continues to increase and shift-staffed emergency shelters develop in order to meet this placement need. The development of emergency foster beds and foster home recruitment strategies, although essential to the child and family services system, are not showing any significant impact on the high number of young children that continue to be placed in shift-staffed shelter facilities. More than 12% of the EPR shift-staff emergency shelters are licensed for children in the age category of 0 – 8 years. Most of these shelters are licensed for four or more children.

EPR Shift-Staffed Shelters Licensed for Age Categories

| | 0 – 8 | | | 0 – 11 | | | 8 – 11 | | | 9 - 17 | | |
|---------------------------|-------|---|------|--------|---|------|--------|---|------|--------|---|------|
| EPR Shift Staffed Shelter | M | F | Coed | M | F | Coed | M | F | Coed | M | F | Coed |
| Licensed for 2 children | | | | | | 2 | | | | 6 | 1 | |
| Licensed for 3 children | | | 2 | 1 | | 14 | | | | 4 | 4 | |
| Licensed for 4 children | | | 2 | | | | | | | | 1 | |
| Licensed for 5 children | | | 2 | | | | | | | | | |
| Licensed for 6 children | | | 1 | | | 1 | | | 2 | | | |
| Total | 0 | 0 | 7 | 1 | 0 | 17 | 0 | 0 | 2 | 10 | 6 | 0 |

The EPR unit currently operates 54 shift-staffed emergency shelters with an additional six shelters in development. Of these shelters, 43 are licensed; while 11 operate as Places of Safety. Shelters have varied age, gender and bed_space licenses. Most shelters licensed for younger children do not stipulate gender, however, staff indicate that children of different genders over 5 years of age do not share a bedroom. Also children between the ages of 0 – 5 years cannot share a bedroom with a child older than 8 years. Therefore, if children are over the age of 5 years, the shelters become gender specific unless they accommodate a sibling group. Shelters for older youth are gender specific. More 2-bed shelters are licensed for adolescent male youth than for any other age group.

Some emergency shelters outside the city of Winnipeg are not gender specific allowing for flexibility when an emergency placement is required.

Length of Stay in EPR Shelters

The OCA referred to the Child Welfare League of America best practice standards for emergency residential facilities to review the length of time children should remain in emergency residential facilities. According to the CWLA, the length of stay in an emergency placement facility should be limited to 30 days, with the option of requesting an extension of an additional 30 days to a maximum stay of 60 days. The SRIC left the decision on the length of time children and youth can stay in an emergency facility to the CFS Authorities. They responded that the “Authorities will implement a flexible approach regarding the length of stay”. According to the SRIC, the Authorities recognize the need to move children and youth into stable environments but resource limitations may demand stays longer than 60 days in emergency facilities. At the time of the SRIC final report, it was stated that the Authorities are currently considering procedures for approval of stays longer than 60 days.

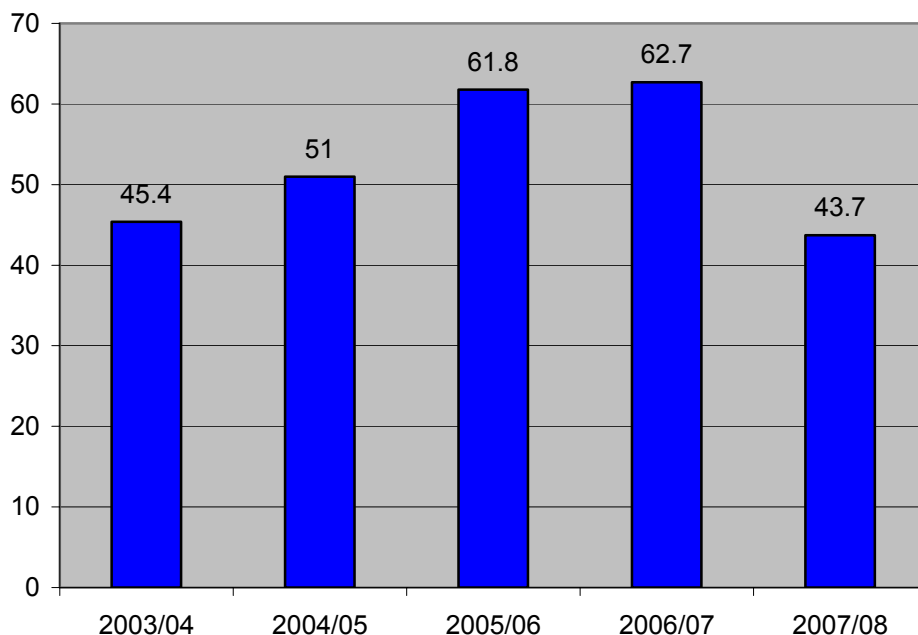
Senior managers with WCFS state that the 30-day length of stay is a goal that they try to meet. There is no policy in place regarding the length of stay in an emergency facility. The EPR shelter system has implemented an informal policy that all

children in emergency placements for over 30 days are referred to the STEP (Short Term Emergency Placement) Committee. This Committee has been in place for several years and is made up of WCFS Foster Care and EPR management staff, the DFSH provincial placement desk staff and representatives. While representatives from other agencies providing child and family services in Winnipeg have been invited to participate as representatives on the Committee, this is not done on a consistent basis.

Caseworkers may, however, attend the Committee by invitation to discuss plans for children in the EPR shelter system over 30 days. The STEP Committee has both a planning and accountability function. Caseworkers from CFS agencies are invited to attend to discuss their plans for children in the EPR shelters and with the help of the representatives on the Committee locate long term placements for the children. The biggest problem that the STEP Committee is experiencing at this time is the lack of attendance by caseworkers to discuss plans for the children they are working with. This Committee has a lot of potential to become a coordinated planning group for children in emergency shelters, if it can be developed to include participation of foster care/resource coordinators from all the agencies providing child and family services in Winnipeg and using the EPR shelter system as an emergency resource for their children in care.

Although the number of children entering the EPR shelter system is increasing, the average number of days they stay in shelter care continues to be near, or less than, the 60 day maximum recommended by the OCA.

Average Number of Days in Shelter Care



Although the average length of stay in emergency shelters may not seem unreasonable for older children, forty to sixty days is a significant length of time in a shift-staffed shelter for the large number of young children that are admitted to emergency shelter care. With the data showing that almost one-half of the children are under the age of 8 years, the average length of stay in an emergency shelter is too long. Shift-staffed shelters with rotating staff, and purchased service staff, do not provide the consistency that will benefit younger children.

Children with Special Needs

In the Shelter Review (2004), the OCA reported on the lack of available resources for children with special needs. Shelters were designed to meet the basic needs of children, and staff working in shelters did not have the specialized training needed to provide care for children with special needs. The development of specialized services within the emergency care system was recommended.

- √ Shelter settings up to six beds shall be designed to accommodate sibling groups.
- √ Shelters of up to four beds shall be designed to accommodate the physically challenged children and youth. No child under age 7 shall be placed in these shelters unless it is to accommodate a sibling group. These shelters shall be wheelchair accessible and designed to accommodate the special needs of physically challenged children and youth.
- √ The DFSH enter into discussions with those organizations now providing shelter services and community-based programs with respect to expanding street shelter programs (bed space availability) and out-reach programs to assist youth.
- √ Until the CRDO is fully operations, the DFSH and Manitoba Justice enter into discussions to develop emergency care shelters for youth leaving Youth Custody Facilities who are unable to return home or secure alternative care.

- √ Until the CRDO is fully operational, the DFSH enter into discussions with the Department of Health (Child Mental Health) to develop emergency care services for youth leaving child mental health facilities who are unable to return home or secure alternative care.
- √ Single or two-bed shelters may from time to time be required due to the high or special needs of a child or youth. The system still requires the ability to create this alternative.

In addition to coordinating emergency placements in the B & L and CLOUT foster homes and other external emergency facilities, the WCFS EPR shelter system manages 54 shift-staffed shelters in Winnipeg with a capacity to provide emergency placements for 165 children and youth at any one time. Shelters vary in the number of licensed bed spaces with 3-bed shelters being the most common. There is sufficient flexibility in the shelter system to obtain variances to meet the special needs of children.

Licensed Bed Spaces in EPR Shelters

| One bed shelters | Two bed shelters | Three bed shelters | Four bed shelters | Five bed shelters | Six bed shelters |
|------------------|------------------|--------------------|-------------------|-------------------|------------------|
| 1 | 10 | 33 | 4 | 2 | 4 |

The majority of shelters are licensed for three children. Two 6-bed shelters have been specifically designed to accommodate sibling groups. One shelter is wheel chair accessible and can be used to care for children with physical disabilities. According to EPR management staff, the one shelter seems to be enough to meet the demand for specialized shelters and the EPR unit is not considering opening additional wheel chair accessible shelters.

Children with special medical needs are cared for in the shelter system. Senior staff with the EPR reported that several shelter staff have the skills and experience to

care for children with these needs and their skills are matched, as much as possible, to the care needs of children placed in shelters. An example was provided regarding a 16-year-old youth who has been in an emergency shelter for over a year. This youth has multiple needs including Down's Syndrome, FASD and spina bifida and requires special care involving the use of a catheter and regular enemas as well as relying on a number of different medications. Two shelter staff are assigned to care for him in a shelter facility where he is the only child. The two staff have the knowledge, skills and experience to meet his medical needs. Each staff works a 12-hour shift. When a replacement is needed for one of the staff, a double staff team, including a health care aide from a purchased service agency and a casual shelter worker, is used. The child's needs are being met in this arrangement. Attempts to locate a long-term placement for this child have not been successful.

Shelter staff are matched, as much as possible, to children with special needs. Where a child has medical needs that require specialized care, the services of a health care aide are purchased to provide this care. The health care aide works alongside a shelter staff.

Alternative Placement Options

A large number of youth referred for emergency placement in the EPR emergency shelter system enter the system from the criminal justice system and the mental health system. These youth present with challenging behaviours and special needs that require intensive care plans. Prior to the Hotel Placement Policy these youth would be accommodated in a hotel placement. In addition, the youth are not always cooperative with care plans and leave without permission whenever they want. They make up a group of youth that move between the criminal justice and child and family service systems, and occasionally the mental health system. These youth do not do well in emergency placements because they don't want to be there. To address the placement needs of this group of youth, the OCA, in the first review of the shelter system, recommended that the DFSH expand the number of bed spaces and outreach activities provided by street shelters. The care needs of some of these youth can just as well be accommodated in a more flexible arrangement. The OCA recommended an expansion in the number of safe houses and street shelters that are currently available.

Several initiatives have resulted in an increase in the number of safe houses and new placement resources available for youth. Along with the Manitoba Justice, the DFSH has been involved in the Manitoba Strategy on Child and Youth Sexual Exploitation. This initiative is a partnership between several government departments and community organizations and has resulted in the development of several resources for children and youth.

1. Honouring the Spirit of Our Little Sisters Safe Transition House

Operated by the Ma Mawi Wi Chi Itata Centre Inc., Honouring the Spirit of our Little Sisters, is a six-bed transition home for female and transgendered youth, ages 13 to 17, who have been subjected to or at risk of continued sexual exploitation.

2. Marymound Inc. – Rose Hall Facility

Marymound Inc. operates Rose Hall, a residential care facility offering special services for young women ages 13 to 17 who have been sexually exploited.

3. RaY Inc. Emergency Youth Services

Resource Assistance for Youth (RaY Inc.) receives provincial funding to assist youth living on the streets to connect with services aimed at repatriating them with their families. A variety of services are available, including emergency housing, for youth.

4. MacDonald Youth Services – Youth Resource Centre

The Youth Resource Centre offers overnight shelter for youth aged 12 to 17 and provides 24 hour crisis stabilization intake services for children and youth up to the age of 18 years who are experiencing acute psychosocial distress.

Along with increased placement resources, an Outreach Program with four outreach positions, that operate out of residential care facilities in Winnipeg, work to locate youth who run from residential care facilities in order to reduce the number of youth who become at increased risk of sexual exploitation because they are living on the streets. These programs have increased the resources available to children and youth in the City of Winnipeg. Both the DFSH and Manitoba Justice are working with federal government departments to advocate for sustainable funding for organizations providing these services.

According to senior staff with the WCFS, the EPR shelter system continues to be the placement option for youth discharged from correctional and mental health facilities. These youth present a serious challenge to the shelter system and strain both the fiscal and human resources in the system. Frequently, shelters must be double staffed because of the volatile and unpredictable nature of some of the youth. Many are gang-affiliated, use substances and drugs and are prone to violent outbursts. In addition, some of the youth present a safety risk to staff and other residents by bringing weapons into the shelters or through threats and intimidation. An example was provided of a 17-year-old youth who is 6' 8" tall and weighs 240 pounds but functions at a developmental age of five years. This youth is easily angered and prone to temper tantrums that, because of his size and lack of maturity, can present a danger to staff and to other residents. As a result, this child cannot be placed with other residents. Management staff report that in a systems meeting around this child, other service organizations clearly acknowledged that they could not accommodate this child because he presented a risk to others. There was no other resource available to care for him but the emergency shelter system. Regardless of the fact that this child presents a physical threat to others, the emergency shelter system is the only system that can't refuse to care for him.

Multidisciplinary Team Planning

Like the youth described above, there are many others that present such challenges that no other placement option is available to them, including a reunification with family members. These children and youth remain in the shelter system on a long-term basis as the system struggles to find appropriate resources for them. The OCA

recommended that a Multidisciplinary Treatment Team be established to assess and develop treatment plans and locate appropriate alternative placement arrangements for these children and youth.

- √ That the DFSH, along with the Four Authorities establish geographically-based multidisciplinary treatment teams to develop comprehensive care and treatment plans for high needs children and youth. Membership on these teams must also include community members and line social workers from CFS agencies.

In response to this recommendation the SRIC noted that the use of multidisciplinary treatment teams to support families involved with multiple service providers is common practice throughout the CFS system. In the *Detailed Implementation Plan (June 2005)*, the SRIC wrote, “The CFS Authorities will establish standards of practice for multidisciplinary treatment teams for each agency under their jurisdiction”. The importance of properly assessing the needs of youth in the child and family services system and providing the specialized supports that are specific to the needs of this youth has been documented in the OCA report, *Honouring Their Spirits: A Child Death Review (2006)*. The review team found that the service needs of this group of children and youth required a multidisciplinary treatment-focused response. This can be accomplished through collaborative planning by representatives from different areas of knowledge and expertise.

It was not easy to ascertain whether multidisciplinary teams are used in all agencies to plan for children in care. There really appears to be no evidence of a formal structure of treatment planning using multidisciplinary teams, however, it likely this occurs on a case to case basis simply because many children in care are involved with other systems in addition to child and family services. The WCFS Short Term Emergency Placement (STEP) Committee is the formal body used to review emergency placements and make recommendations for children that are in the shelter system. This committee has the flexibility to invite representatives from other systems to participate in case planning. However, this is not frequently done.

The importance of intersectoral communication and planning has been a recurring theme through the external review reports that the Standing Committee has been working on. In response to recommendations in this area, the Interim Child Welfare Inter-Sectoral Committee has been established to begin working on recommendations related to the need for increased collaboration and integration of other systems. Two multi-disciplinary action teams have been developed to work on initiatives related to providing assistance to youth with Fetal Alcohol Spectrum Disorder (FASD) and developing a province-wide strategy for suicide prevention.

Although the above initiatives will enhance services to youth, they will not replace the need for child-specific treatment plans that include assessments of need and development of treatment plans to address the multiple needs of a large number of children and youth in care. To achieve this, multidisciplinary treatment teams are critical. At this time, no formal standards are in place to guide interdisciplinary planning at the casework level. Issues concerning children in care cross several government departments and community organizations providing an opportunity to coordinate effective and efficient responses and treatment planning for successful outcomes. Children and youth in care utilize a wide array of services such as education, medical, mental health, justice, substance abuse and counselling. Partnering in developing “wrap around” treatment plans for children in care should be an essential component of treatment planning. Unfortunately, at this time, the task of coordinating multidisciplinary team planning is left to the responsibility of caseworkers, creating a “hit and miss” situation where some caseworkers arrange interdisciplinary meetings to plan for their children in care frequently, some do so occasionally and some do not do so at all.

Shift Configurations

Many staff that work in the EPR program facilities were initially hired to work 24-hour shifts as this configuration was regarded as the closest alternative to the continuous care environment that a foster home would provide. In 2000, guaranteed hours were inserted in the collective agreement for Child Care Support Workers. During the initial review of the WCFS emergency shelter system, the OCA reported that the existing guaranteed 12-hour and 24-hour shifts impacted the care provided to children. Shelter staff had reported that the shifts were too lengthy and, due to the care needs of

the children, resulted in staff becoming fatigued risking errors in judgment. The OCA also found that a large percentage of the incident reports involved staff working 12-hour shifts. As a result, the OCA recommended that:

- √ All shelters shall operate under an eight to a maximum of 10-hour shift configuration.

In response to this recommendation, the WCFS took measures to phase out 24-hour shifts. The bargaining unit for the shelter staff opposed this move and the matter was referred to arbitration. After a lengthy arbitration process, WCFS was awarded the right to eliminate this shift configuration but guarantee 12 hour shifts to the affected employees. The arbitrator ruled that there would be no deletions of the 12-hour shifts for the duration of the collective agreement. Approximately 100 shelter staff are currently working 12-hour shifts in 8 x 12 or 7 x 12 configurations in a two-week period. The WCFS has started hiring new staff for 8-hour and 10-hour shifts.

Staff – Child Ratio

In the Shelter Review (2004), the OCA recommended changes to the staff-child ratio for children between the ages of 8 and 18 in shift-staffed emergency shelter facilities.

- √ Child to staff ratio shall be one staff member for every two children/youth throughout all shifts. Particular attention needs to be paid to bringing on additional staff or scheduling of staff during times when incidents would most likely occur.

This recommendation was made with the assumption that children under the age of 8 years would no longer be placed in shift-staff shelter facilities. The OCA, in the Shelter Review (2004) clarified that, “as children ages 0 to 7 are removed from the shelter care (with the exception of those that fall under the exception category), and a clear delineation has been made for the 8 to 18 age group, the child to staff ratios and subsequent staff hours should be changed”. The current reality is that there are not sufficient emergency or other foster care beds available in the system for the large

number of children that enter the child and family services system and, therefore, children under the age of 8 continue to be placed in shift-staffed emergency shelters.

The staff-child ratio varies in shelters depending on the ages and needs of the children. As most shelters are licensed for three - four children, one staff working a 12-hour shift is the regular practice. However, depending on the needs of the children, it is not unusual for two staff to be present during a 12-hour shift. In some shelters only one staff works the night shift while two are present for the duration of, or part of, the day shift. Shelters with older children may require two staff per shift at all times. The shelters licensed for more than three children have at least two staff working at all times. Again, based on the needs of the children in the shelter, a third staff may be required. At the same time, occasionally a shelter with one or two children may require two staff at all times. There is considerable flexibility in determining staff-child ratios and the needs of the children or youth in the shelter facility at the time are the biggest determinants of staff-child ratios.

The EPR unit has 24-hour On Call Dispatch staff available to shelter staff in the event that they need to consult on a matter after hours and a Coordinator is not available. The On Call Dispatcher has the authority to increase staffing in situations where the staff on duty is experiencing difficulty with a child or is dealing with a critical event. A roster of casual on-call staff that could be contacted to attend at a shelter to offer assistance to the staff on duty is maintained. Supervisory access is available 24 hours a day through a system of shift rotations by management staff within the EPR.

Provincial Abuse Investigator (PAI)

The Provincial Child Abuse Investigator position was created by the Department of Family Services and Housing in 1999 to investigate allegations of child abuse made against staff in residential child care facilities across the province. The definition of Abuse, in accordance with *The Child and Family Services Act*, is:

An act or omission by any person where the act or omission results in:

- a) physical injury to a child

- b) emotional disability of a permanent nature in the child or is likely to result in such a disability, or
- c) sexual exploitation of a child with or without the child's consent.

The Shelter Review (2004) reported that the definition of abuse limited investigations to allegations of child abuse as defined under the Act and did not include questionable or inappropriate child management practices. In addition, abuse investigations were limited to WCFS staff employed in shelters and not to purchased services staff. The latter were investigated by WCFS agency staff. The OCA expressed concerns that, although the results of the investigation were shared with the employer, the PAI was restricted to recommendations that did not affect an individual's employment status.

Following a review of the interface between the PAI office and the WCFS shelter system the OCA, in the Shelter Review (2004), made seven recommendations involving the office of the PAI and the WCFS shelter system:

- √ The DFSH create one additional position to investigate allegations of child maltreatment in all forms of residential care licensed by the Province of Manitoba. These positions remain centralized to the DFSH given that it is the department that is the licensing authority.
- √ The PAI should not be bound by the definition of abuse but be allowed to investigate all concerns related to questionable child management practices and provide recommendations for corrective actions.
- √ The PAI should be allowed to make a variety of recommendations, including a person's employee status, as it relates to conclusions reached by the investigator of the appropriateness of a staff person's individual behaviour and job performance.
- √ The PAI be required to investigate all allegations against all staff, either permanent or purchased-services staff, providing care in the shelter system.

- √ The Agency institute a mechanism to respond to all future PAI reports, outlining corrective actions with stipulated time lines. Further all PAI reports are copied to all required management personnel, including the Human Resources Director in WCFS for information and direction.
- √ The DFSH, as the Licensing Authority, institute a mechanism to track all of the PAI reports to ensure compliance with recommendations.

The DFSH prepared a response to the OCA Shelter Review shortly after the release of the Report. In the *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, dated April 7, 2004, the DFSH presented an action plan to address the recommendations made by the OCA. The action plan contained the following immediate actions to be taken with respect to the Provincial Abuse Investigator:

- Expand the mandate of the Provincial Abuse Investigator as proposed in the Advocate's report and develop a program standard to ensure the Investigator's reports are tracked and recommendations followed.
- Add one more staff position to the Provincial Abuse Investigation Unit.

An update on the above recommendations shows that the office of the Provincial Abuse Investigator has grown in both staff and responsibility since the previous review. As recommended by the OCA, a second Abuse Investigator was hired in November 2004. A third Investigator was hired in April 2008 and approval has been obtained to hire a fourth investigator. At the time of this review, the DFSH has set up interviews for the hiring of the fourth investigator.

The office of the PAI continues to be centralized with the DFSH. In the 2007/2008 fiscal year the PAI unit screened approximately 4000 complaints of alleged abuse against a child. Follow-up activity included reviews, meetings, information clarification, and consultations on a majority of these referrals. A total of 120 abuse reports were investigated in full in 2007/2008. More recently the responsibilities of the

PAI office have been extended to include reviews of all abuse investigations in foster homes. Although the office is not currently investigating these abuse allegations, they are provided with copies of investigative reports and review these for quality assurance, best practice, and compliance with child abuse protocols.

The OCA, in the Shelter Review (2004) recommended that the PAI office not be bound by the existing definition of abuse and proceed to investigate concerns related to questionable and inappropriate child management practices and recommend corrective actions. Due to considerable research on the subject over the past few years, the definition of child abuse has been interpreted in a broader sense to include incidents where no physical signs of harm are evident. This allows for a broader interpretation of child abuse and allows for the PAI unit to proceed with investigations in situations where no physical signs of harm are present but questionable practices involving a child are reported. The Provincial Advisory Committee on Child Abuse (PACCA), an interagency group with representatives from provincial government and community organizations established to address policy issues related to child abuse in the province, has added the following interpretation in its Child Abuse Protocols for Social Workers.

“A child can be considered in need of protection for acts of omission, where a person fails to do something to protect the child. This could include failure to provide proper physical care, failure to provide proper medical care or failure to protect the child from harm”. [PACCA - Provincial Advisory Committee on Child Abuse](#)

The RCMP define child abuse as follows,

“....any form of physical, psychological, social, emotional or sexual maltreatment of a child whereby the survival, safety, self-esteem, growth and development of the child are endangered.” [RCMP What is Child Abuse](#)

The broader definition of child abuse has enabled the office of the PAI to investigate a range of allegations of mistreatment to children in residential care facilities. According to senior staff with the DFSH, in the last two years the scope of abuse investigations has increased to deal with inappropriate staff behaviours toward children such as investigations of non-observable injuries. An example was provided of an

allegation that a staff shut a door on a child resulting in the child complaining of having a sore back. In this situation the investigator concluded that abuse has occurred. Other incidents leading to abuse investigations include situations where staff become too forceful in dealing with a child management issue or too lenient in allowing children to leave the facility in anger or at an hour when they may be endangered on the streets.

Once an abuse investigation is completed, recommendations are forwarded to the Executive Director and Program Manager of the agency or organization operating the residential care facility. Recommendations focus on fundamental structural and basic needs issues and do not include specific recommendations on human resource issues such as performance status or disciplinary action. In the Shelter Review (2004), the OCA recommended that the PAI should be allowed to make recommendations on an individual's employment status as it relates to the conclusions of the investigation and the appropriateness of that individual to work with children and youth. According to a senior manager of the DFSH, recommendations resulting from an abuse investigation do not go as far as recommending that an individual should be discharged from a position, however, recommendations to employers are quite specific, such as, "this staff person should not be working with children under six years of age" or "with teens". The onus remains with the employer to take action to deal with the individual. Because of specific collective agreements and disciplinary action procedures, employers remain responsible for decisions to discharge or reassign an individual to another position. An example was provided of a staff person who was investigated on three occasions for inappropriate conduct involving youth. The Agency's attempts at disciplinary action led to a grievance to the employee's bargaining unit and a ruling that the employee be reassigned to another position rather than have employment terminated. According to one employer, it is difficult to reassign an employee to a position that does not involve some contact with children or youth in their organization. All bargaining unit positions in that organization involve direct contact with children and youth.

The PAI unit has been contacted by representatives from bargaining units, on behalf of employees disciplined for abuse, challenging recommendations and demanding that employees be paid if they are suspended while an abuse investigation is in progress. Several meetings regarding the results of PAI investigations have included bargaining unit representatives. One such meeting included an employee who was

discharged for using a severe form of physical restraint. The grievance process resulted in a reinstatement of this individual. Due to the complexity of making recommendations to suspend or discharge an employee found to be abusive to a child, at this time the office of the PAI does not make recommendations on disciplinary action or employment status.

The OCA recommended that the office of the PAI investigate allegations of abuse involving purchased-service staff as well as employed staff. The PAI unit started investigating abuse allegations involving purchased-service staff that are working in residential child care facilities or group homes in 2005. Since the office of the PAI included purchased-service staff in their responsibilities, several investigations have occurred. One of the most notable concerns was that purchased-service staff are not adequately prepared and trained to work with children or youth with behavioural challenges. The most common recommendations resulting from abuse investigations involving purchased-service staff are that two purchased-service staff should not be working together on a shift, but that they should always be working with an employed staff person, and that the purchased-service staff be adequately prepared and trained to work with children and youth. If an abuse investigation finds that a purchased-service staff is overly aggressive with children or youth, in addition to advising the agency or organization responsible for the child care facility or group home, the organization that employs the purchased-service staff is notified.

All recommendations resulting from an abuse investigation are submitted to the Executive Director and senior manager of the facility in question. The OCA recommended that the Human Resource Director of WCFS receive a copy of the investigation report and recommendations. At this time, the office of the PAI is not sending reports directly to the Human Resource departments but expects that the Executive Directors forward copies of abuse investigation reports and recommendations to the appropriate individuals and departments. According to DFSH staff, a meeting with Human Resource Coordinators resulted in a decision that it was not necessary for them to receive the conclusions and recommendations directly from the PAI. This information will be obtained from the Executive Directors.

The OCA recommended that WCFS put in place a mechanism for responding to PAI recommendations, outlining corrective actions and stipulating time lines. At this time this is not being done. Although, as stipulated in the Child Caring Facility Licensing and Standards Manual, there is an expectation that an agency reports back to the PAI on corrective actions taken in response to recommendations, there is not a formal process for doing so. It is a hit and miss situation where the WCFS Branch coordinator may get back to the PAI investigator to report what occurred following a recommendation, or it may be the PAI calling the coordinator as a follow-up asking what corrective actions were taken with respect to a recommendation. Once any response is received it is entered in the file and remains there primarily because the PAI Unit database does not have the mechanism to track this information at this time. According to PAI unit staff, very few reports are received back from the EPR unit or any other residential care facility advising what corrective action was taken in response to the recommendations following an abuse investigation.

The OCA recommended that the DFSH institute a mechanism to track the PAI reports to ensure compliance with the recommendations. A shared database for the PAI unit was developed approximately two years ago. Initially, with only one PAI, data was entered and maintained by this individual in a system that she developed. With the increase in staff, a shared database was necessary. The new database has the potential to collect compliance information, but it is not currently set up to track this information. It appears that, in general, the recommendations from the office of the PAI are not tracked on a database and there is no mechanism in place to ensure that there is compliance by agencies and organization with the recommendations.

Senior DFSH staff noted this as a concern and stated that they will begin sending letters to educate and remind all residential care facilities, including the WCFS EPR unit, of the role of the PAI, and advising that a response to recommendations is required within a four month time period. Additionally, it was noted that the database must be improved to include the capacity to collect data from residential child care facilities on corrective actions taken in response to abuse investigation recommendations.

Integrated Services Planning

During the process of reviewing the WCFS Emergency Placement and Assessment Department, the OCA heard that a large number of children residing in emergency shelters present with a complexity of special needs. However, once the children entered the CFS system, the agency was alone in planning for them. Lack of supports and resources and institutional barriers prevented many children from accessing the services that they required from other systems. As a result of these concerns, in the Shelter Review (2004), the OCA recommended:

- √ That the DFSH examine the feasibility of creating an Integrated Departmental Services Committee (similar to that of the Inter-Ministerial Provincial Advisory Committee – IMPAC, in Ontario) that would address barriers created through policy that prohibit continuity of planning for children across government service sectors.

In the *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT* dated April 7, 2004; the DFSH concurred with some elements of this recommendation and advised that action will be taken to:

- Initiate discussions with service providers and other departments to consider how specialized resources can be developed to provide emergency care for siblings, children with disabilities and children leaving the Justice system.

Staff at all levels of the EPR unit reported, both at the time of the first OCA shelter review and again through the process of the current review, that a significant number of youth are discharged from PY1, a mental health assessment unit for children and from the Manitoba Youth Centre, to be looked after in the emergency shelter system. Staff provided an example where a 17-year-old child has been in five different shelters in a period of 5 months because of assaults on staff. When Winnipeg Police Services attend, the child is charged, but within a few days is released from the Manitoba Youth Centre and in need of an emergency placement again. As no other placement resource is available to him, and he cannot live independently because of a very low level of functioning, the EPR program continues to care for him. Another youth, 16 years of age with severe depression and 3 suicide attempts, was discharged from the adolescent

mental health services to the EPR unit with the advice that the child is at high risk of suicidal behaviour. The shelter system was charged with the responsibility to ensure that he does not follow through on a suicide attempt. Shelter staff and coordinators provided additional examples of children and youth that are in emergency shelter care who were known car thieves, fire starters, gang members, and youth engaged in selling drugs and carrying dangerous weapons. According to shelter staff, there are no other systems available to care for many of the youth who come in and out of the emergency shelter system. Shelter staff are frustrated with the isolation that they feel in dealing with some of the difficult youth in care. They find that other systems that should be involved with these youth tend to become unavailable once the child is in care.

An Interim Child Welfare Intersectoral Committee (CWIC) was created by the Standing Committee to identify and involve key intersectoral partners with expertise related to mental health, addictions, suicide and complex medical needs that affect children. The Committee had its first meeting in September 2007 and is developing a detailed work plan for addressing intersectoral working relationships. Currently, a critical lack of equity and accessibility to programs and resources across government departments is a concern. Services for children may have to be sought from as many as six different departments or agencies. This issue is not unique to this province and is an area that has been raised as a concern in other jurisdictions.

Judy Finlay, Chief Advocate with the Office of Child and Family Services Advocacy in Ontario, wrote a report on the critical lack of equity and accessibility to programs and resources across government departments in Ontario. In the report, *"Snakes and Ladders: A Dialogue"*, Finlay cites several reasons why the current system of departmentalizing services impacts on the provision of equitable and accessible services, particularly for children with high or special needs. She notes that departmental or agency policies are often developed in isolation from each other, delegating responsibility for specific services only within that particular department or agency. High and special needs children present with a multitude of different needs. Departments or agencies providing a specific service lack the flexibility to respond to multiple needs and, as a result, the child must access services from several departments or agencies to address their multiple needs. Finlay cautions that, in this system, there is

a risk of specific needs being easily reframed as someone else's responsibility and the child referred to another department or agency.

Funding is attached to departments or agencies, service delivery systems or types of services provided. This intensifies the so-called "silo" effect, says Finlay, and impedes the development of substantial collaboration and meaningful partnerships across departments. Furthermore, resource limitations and instability in funding has led to high caseloads. This impinges on the ability to participate in community engagement and collaboration activities, which is often regarded as extra work that tends to fall to the side when caseload priorities take the forefront.

An Integrated Service Plan would consider services to children with high needs as a single service system, and have the capacity to develop joint service plans, including coordinated assessments and interventions and target the services needed to meet the needs of the child. This would ensure inclusive access for all children to required services. In an integrated service delivery plan, the needs of the child are at the forefront and the required services are accessed to meet the needs.

In the last few years the DFSH has moved forward with an integrated service system bringing services and resources closer together geographically and in proximity to each other making accessibility to health and social services much easier for the public. This is a positive step forward. A strategy to integrate services to special needs children would ensure accessibility and consistency for all children with high or special needs in the province.

Collateral Service Systems

Both the Youth Emergency Crisis Stabilization System (YECSS) and the Winnipeg Police Services (WPS) have a consistent involvement with the WCFS EPR Shelters in that staff frequently contact one of these services as a resource to assist them in dealing with youth who may be out of control. The YECSS is a 24 hour community-based crisis intervention service for children and youth and their families who are experiencing acute psych/social distress and behaviour difficulties. Staff working in emergency shelters are advised to call the YECSS if they are caring for a child who is

exhibiting extreme behavioural or mental health concerns. The EPR Home Manual, a policy, procedure and information manual for staff working in emergency shelters advises that YECSS should be called when children or youth are physically acting out or showing an escalation in their behaviour that may present a crisis or a dangerous situation. WPS are to be called whenever a child leaves the Shelter without authorization, does not return by curfew or is becoming violent and a threat to either self, staff or other residents.

In the Shelter Review (2004), the OCA made two recommendations following an examination of the role that the Youth Emergency Crisis Stabilization System (YECSS) and the Winnipeg Police Services (WPS) had with WCFS Emergency Shelters:

- √ The DFSH review the information provided by the OCA with respect to the YECSS system. The DFSH then enters into discussion with the Agency and the YECSS to determine if the shelter system is adequately utilizing the YECSS program. Further these discussions continue as the new shelter system is developed to ensure that any new system has ease of access to YECSS resources as required.
- √ The DFSH review the information provided in this report as to the shelter's use of Winnipeg Police Services. The DFSH and the Agency then enter into discussions with the WPS to formulate policies and procedures formalizing police response to both the current and future shelter system.

The DFSH acknowledged that closer working relationships with the above service providers were needed to ensure existing resources are being used effectively and new resources created to service children with special needs. In response the DFSH proposed the following immediate action plan.

- Initiate discussions with the Youth Emergency Crisis Stabilization System and Winnipeg Police Services to ensure resources are being used appropriately within the shelter system

The YECSS Emergency Response Service

Senior staff with the WCFS EPR unit reported that they infrequently use the YECSS intervention service and do not collect specific information on the reason and frequency of contact with this service. Although any contact with YECSS or WPS would be documented in Incident Reports, the EPR unit did not have the Incident Reports entered on a database and, as a result, the task of accessing this information manually was insurmountable. It was reported that the existing database can contain this information but the process of entering the data from Incident Reports has not been completed. Therefore, this information was not available. Contact with the MYS YECSS program also produced limited information. Although the YECSS database collects referral information, it is not able to provide information about the type of incident that was responded to or the outcome of the response. YECSS staff reported that in the fiscal year 2007/2008, the YECSS received 80 calls from Emergency Receiving Resources. This category, however, is not limited to the EPR emergency shelters but may include other emergency facilities other than foster homes. In order to obtain information about the contacts, a manual search of written information would be necessary. This, however, would be complicated by the fact that all written information was attached to child specific files.

The OCA recommended that the DFSH, which provides partial funding for the emergency response service, enter into discussions with the WCFS Branch and the YECSS to determine if the service is being reasonably utilized and to work out a system of access and usage. In response to the OCA recommendations, meetings were held between the DFSH, WCFS Branch and the YECSS program to discuss improvements in coordinating the working relationship between the EPR shelters and the program. The YECSS program arranged a workshop with EPR Shelter Coordinators to review policies and practices. Guidelines were established to improve the working relationship between the two systems

As it was not possible to obtain data from either the YECSS program or the EPR unit on the frequency of referrals and responses to calls regarding children in emergency shelters, the DFSH was asked to assist. The DFSH only maintains records of children and youth placed in the Crisis Stabilization Unit (CSU). From those records, it appears

that the crisis stabilization unit for girls is reasonably used as expected but that the crisis stabilization unit for boys could be better utilized. This issue was flagged by the department and a plan to establish a committee to review the crisis stabilization unit for boys will be set up. At this time there is no committee in place to further review the access arrangement and usage of the YECSS by the WCFS EPR system.

The Winnipeg Police Services (WPS)

Due to the challenging and high-risk behaviours associated with some of the children and youth in the EPR shelters, the presence of Winnipeg Police Service in EPR shelters is notably frequent. In the Shelter Review (2004), the OCA reported that police involvement with EPR shelters equated “police attending a shelter every 2.35 days over a year”. The EPR Home Manual provides guidelines for shelter staff on when they should be calling the police:

- “If the child presents under the influence, and is aggressive, and/or potentially assaultive, then staff need to immediately contact WPS for assistance.”
- “When considering locating and returning a child, ensure police assistance whenever possible.”
- “If a child does not come home in time for curfew or takes off after curfew, they should be reported to missing persons.” “If police refuse to accept the report, ask for their name/badge number so we can have a record of attempting to place a Missing Persons Report.”
- “If we are physically incapable of stopping (the child’s) behaviour, the police should be contacted through 911 immediately.”
- “If children hurt other children purposely, we may choose to involve the police on their behalf if we have witnessed the assault.”
- “If behaviour is escalating quickly or is becoming dangerous contact the Mobile Crisis Team or the police.”

- When a child or youth has been a victim of a sexual assault or sexual exploitation.

The OCA recommended that the DFSH and the WCFS Branch enter into discussions with the WPS to develop policies and procedures formalizing police response to the EPR shelters. In 2006 the DFSH established the High Risk Youth Committee, comprising of representatives from several departments of the WPS, the DFHS, the WCFS Branch including the EPR department, ANCR, and the Manitoba Association of Residential Treatment Resources (MARTR). The purpose of this Committee was to formalize access and response policies and procedures between the WPS and residential care facilities in Winnipeg, including the EPR shelters. The WPS are concerned about the high number of calls that they receive in response to issues concerning children in care. As one member states, “CFS kids make up 75% of police work”. The workload issues revolve primarily around the high number of Missing Person reports because children/youth have simply walked out of care facilities. Once the children/youth are out on the streets, involvement in criminal activities and the risk of sexual exploitation increases. The WPS are concerned that the CFS system is not doing enough to prevent children in care from being on the streets. They are questioning why staff do not do more to stop children from leaving. They argue that it is the responsibility of shelter staff to ensure that children do not leave. As a result of these concerns, the WPS Missing Persons unit is beginning to collect data on the number of CFS children in care that are being reported missing. On the other hand, staff in shelter facilities are not encouraged to act in a way that may result in a confrontation with a child. The EPR Home Manual tries to provide guidelines for staff when a child should be reported as a missing person. It identifies several factors that should be considered to determine if police should be contacted. These include developmental or chronological age of the child, whether this is an isolated or repeated incident, whether safety of the child is a concern, if the child left alone or with someone, and the risk factors. The advise in the Home Manual is that, “if the child is young, or the behaviour is uncharacteristic, or we think they are in danger, contact police immediately”. This suggests that only some children and youth are reported to police as missing persons. Other children and youth are not even reported missing if they leave or don't return to the shelter at curfew time. A review of the EPR Incident Reports for the four-year period

from Jan 2004 to Dec 2007 shows that 1059 children were AWOL from a shelter. It is not known how many of these children were reported as missing persons to the WPS. EPR shelter staff report that it is difficult to get through the WPS Missing Person phone line and sometimes they just give up.

Over the last year, the High Risk Youth Committee has been active in developing and promoting several activities:

- A workshop was presented on utilizing charges under *The Child and Family Services Act* as an alternative tool for child welfare and law enforcement in reducing risk to children.
- A joint workshop for law enforcement officers and CFS Workers was held in March 2008. The focus was on collaborative approaches to deal with child abuse.
- Discussions continue on alternative ways to try to communicate with and locate missing children. For example, using text messaging, Hotmail, cell phones, etc.
- Discussions continue on developing a risk-assessment tool for group facilities to assess what kind of risk children are at when they leave.
- Inclusion of the four Outreach Workers, working with some of the larger residential facilities in Winnipeg, in the Committee.

Final Thoughts

Approximately 78 recommendations were made to the DFSH and the WCFS in the Shelter Review (2004). Both the DFSH and the WCFS, now a Branch of the DFSH, made a concerted effort to respond to a number of the recommendations.

Shortly after the release of the Shelter Review (2004), the Minister of Family Services and Housing, at the time, responded by adding 50 new emergency foster home bed spaces in Winnipeg and creating the Shelter Review Implementation Committee

(SRIC) to develop an action plan to respond to the recommendations. During its one-year term, the Committee arranged for a province-wide needs assessment, including a literature review of the out of home care needs of children and youth, and developed a detailed implementation plan for an emergency care system. The First Nations Child Caring Society (FNCCS) was hired to complete a literature review while the Policy and Planning Branch of the DFSH embarked on a needs assessment using three survey instruments to obtain information from child and family service workers and residential care providers, and the CFSIS database.

By the time the SRIC ended its term, it proposed principles for a continuum of care for child and family services in the province, and drafted a vision statement and principles for an emergency care system. It also left a wealth of information behind as it handed over the responsibility for further work on the implementation plan to the Child and Family Services Standing Committee.

A total of 78 recommendations were reviewed in this report; some of the recommendations were so similar that they were combined while other recommendations included more than one required action and, therefore, were assessed as two parts to the recommendation. This brought the total recommendations to 80. All recommendations were assessed for action taken using the following criteria:

1. Completed – the recommendation or portion of the recommendation was completed in full and no further action is necessary,
2. In Progress – the recommendation is being addressed but has not been fully completed.
3. Ongoing - the recommendation is part of larger context or a series of actions that are currently being addressed.
4. No Change – the recommendation has not been addressed and policy and practice continues as it did prior to the recommendation.
5. Rejected – the recommendation was reviewed and a decision was made to reject the recommendation.

A total of 50 recommendations, or 63%, were either completed, in progress or

being addressed as part of a larger plan (ongoing) for child and family services in the province. There was no change to 23 recommendations and 7 recommendations were rejected after being reviewed and considered.

Twenty recommendations, or 25% of the total recommendations, were completed at the time of this review.

- A province-wide community assessment of out of home care was completed in 2005.
- An additional Investigator was added to the Provincial Abuse Investigators unit in November 2004. Since then the PAI unit had doubled to four.
- A second Provincial Licensing Specialist was added to the DFSH Licensing Branch in October 2004. Approval to hire a third Licensing Specialist was obtained in May 2008.
- The scope of investigating abuse allegations was expanded for the PAI unit to include investigations of questionable child management practices.
- Alleged incidents of abuse by purchased service staff working in licensed residential facilities is now being investigated by the PAI unit.
- An internal financial audit was completed on WCFS in 2005.
- As recommended by the OCA in the 2004 Shelter Review, the EPR program is managed by the WCFS, which is a Branch of the DFSH until it is transitioned to the Southern Authority.
- The WCFS developed the Home Manual in 2005. This manual is a combination of policies, procedures and step-by-step guidelines and relevant information for EPR program shelter staff.
- The WCFS developed the Systematic Tracking of Emergency Placements (STEP) database in 2005.
- The management structure in the EPR program was strengthened with a clear designation of responsibilities for the program manager, the addition of a supervisor position, and the continued assistance of a seconded position from the DFSH.
- Supervisory responsibility of shelter coordinators has been designated to a management team consisting of the program manager, and two supervisors. Shelter Coordinators provide direct supervision to shelter staff.

- Shelter coordinators complete site inspections in shelter facilities on a monthly basis.
- Non-Violent Crisis Intervention (NVC) training is mandatory for all staff who work in EPR shelter facilities. This includes regular, casual and purchased-service staff.
- Two positions were added to the WCFS Human Resource Department that support the EPR shelter staff; A Labour Relations/Compensation Coordinator and an Employment Equity Coordinator.
- Variance Orders are posted in shelter facilities.
- 24-hour shifts were eliminated.
- Information on the Office of the Children's Advocate was visible in all shelters that were attended.
- Fifty emergency foster bed spaces were created for children under the age of 8 years in Winnipeg in 2005. These have increased to 165.
- Increases in foster home rates were announced and implemented over a two-year period.
- A province-wide foster home recruitment strategy was developed and implemented.

Twelve recommendations are currently in progress.

- The DFSH and the Four Authorities, through the Alternative Care Sub-Committee are working on the standardization of special rates for foster homes, and a standardized classification system for placement resources in the province.
- Integrated service planning for high needs children and youth was recommended in the Shelter Review (2004) and was a common theme in several other reviews on child and family services. In 2008 the Standing Committee created the Interim Child Welfare Intersectoral Committee (CWIC) to develop a work plan for addressing intersectoral working relationships.
- The High Risk Youth Committee was established in 2006 with representatives from the DFSH, RCMP and Winnipeg Police Services, Child and Family Services and the Manitoba Association of Residential Treatment Resources (MARTR).

- Funding for an emergency care system is part of the province-wide budgetary process for child and family services. The EPR program is in the process of being transferred from the DFSH to ANCR, an agency of the Southern First Nations Authority.
- Analysis of EPR program expenditures is included in the transitional planning process currently underway by the Joint Management Committee for ANCR.
- Budgetary planning is part of the transitional planning process for the EPR program's transition to ANCR.
- The transitional planning process for the EPR program includes an evaluation of operational and programming responsibilities.
- Supervisory access across all shifts has been improved somewhat through flexible working hours by some shelter coordinators, a rotating on-call schedule for EPR managers and an On-Call Dispatch Service for shelter staff after regular working hours. This process continues.
- Shift configurations in shelters are in the process of changing. 24-hour shifts have been eliminated and new shelter staff are hired for 8 and 10 hour shifts.
- The DFSH and Manitoba Justice are working collaboratively with federal departments to advocate for sustainable funding for organizations providing street shelter services.
- The DFSH and the Four Authorities are working on the recruitment and retention of foster homes, foster care standards and foster parent training program.
- A province-wide foster home recruitment strategy was announced in October 2006 with an investment of \$6.1 million to improve the foster care system in the province.

Ongoing work continues on 18 recommendations as part of the larger restructuring and funding process for the child and family services system.

- The Standing Committee continues to work on regulatory, service and fiscal strategies for the child and family services system.
- Child and Family Service Authorities and agencies are working on a continuum of care specific to their target population groups.
- Ongoing work is needed to enhance the capacity of the WCFS STEP database. The information system is limited in its capacity to generate

meaningful reports and lacks a dedicated staff position to ensure data entry is kept up to date.

- The capacity of the Provincial Abuse Investigators and the Licensing Branch databases does not allow for accurate tracking of investigation reports and incident reports to determine if residential facilities have complied with corrective action to ensure that children are not left at risk. The Child Protection Branch is aware of the limitations of the current databases and has requested approval to develop an effective information and tracking system.
- Monthly meetings of shelter staff are not consistent. Work is in place to improve this.
- All shelter staff and purchased service staff are required to be certified in Non-Violent Crisis Intervention (NVCi). This requires yearly re-certification. A process is needed to ensure this is available and re-certification is monitored.
- Human Resource standards, policies and procedures continue to be developed in accordance with the collective agreement for shelter staff.
- The WCFS and the staff – management Joint Training Committee is reviewing feasible ways to offer competency-based training to all shelter staff.
- Although it is regular practice to complete annual performance evaluations on all staff, shelter coordinators report that they not up to date in completing performance reviews with shelter staff.
- The DFSH created 50 additional emergency foster bed spaces in Winnipeg in 2005, in response to the recommendation that no children ages 0 – 7 are placed in any emergency group care facility. These bed spaces have increased to 165. However, children under the age of 7 years continue to be placed in emergency group shelters and in hotel placements.
- Licensing group care shelter facilities is an ongoing process, as shelters are developed to meet the specific needs of children requiring emergency placements.
- Most shelter facilities for youth are gender specific. However, some facilities in smaller communities are licensed as co-ed to provide the flexibility of placing children of either gender when an emergency placement is required. Ongoing work is required to ensure that adequate procedures are in place in these arrangements.

- The development of shelter facilities and foster homes able to accommodate large sibling groups is an ongoing process.
- There is sufficient flexibility in the shelter care system to develop care plans that are specific to special needs children and youth. Shelter facilities are renovated or created to meet specific care needs such as wheel chair accessibility.
- Discussions between the DFSH and Manitoba Justice have started to address youth who are concurrently involved with both systems, however no emergency care shelters have been developed specifically for youth leaving correctional facilities.
- While information on the OCA is available in all EPR program shelters, there are no formal standards directing agencies to make children in care aware of the OCA. Continued work is required by the DFSH to ensure a formal process is in place to communicate the information of the OCA to all placement resources in the province.
- On going support is provided to the Manitoba Foster Family Network (MFFN) for research, foster parent training and advocacy.

There are no changes to 23 recommendations.

- No change is evident in the recommendations made on restructuring the Provincial Placement Desk.
- The Provincial Placement Desk is not made up of a committee with a consistent multi disciplinary membership. The Desk does not travel to rural and northern communities.
- The Provincial Placement Desk does not track residential care placement breakdowns.
- Communication about residential care facility bed space vacancies is not accessible to child and family service staff through a secure web site.
- The WCFS EPR program does not have a standardized mechanism for tracking and responding to recommendations made by the Provincial Abuse Investigators.
- The Provincial Abuse Investigators database does not have the capacity to track reports to ensure compliance by facilities to recommendations.

- Although some initial meetings were held between the DFSH and the YECSS program, no committee is currently in place to review the working relationship between the EPR shelter system and the YECSS.
- Experts in residential care have not been consulted on developing a program model for the EPR unit. A program model for the WCFS EPR program has not been developed.
- Shelter Coordinators do not directly supervise purchased service staff.
- Purchased-service staff are not coordinated through one central management position. Purchased-service staff are indirectly supervised by the coordinators of the shelters that they work in.
- No standards or licensing regulations specific to emergency, short-term care for children have been developed. The emergency shelter system continues to operate under standards developed for long-term residential child care facilities.
- The OCA recommended a needs assessment and a site inspection prior to issuing a variance order. The process for obtaining variance orders has been simplified to include verbal approvals over the telephone without a site inspection and the delegation of authority to the EPR Program Manager to approve variance requests after working hours. The emergency nature of some placements requires immediate action to ensure children are not left without a placement while site inspections take place.
- Funding to cover shifts while EPR shelter staff attend competency-based training has not become a part of the EPR program funding formula.
- There has been no commitment to offer competency-based training to emergency shelter staff.
- There is considerable flexibility in determining staff-child ratios. Child – staff ratios are not limited to one staff for 2 children or youth but are flexible and subject to change dependent on the needs of children/youth. The needs of children are the biggest determinants of staff-child ratios.
- There is no evidence of discussions between the DFSH and Child Mental Health regarding collaborative and integrated approaches to service delivery.
- Working with geographically based multi disciplinary teams is not a consistent or standard practice, but multi-disciplinary teams may be established when required by an agency or a caseworker regarding a specific child or family.

- There is no change to recommendations to create a Health Specialist for the EPR program at this time.
- There is no change to recommendations to create an Educational Specialist for the EPR program at this time.
- Information on VOICES: Manitoba's Youth in Care Network is not available in all residential facilities.
- Most youth interviewed by the OCA were not aware of Voices: Manitoba's Youth in Care Network.
- A process for communicating information on Voices: Manitoba's Youth in Care Network, to agencies, and placement resources, has not been established.
- There is no province-wide tracking system in place to accurately and reliably monitor foster home breakdowns and maintain information on foster bed spaces.

Seven recommendations were reviewed and rejected.

- The recommendation to create a Community Resource Development Office to be housed with the DFSH was rejected by the Shelter Review Implementation Committee (SRIC).
- The DFSH reviewed the implications of the Provincial Abuse Investigators ability to make recommendations regarding the employment status of an individual and rejected this recommendation.
- The SRIC rejected the recommendation that all shelter staff have on-site access to the WCFS internal computer information communication system, because of the cost that would be involved.
- The SRIC concluded that the implementation of competency-based training for shelter staff would neither be practical or cost effective.
- The SRIC rejected the recommendation that Competency-Based training be made mandatory for purchased service staff.
- The SRIC rejected the recommendation that successful completion of Competency-Based training be a part of the licensing requirements for emergency shelters.

- The WCFS management reviewed the OCA recommendation to physically store and maintain all EPR shelter personnel files within the Human Resources Department and decided that this was not feasible as shelter coordinators required regular access to the personnel files.

6. The Present State of Emergency Placement Resources

There continues to be very little literature available on emergency shelter care for children. As the previous OCA shelter review found, “the EAPD concept of shelter care is a relatively new phenomenon”. Only recently has there been any acknowledgement that emergency placement resources should be part of a full range of therapeutic and placement options for children that require out of home care. Child Welfare League of America (CWLA) President and CEO, Shay Bilchik wrote an article on May 1, 2005 where he raised the question whether emergency foster care or emergency shelter care is best suited for children removed from their families because of abuse or neglect. His intent was to challenge the assumption that emergency foster care is the preferred option for children requiring an emergency placement. He suggested that there are a number of children who do not do well in foster care and because of attachment and intimacy issues adapt better to a setting that is less personal. The assumption that emergency foster care is favourable to shelter care, according to Bilchik, is not based on any research evidence, yet continues to be the premise behind the argument that emergency shelters are not the best setting for younger children.

As a result, emergency shelters continue to remain outside the mainstream placement resources for children in care. Bilchik concluded that both options are necessary to fully meet the needs of children who require emergency placements. He suggested that, “Emergency care should be part of a full array of treatment and placement options that begins with family supports for children who can remain safely at home and includes kinship care, family and therapeutic foster care, and residential treatment. It must also integrate community-based support networks for children placed in family settings or residential facilities”. Notwithstanding that both emergency foster care and shelter care have a place in the continuum of out of home resources for children in care, Jennifer Michael, in *Children’s Voice* (2006), suggested that smaller

communities can rely on emergency foster care, but in larger centres, emergency shelter care is a necessity in addition to foster care due to the greater number of children with a greater variety of needs that demand care. Both emergency foster homes and shelters, says Michael, should operate as one coordinated program, overseen by the same administrator.

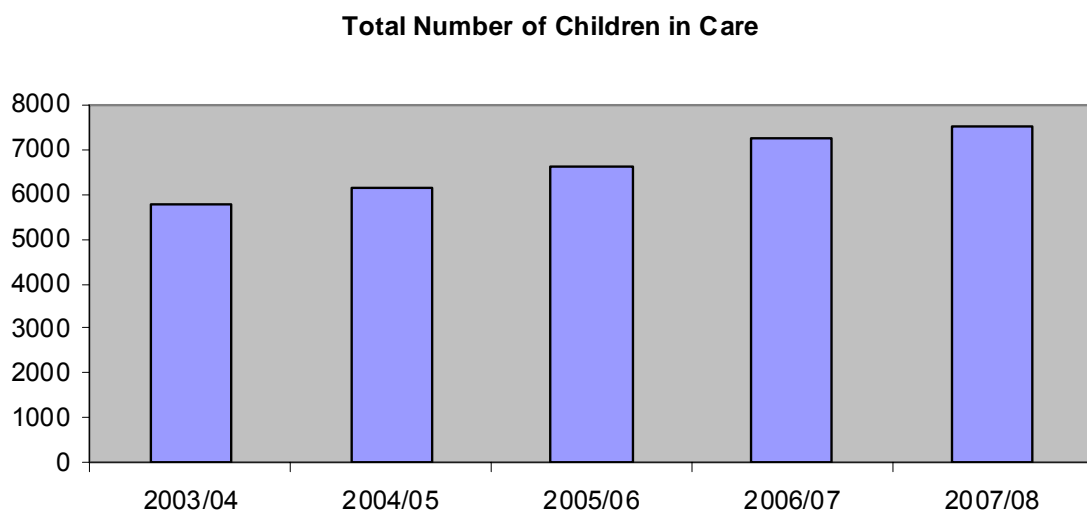
Emergency shelter care is a term used in child welfare literature to identify placement resources that are not foster homes but are established primarily to provide short-term care to children. Shelters can be operated by licensed and paid foster parents living in an agency-operated facility or staffed by child care workers who work different shift configurations. The concept of emergency shelters is not totally new to the child and family services system, although the present arrangement is somewhat different. Formerly, in the absence of foster beds, receiving homes accommodated anywhere from six to eight children, cared for by hired staff. The larger, more institutional receiving homes are still in operation in many areas of the United States. In this province, the concept of the receiving home faded in the 1980's when these were considered institutional compared to the home-like environment that foster homes offered. As a result, in Manitoba, the receiving homes were gradually closed and foster care became the preferred placement option. As foster bed spaces became less available, a movement developed to hire "professional foster parents" and place them in agency-operated homes (shelters) set up for three to four children. The professional foster parents lived in the agency-operated homes and were licensed by child and family service agencies. They were paid to receive children who were in need of an emergency placement at all hours of the day or night. As the demand for emergency placements increased, the supply of people interested in working as professional foster parents began to decline. To maintain the shelters, child care workers were hired for 24-hour shifts with the assistance of respite workers. Soon different shift configurations emerged as the number of shelters increased and more staff were required to keep up the operations of the shelter system.

There is very little evidence-based information available on emergency care, including the impact of shelter care on children. No comparative research on emergency care facilities and no reliable information about the impact of both emergency shelter and family foster care on the child can be found. Assumptions about shelter care

suggest that it should be short-term until a more permanent resource option is located. However, there is no research evidence to support this assumption. Shelter care is costly and this may be the primary driver toward keeping shelter care short. Every type of care is valuable if it meets the needs of a child. Emergency shelters provide a setting that protects and nurtures the child while protecting him or her from behaviour that may be harmful. Shelter care may be the most appropriate setting to meet the needs of some children and youth.

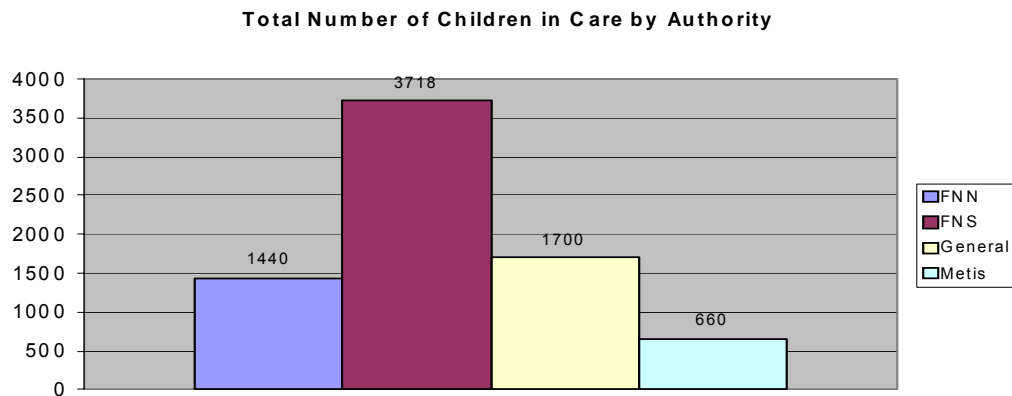
Total Number of Children in Care

The DFSH tracks information on children in care using the Child and Family Services Information System (CFSIS). Because access to this information system is not available in all parts of the province, a manual information form is used to ensure data accuracy. This form is completed by agencies that do not have access to this system, forwarded to the department and manually entered into the database. The information from CFSIS shows that the total number of children in care in the province has risen steadily from 5,782 in 2003/04 to 7,518 in 2007/08. The number of children in care is closely associated with the demand for placement options for them. The EPR emergency shelter system is but one placement option for children in care. While the majority of children in care reside in extended family or foster homes, some are placed in residential and group facilities.



Number of Children in Care by CFS Authority

In 2004/05 the delivery of child and family services was transferred to four new culturally-specific Authorities, who through the work of 25 agencies in the province, assumed responsibility for all aspects of service delivery to children and families including responsibility for children in care. Changes to the operational structure of the child and family services system has not reduced the number of children coming into care. Demographic information shows a steady increase of children entering care since the restructuring of the child and family services system in 2004/05. In 2007/08, each Authority had a number of children in its care.



The Management of Emergency Placements

The development and management of emergency placement resources is the responsibility of agencies providing child and family services in the province, along with the Authorities that the agencies are responsible to. As with all programs and services, emergency placement resources should take into consideration community and geographic differences and influences when developing the most suitable resources for children in care. A variety of emergency placement options are available throughout the province. According to caseworkers and placement coordinators with several child and family service agencies, placements in a place of safety (POS), sometimes referred to

as kinship homes, and emergency foster homes are the primary emergency resources for children. The use of hotels for emergency placements has been reported throughout the province until the hotel reduction strategy and the Hotel Placement Policy prohibited using hotels as emergency placements for children after August 1, 2007, with some exceptions. All child and family service agencies have some type of emergency placement resources in different locations throughout the province.

The WCFS Emergency Placement Resource (EPR) Program

The WCFS EPR emergency placement system is, by far, the largest and most utilized emergency placement resource in the province. Although initially developed to provide emergency placements for children and youth in Winnipeg, the EPR now receives placement requests from agencies providing child and family services in rural and northern locations as well as in the city of Winnipeg. Approximately 13% of all children in care go through the EPR shelter system before a longer-term placement is located for them and many of the children have multiple admissions to the shelter system. The EPR shelter system, once consisting of 3 and 4 bed emergency shelter facilities, now coordinates emergency placements for children into a number of various emergency resources through the Emergency Placement Desk. The range of emergency placement resources includes:

- ◇ 54 shift-staffed shelters
- ◇ 26 Emergency foster homes
- ◇ 22 Reunification foster home
- ◇ Circle of Care (a group resource for adolescent females managed by the Ma Mawi Wi Chi Itata Centre)
- ◇ Williamson Assessment Unit (group resource for adolescent boys managed by Macdonald Youth Services)
- ◇ Ndinawe Group Home
- ◇ Youth Resource Centre YRC (operated by MacDonald Youth Services)
- ◇ Golden Eagle facility (operated by the Southern Authority and Project Neecheewam)
- ◇ Eagle Nest Emergency Home (operated by Metis CFCS in Selkirk, MB)
- ◇ Hotel Placements, in accordance with policy exceptions.

At the time of this review there were 6 additional 3-bed shelters and 2 emergency foster homes in development.

According to information obtained through Emergency Placement Desk records, requests for emergency placements for children come from almost every agency providing child and family services in the province. Caseworkers from northern communities, unable to find emergency placements for youth who have run to the city, will contact the EPR unit for a placement resource.

Structure and Organization

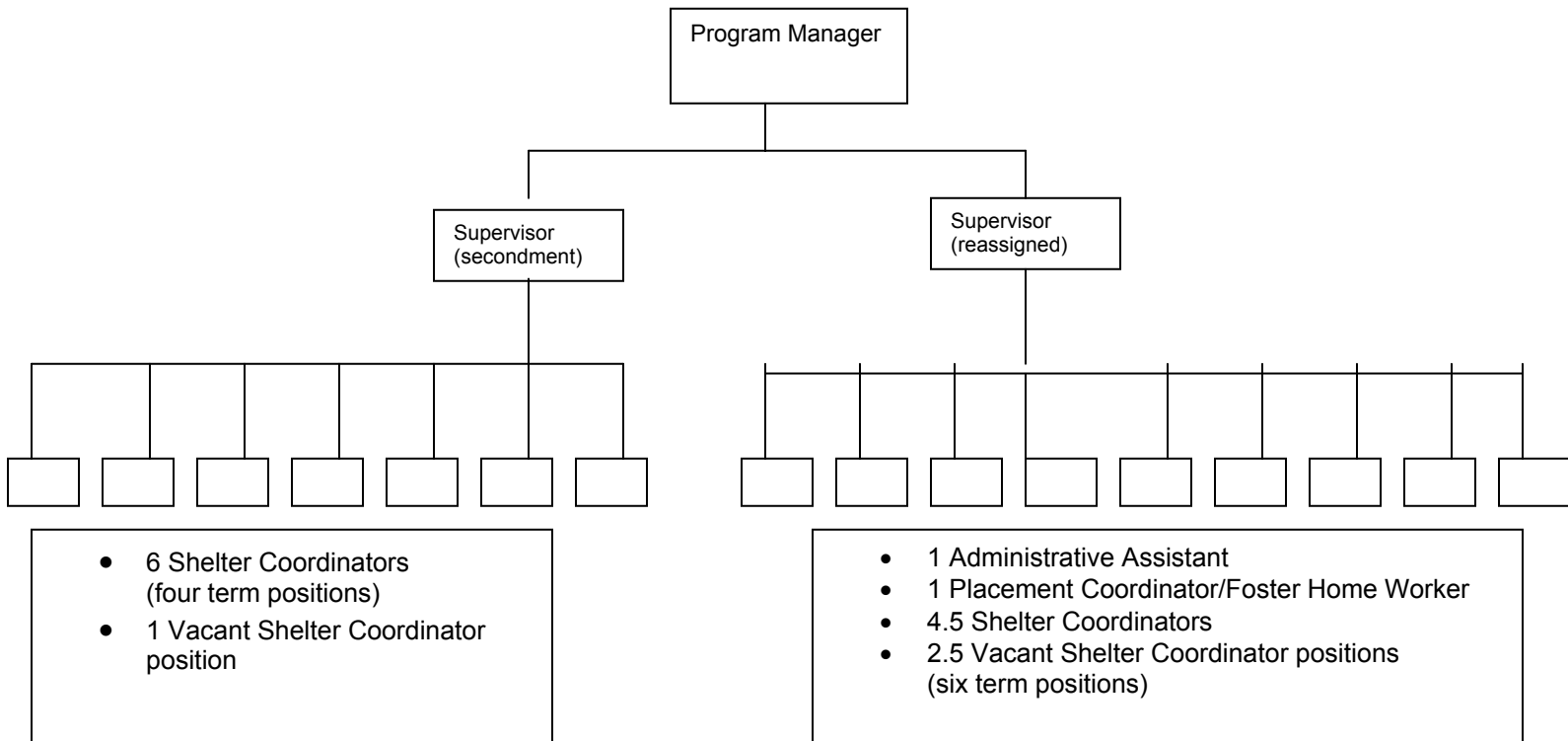
The WCFS EPR unit was initially developed to provide emergency placements for children in care of WCFS. In the restructured child and family services system, the conceptual plan called for a transfer of the EPR unit to the newly created Intake Agency for Winnipeg (ANCR). The transfer process has not yet been completed and, at the time of this review, the EPR unit continues to be responsible to the WCFS Branch as planning for its transfer to ANCR proceeds.

The EPR unit has been operating in a state of transition since 2005, and without certainty about its future. It has been in a state of limbo since the restructuring of the child and family services system. While the EPR unit relocated to be in closer proximity to ANCR in 2005, it was not included in the planning for ANCR until February 2008 when the Joint Management Group (JMG) for ANCR started looking at the transition of the EPR program to ANCR.

Although the responsibility for the EPR program was designated to ANCR, an Agency managed by the Southern Authority, in the AJI-CWI conceptual plan, the management of the unit has remained with the WCFS Branch, a branch of the DFSH and governed by the General Authority. At the time of this review, the EPR unit organizational structure consisted of a program manager, two supervisors seconded or reassigned from the DFSH, an administrative assistant, an emergency placement desk coordinator and 15 shelter coordinator positions. There were 4.5 vacant positions in the unit; 3.5 shelter coordinator positions and the coordinator responsible for the emergency placement desk. With the exception of five permanent shelter coordinators and the

program manager, the remaining staff are hired as term positions or, as mentioned before, are seconded from another program area.

Emergency Placement Resource Unit May 2008



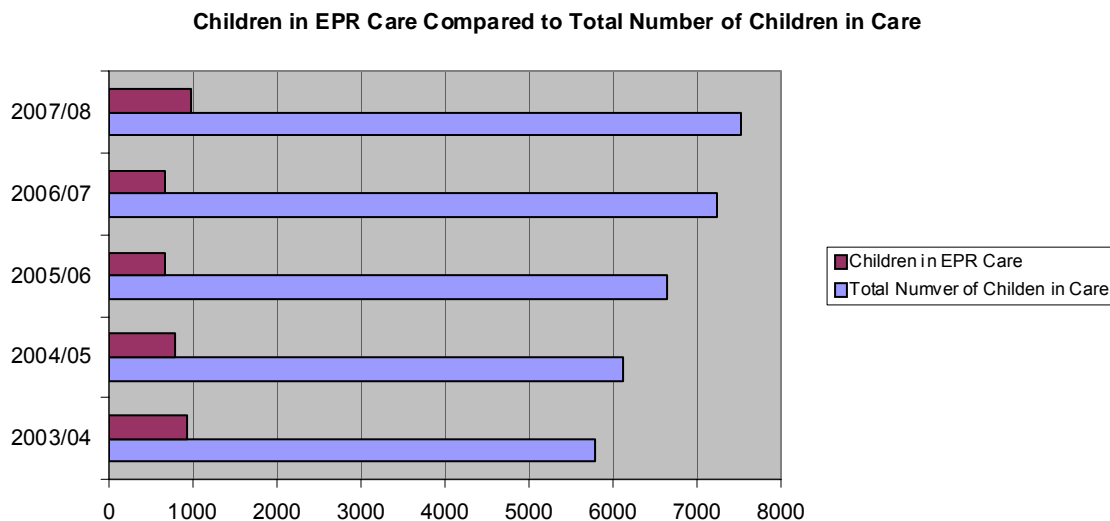
During the AJI-CWI Resource Transfer Process, 12 full time management and coordinator staff positions were designated for transfer from the WCFS to the EPR unit managed by ANCR. This was seven fewer positions than currently employed with the EPR program. Only one management position was included in the initial conceptual plan for EPR, the Program Manager. Two supervisor positions and four coordinator positions were added to the EPR program since the conceptual plan to meet the existing workload demand.

Additionally, over 250 permanent and casual child care support staff work in shelters, assisted by purchased service staff from private health care and home care organizations.

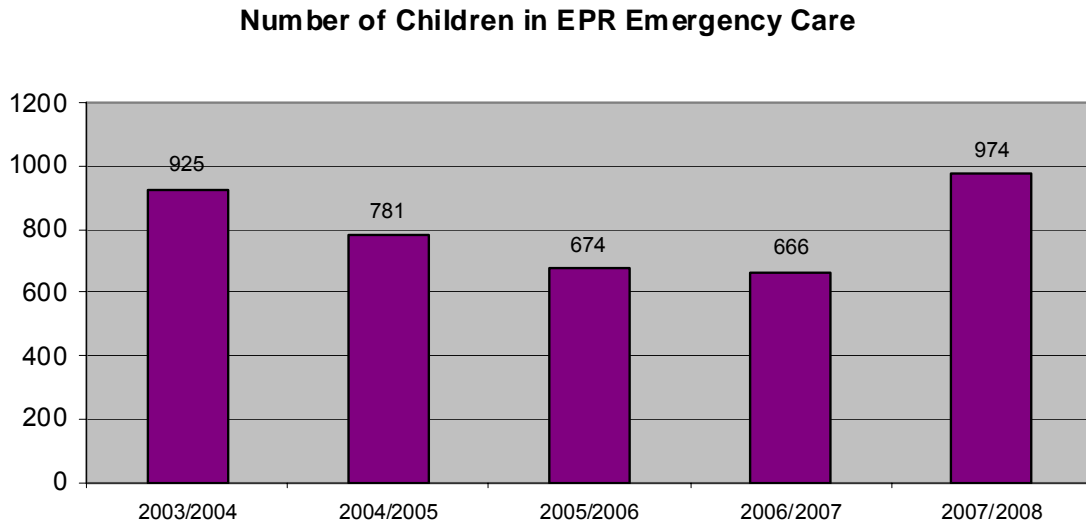
The Children in the EPR Shelter System

The EPR unit keeps demographic information on children entering and leaving the emergency shelter system using a database created for that purpose. The Systematic Tracking of Emergency Placements (STEP) contains information on the age and gender of children in the emergency placement system and tracks admissions and discharges. One administrative position is allocated to maintaining the data along with all other administrative responsibilities for the EPR unit. Staff report that entering information and maintaining the database is a challenge without dedicated staff committed to solely to this purpose. The WCFS Branch has a person responsible for the Branch information system. This person was able to obtain some demographic information from the STEP database that is used in this report. The data presented here is specific to the WCFS EPR system.

The percentage of children in the EPR shelter system ranges between 9% and 16% of the total number of children in care.

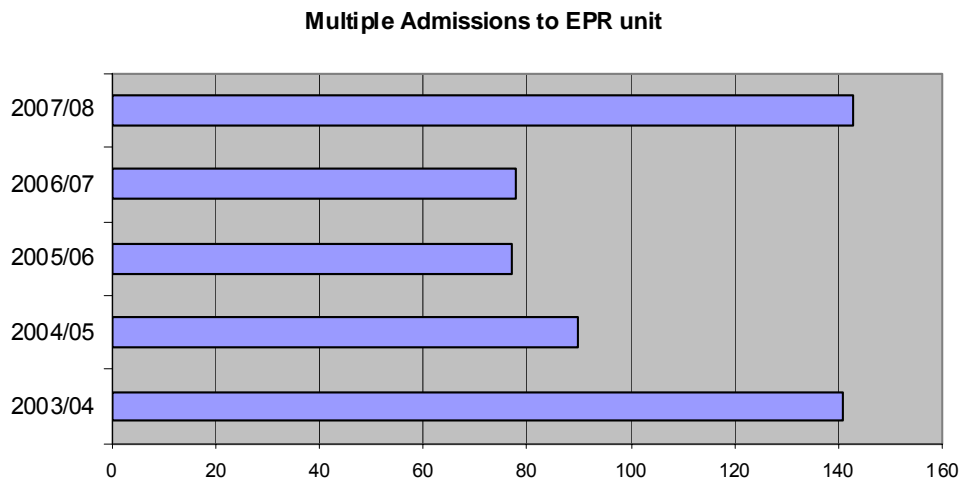


According to information provided in the STEP database, a total of 4020 children were placed at one time or another in the EPR emergency shelter system in the last five years. This is 935 more children than in the previous five-year period reviewed by the OCA and reported in the initial Shelter Review (2004).



Approximately 12% of the children admitted to the emergency shelter system have had previous admissions. Because of the short-term nature of the emergency shelter system, children may be admitted only for a few days and then return to family. If the family continues to have problems, the children may re-enter care only to continue this process. Children admitted to criminal justice facilities are often discharged after several days and the emergency shelter system may be the only placement alternative for them. Often these children re-offend, are admitted to MYC, and discharged again, and so on. There is no doubt that a certain population group of youth make up a large percentage of the multiple admissions to the shelters. These youth are heavily involved in criminal activities, may be gang-involved and are often aggressive and violent. If they are not contained in a secure criminal justice facility, then they can often be found placed in an emergency care facility because no other facility or foster home can care for these youth and their own families cannot manage them. Many of these youth come into care, leave without permission, are readmitted and leave again. Prior to the Hotel Placement Policy, some of the youth were admitted to hotel placements. Without this option, transient youth are placed in shelters where they may have to be the sole resident

because of actions that may present a risk to other children or youth. This group of youth present placement challenges that may be better addressed by a more suitable placement alternative that can meet their specific needs and assist them in transitioning into treatment facilities. The needs of this group of youth are multiple and require a collaborative and integrated systems approach to establish placement resources that can address these needs.

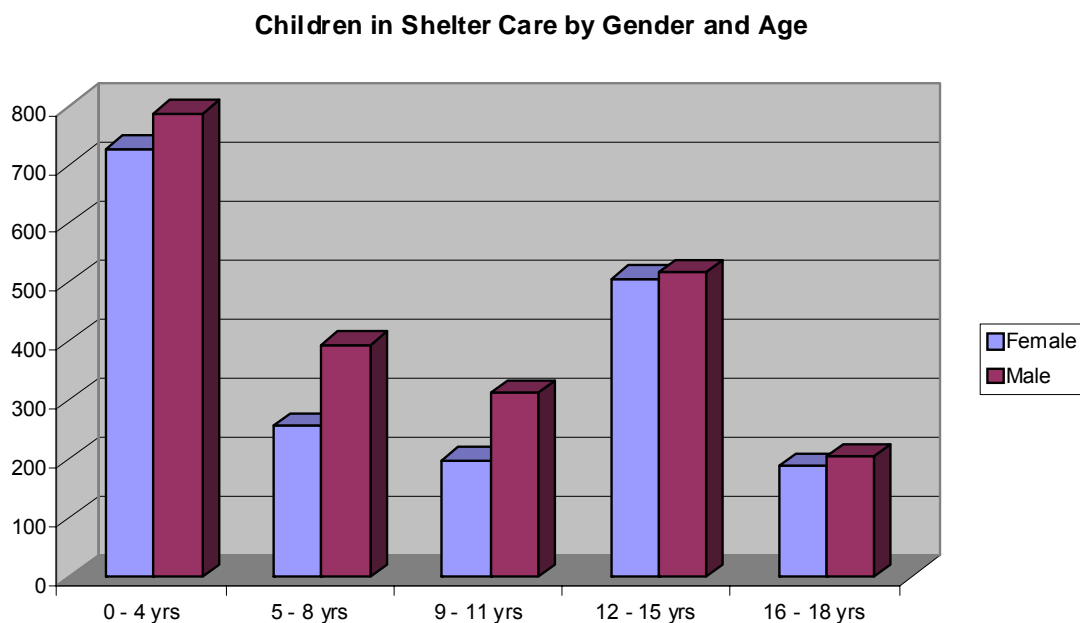


As with hotel placements, children in the age category of 0 – 4 make up the largest component of children in emergency care. In the previous shelter review, the OCA found that 25% of admissions to the emergency shelter system were children between the ages of 0 and 4 years. The present review found that 37% of the children entering the emergency placement system were under the age of 4 years. This is a 12% increase in admissions of children in this age category. Having emergency foster homes as placement options is a positive move to address the large number of young children requiring emergency placements. However, the number of emergency foster care bed spaces is not sufficient and shelters continue to be used as placements for very young children. In most circumstances, the very young children are part of sibling groups and the siblings are placed together in a group shelter facility.

Approximately 16% of children in emergency care were in the age category of 5 – 8 years and another 12.5% were between 9 – 11 years. The second largest group of children in the EPR shelter system were in the age category of 12 – 15 years. 25% of

children/youth in this age category were in shelter care and 9.5% were in the age category between 16 – 18 years.

Of the children and youth placed in the EPR system, 46% were female and 54% were male. This differs slightly from the previous OCA review on the shelter system that found 48% of the children and youth to be female and 52% to be male. A larger difference between genders can be found in the age group less than 12 years where 56% of the children in care were male compared with 52% that were female.



The Special Needs of Children in Emergency Shelter Care

Throughout this review, reports of children and youth with high medical needs and other special needs and challenging behaviours were heard. To better understand the special needs of the children and youth in shelter care, shelter coordinators were asked to discuss some of the more challenging children and youth currently residing in emergency shelters. Several examples of children with special needs were provided.

1. D is a 13 year old male child who was admitted to an emergency shelter

from home when his mother could no longer care for him after he started exhibiting suicidal behaviour. D is both blind and deaf and functions at the cognitive level of a 3 year old. At 220 pounds he can potentially cause harm to himself or to an adult trying to intervene to curb his out of control behaviour. Because of his medical needs, a health care aide is present to assist with his care while a child care support worker is required to ensure that D receives the care he needs without causing harm to himself or his caregivers. Two staff are needed at all times to care for D. In order to accommodate him, a shelter facility required adjustments to its physical set up to ensure the bathroom facilities were accessible and training in sensory communication was provided to staff caring for D.

2. T is a 14-year-old male youth with an IQ of 40. He is placed in an emergency shelter with another youth and because of his size two staff are needed at all times. It is difficult to reason with T and he uses his size to intimidate in order to get what he wants. He is followed by a psychiatrist and is on medication. He has been refused admission to the Crisis Stabilization Unit because he is a risk to others. On occasion, three staff are required to be present to ensure T does not harm himself or others.
3. J is a 17-year-old male youth with mild autism and very low functioning. He was violent at admission to the shelter after having witnessed the murder of his step-father. J is approaching the age of majority and has had 5 caseworkers in the six months he has been in shelter care. Although he will require services from adult supported living programs, no referral has yet been made. Attempts to encourage the new caseworker to plan for J has been unsuccessful. Two staff have to be present with J at all times, and on occasion, a third staff is required.
4. N is a 10-year-old male child diagnosed with ADHD, anxiety and a severe attachment disorder. He has a history of violence, bullying and is a fire starter. N takes a soother to calm himself and makes threats and allegations against staff. He requires two staff to be present 24 hours a day because of the risk he presents.

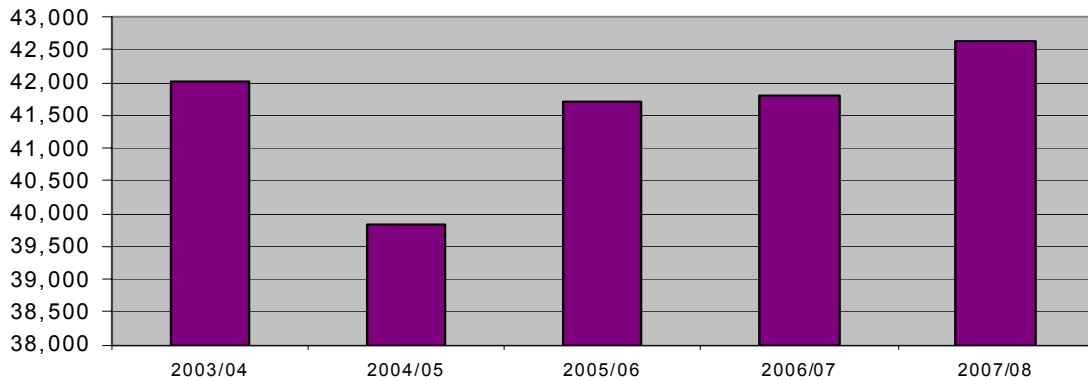
5. M is a 13-year-old female child diagnosed with FASD. She requires constant supervision to prevent her from leaving the facility alone. Unsupervised M is very vulnerable because she lacks the ability to predict outcomes and is at high risk of exploitation and other harm. She demands constant attention, misinterprets adults, and engages in negative behaviour, like throwing things out of a window, to obtain attention. Two staff are required to care for M.
6. P is a 16-year-old male with symptoms suggesting a depression but refuses to cooperate with attempts to get medical assistance. He is gang-involved, a fire starter and has been charged with car theft on three occasions. He requires a mental health assessment but PY1 would not accept him unless he is cooperative. Staff are frustrated because there is no plan for P. He does not attend school or participate in any program; therefore, he requires constant supervision because his running results in a risk of harm to others from the activities he engages in.
7. G is a 7-year-old male youth diagnosed with a neurological disorder. He is hyperactive, aggressive, destroys property, engages in non-stop eating and participates in self-mutilating behaviour. If not supervised constantly he will pull his fingernails and toenails off with his teeth. G has climbed out of windows and has no sense of fear. He is followed by a psychiatrist who has prescribed medication for him. G is the only resident in a shelter facility that is double staffed for the greater part of the day.
8. H is a 17-year-old male youth who has been in an emergency shelter for two years. He has spina bifida and a cognitive delay. H weighs 65 pounds and has medical needs that can be life threatening. In addition to serious medical needs, H has a condition that causes speech and language delay, facial distortions, short stature and difficulties with coordination and balance. He also exhibits sexual offending impulses and lunges at men's private parts. H is the sole resident in a shelter facility and two staff are required to care for him at all times. H is not in a school program or any other day program.

9. L is a 5-year-old male child who suffers from giantism, where he is 5' 5" and weighs 150 pounds. He is confined to a wheelchair and requires assistance with toileting. L is non-communicative and has mental health needs. He was previously in a foster home, which broke down due to the care needs that L has.
10. W is a 10-year-old male with the developmental age of 1 – 2 years and with motor skills at a 15 – 18 month level. He is hearing impaired, non-communicative, and has a form of autism that can result in seizures. W was also in a foster home, which could no longer care for him because of the numerous needs that he has.

Total Number of Days Care in the EPR Shelter System

The total number of days that children spend in emergency care has been increasing with the addition of more emergency foster homes and shelters to the EPR system. The days care reduction shown in the fiscal year 2004-2005 may be attributed to the AJI-CWI devolution process. Since the devolution process, the EPR unit has been providing emergency placements for all child and family service agencies providing services in the city of Winnipeg. From a service point of view, the total number of days care is less significant than the number of days children/youth actually spend in shelter care. For example, in 2005/06, 674 children used 41,702 days, while in 2006/07, 666 children used 41,787 days care. While 8 fewer children used the shelter system than the previous year, these children stayed an additional 85 days. In 2007/08, 308 more children were in the shelter system, but stayed only an addition 846 days. The ratio between the number of children in emergency care and the length of time that they stay is used to determine the average number of days per child in emergency care.

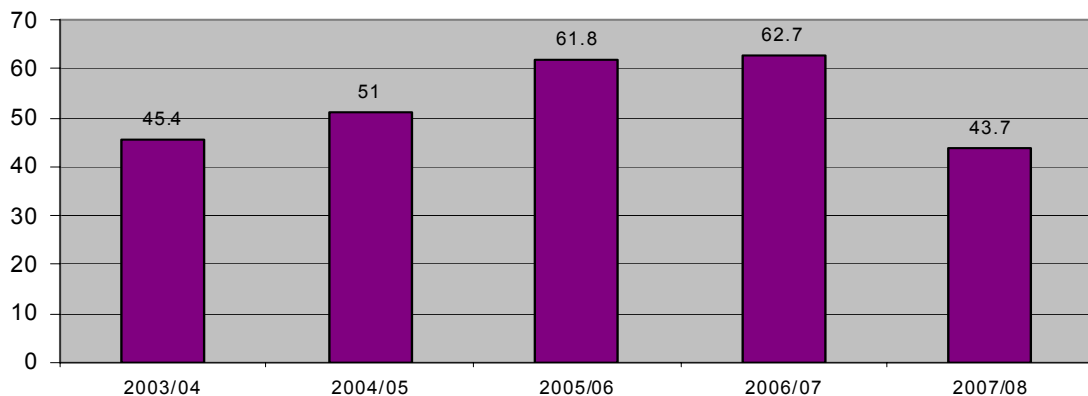
Total Days in Emergency Placement Care



Despite the fact that the number of days in emergency care is increasing, the average stay for children in a shelter or emergency foster home has decreased from 95 days reported by the OCA for the five-year period from 1997/98 to 2002/03 to 53 days in the last five year period. In the last year, the average stay in an emergency placement was 44 days.

The average number of days children are spending in EPR emergency care is now closer to the range recommended by the CWLA standards for emergency care placements of 30 days with an extension of another 30 days to a maximum of 60 days. .

Average Number of Days in Shelter Care



The Cost of Care in the EPR Shelter System

The high cost of shelter care has been a common trend in reviews and discussions about the WCFS EPR system. The OCA, in the initial review of the shelter system reported that the cost of placing children in emergency shelters was well over 11 million dollars in 2002/03. Included in the cost of shelter care are expenses related to salaries and benefits for staff, the cost of purchased services, property taxes, mortgage payments, rent, utilities, property maintenance, capital improvements, food, household supplies, recreation, gifts, transportation, telephones, mileage costs, moving expenses and shelter furniture. Child specific costs such as initial clothing expenses, activities other than shelter activities, special needs, therapy and medically related costs are the responsibility of the child and family services agencies responsible for the child. Direct service costs for the WCFS EPR unit, in the five years from 2003/04 to 2007/08, have risen over 4 million dollars.

Cost of Care

| | No. of Shelters | Maximum capacity | Average No. of Children* | Average Bed Usage | Days in Care | Total Cost | Average Per Diem cost |
|-----------|----------------------------|-----------------------------|---|----------------------------------|-------------------------|-------------------|--------------------------------------|
| 2003-2004 | 42 | 124 | 925 | 115 | 42,020 | 10,633,352 | 253.05 |
| 2004-2005 | 43 | 133 | 781 | 109 | 39,844 | 10,285,584 | 258.15 |
| 2005-2006 | 43 | 136 | 674 | 114 | 41,702 | 11,509,021 | 275.98 |
| 2006-2007 | 45 | 144 | 666 | 114 | 41,787 | 13,560,856 | 324.52 |
| 2007-2008 | 52 | 161 | 974 | 116 | 42,633 | 15,047,392 | 352.95 |

1. The number of children information was retrieved from the STEP system (Systematic Tracking of Emergency Placements).
2. The days care and totals costs information was retrieved from CMS (Child Maintenance System utilized by Accounting, WCFS) and SAP.

A significant percentage of the total shelter costs include the cost of child care support workers and purchased service staff required to provide the care to children in the shelter system. These costs are included in the per diem rate. The costs exclude managers, coordinators, administrative staff and on-call dispatchers. The shelter staff costs as a percentage of the total direct shelter costs are presented below.

Direct Shelter Costs

| | Staff Cost | Total Cost | % of staff cost/total cost |
|-----------|-------------------|-------------------|---------------------------------------|
| 2003-2004 | 8,729,320 | 10,633,352 | 82.09% |
| 2004-2005 | 8,703,699 | 10,285,584 | 84.62% |
| 2005-2006 | 9,990,513 | 11,509,021 | 86.81% |
| 2006-2007 | 11,333,094 | 13,560,856 | 83.57% |
| 2007-2008 | 12,848,356 | 15,047,392 | 85.39% |

The percentage of staff costs in relation to the total cost of shelter care has risen since the OCA review in 2002/03. At that time, the percentage of staff costs compared to total cost was 80.4%. This has risen to 85.39% in the 2007/08 fiscal year. Increases in staffing costs may be attributed to the increase in the number of shelters caring for one or two special needs children/youth. Shelter coordinators report that double or triple staffing in some shelters is not unusual and some youth have probationary conditions attached to their presence in the community requiring constant 24-hour supervision. Additional one-to-one staff are assigned to many youth to ensure that they do not present a risk to themselves or to others.

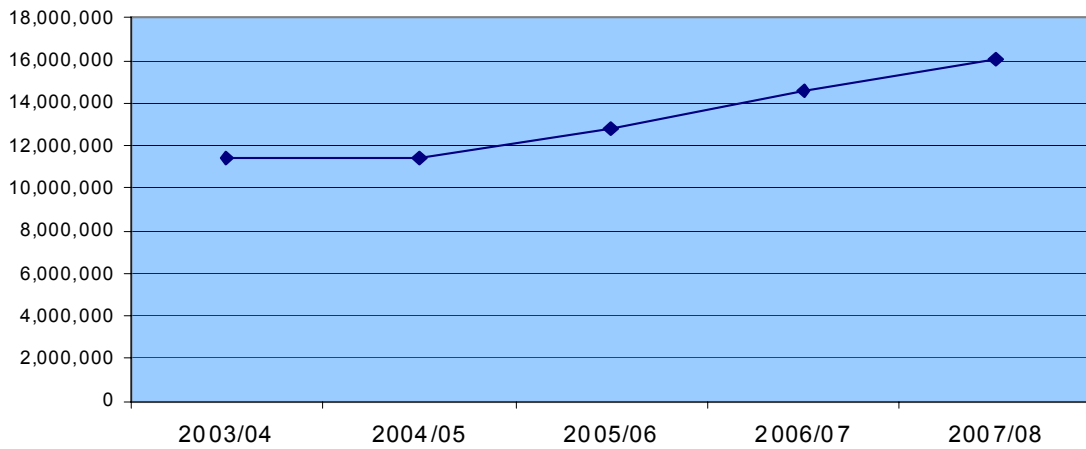
Other Direct Shelter Costs

Other direct shelter costs include the salaries of the program manager, supervisors, coordinators, human resource staff, administrative staff and accounting staff. These costs support the operations of the EPR unit.

| | | | | |
|-------------|------------|-------------|-------------|-------------|
| 2003/2004 | 2004/2005 | 2005/2006 | 2006/2007 | 2007/2008 |
| \$ 958, 418 | \$ 984,707 | \$1,083,110 | \$1,110,757 | \$1,137,308 |
| | | | | |

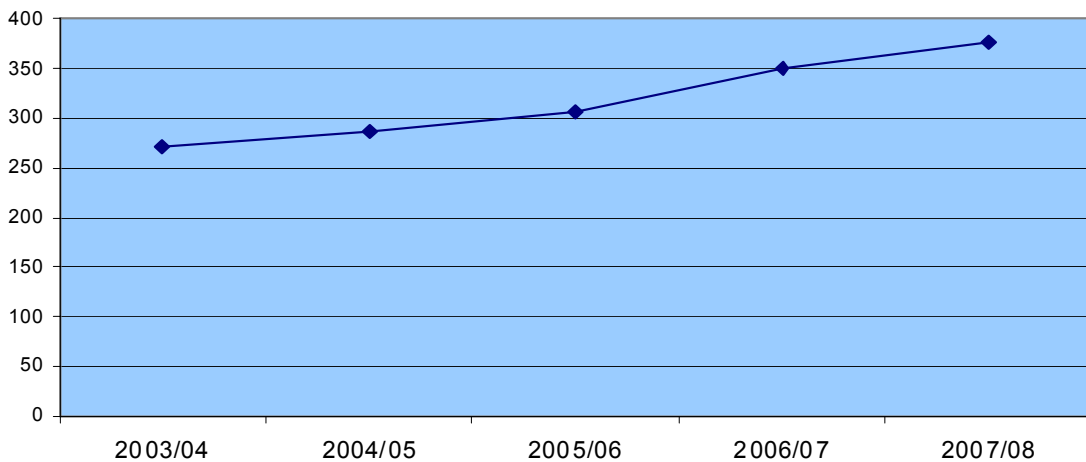
The overall cost of shelter care includes the direct costs associated with the care of the child in the shelter and the indirect administrative costs associated with supporting the shelter system. Child specific costs related to the child would occur wherever the child was placed. The child and family service agency responsible for the child must access these costs. These costs are not included in the overall shelter care cost.

Cost of Care in the EPR System



Along with the increase in the total direct service costs, the per diem cost per child has also risen over the years. In the Shelter Review (2004), the OCA reported that the per diem cost of a child in the emergency shelter system was \$257.06. Five years later this cost has increased almost \$120 a day to \$376.85 per child per day.

Per Diem Cost of Care in the EPR System



Shelter Operating Costs

To operate individual shelters, an allotment of funds is provided to each shelter depending on the number of children it is licensed for. This allotment does not change if the shelter has less than the licensed number of children. The following table shows the semi-monthly allocation of funds to purchase food, household supplies and fund incidental items such as children's allowances. This allocation has not changed in the last five years unlike the steady increase evident in costs related to salaries and shelter operations. Most shelter staff participating in an interview reported concerns about the inadequacy of funds for recreational activities for children, leaving too much time for children in shelter care with nothing to do.

Shelter funds provided on a semi-monthly basis

| | 1-2 bed shelters | 3-4 bed shelters | >4 bed shelters |
|---------------------|-----------------------------|-----------------------------|-------------------------------|
| 2003-2004 | | | |
| Food | 275.00 | 403.55 | 503.55 |
| Household Allowance | 65.00 | 65.00 | 65.00 |
| Recreation | 87.50 | 97.50 | 97.50 |
| 2004-2005 | | | |
| Food | 275.00 | 403.55 | 503.55 |
| Household Allowance | 65.00 | 65.00 | 65.00 |
| Recreation | 87.50 | 97.50 | 97.50 |
| 2005-2006 | | | |
| Food | 275.00 | 403.55 | 503.55 |
| Household Allowance | 65.00 | 65.00 | 65.00 |
| Recreation | 87.50 | 97.50 | 97.50 |
| 2006-2007 | | | |
| Food | 275.00 | 403.55 | 503.55 |
| Household Allowance | 65.00 | 65.00 | 65.00 |
| Recreation | 87.50 | 97.50 | 97.50 |
| 2007-2008 | | | |
| Food | 275.00 | 403.55 | 503.55 |
| Household Allowance | 65.00 | 65.00 | 65.00 |
| Recreation | 87.50 | 97.50 | 97.50 |

The amounts provided above are the "budgets" provided to each shelter. Dependent on the occupancy of a shelter, a shelter may request additional funding, and/or will return the funding not utilized for the month.

Shelter Care Analysis

| Cost Category | 2003/2004 | | 2004/2005 | | 2005/2006 | | 2006/2007 | | 2007/2008 | |
|--|------------|------------------------------|------------|------------------------------|------------|------------------------------|------------|------------------------------|------------|------------------------------|
| | Amount | Average cost per day of care | Amount | Average cost per day of care | Amount | Average cost per day of care | Amount | Average cost per day of care | Amount | Average cost per day of care |
| Total Days Care | 42020 | | 39844 | | 41702 | | 41787 | | 42633 | |
| Direct Shelter Costs: | | | | | | | | | | |
| Salaries & Benefits | 8,729,320 | 207.74 | 8,703,699 | 218.44 | 9,990,513 | 239.57 | 11,333,094 | 271.21 | 12,848,356 | 301.37 |
| Building Maintenance | 607,677 | 14.46 | 703,866 | 17.67 | 594,584 | 14.26 | 774,152 | 18.53 | 807,128 | 18.93 |
| Care Costs | 601,927 | 14.32 | 576,482 | 14.47 | 650,456 | 15.60 | 694,057 | 16.61 | 758,340 | 17.79 |
| Other | 197,117 | 4.69 | 187,874 | 4.72 | 220,310 | 5.28 | 256,588 | 6.14 | 284,907 | 6.68 |
| Child specific expenditures | 203,524 | 4.84 | 261,817 | 6.57 | 577,218 | 13.84 | 104,724 | 2.51 | 118,439 | 2.78 |
| EAPD | | | | | | | | | | |
| Dispatchers/drivers | 294,087 | 7.00 | 280,353 | 7.04 | 250,180 | 6.00 | 451,368 | 10.80 | 230,222 | 5.40 |
| Total Direct Shelter Costs as per WCFS Analysis | 10,633,652 | 253.06 | 10,714,089 | 268.90 | 12,283,261 | 294.55 | 13,613,984 | 325.79 | 15,047,392 | 352.95 |
| Other Direct Shelter Costs | | | | | | | | | | |
| EAPD Co-ordinators | 556,245 | 13.24 | 572,907 | 14.38 | 583,858 | 14.00 | 598,463 | 14.32 | 613,350 | 14.39 |
| EAPD Project Manager | 79,377 | 1.89 | 81,680 | 2.05 | 83,232 | 2.00 | 85,313 | 2.04 | 87,477 | 2.05 |
| EAPD Supervisor | 71,527 | 1.70 | 73,602 | 1.85 | 149,986 | 3.60 | 153,737 | 3.68 | 157,560 | 3.70 |
| EAPD Admin. Support | 48,647 | 1.16 | 50,180 | 1.26 | 51,145 | 1.23 | 52,424 | 1.25 | 53,735 | 1.26 |
| WCFS Payroll Clerk | 50,103 | 1.19 | 51,557 | 1.29 | 52,533 | 1.26 | 53,847 | 1.29 | 55,202 | 1.29 |
| WCFS Accounting Clerk | 36,476 | 0.87 | 37,534 | 0.94 | 38,245 | 0.92 | 39,202 | 0.94 | 41,224 | 0.97 |
| WCFS HR Support | 116,043 | 2.76 | 119,245 | 2.99 | 124,111 | 2.98 | 127,771 | 3.06 | 128,760 | 3.02 |
| Total | 958,418 | 22.81 | 986,705 | 24.76 | 1,083,110 | 25.97 | 1,110,757 | 26.58 | 1,137,308 | 26.68 |
| Adjustments: | | | | | | | | | | |
| Child Specific expenditures | (203,524) | (4.84) | (261,817) | (6.57) | (577,218) | (13.84) | (104,724) | (2.51) | (118,439) | (2.78) |
| TOTAL DIRECT SHELTER COSTS | 11,388,546 | 271.03 | 11,438,978 | 287.09 | 12,789,153 | 306.68 | 14,620,017 | 349.87 | 16,066,261 | 376.85 |

The direct shelter costs per WCFS financial reports for 2004/05 total \$10,285,584. This amount is \$428,505 lower than the total reported of 10,714,089 on the Shelter Analysis prepared by WCFS. This amount is calculated by WCFS and is transferred to the Exceptional Circumstances program from the shelter program for budget control and financial reporting purposes.

The direct shelter costs per WCFS financial reports for 2005/06 total \$11,509,021. This amount is \$774,240 lower than the total reported of 12,283,261 on the Shelter Analysis prepared by WCFS. This amount is calculated by WCFS and is transferred to the Exceptional Circumstances program from the shelter program for budget control and financial reporting purposes.

Effective 2005/2006, due to AJI/devolution, WCFS is no longer financially responsible for Child specific expenditures for children from other agencies. These expenditures include initial clothing, activity outside shelter activities (ie: camp), special needs required by the child, therapy, medical needs. WCFS continues to report Child Specific Expenditures against the shelters for children in its care.

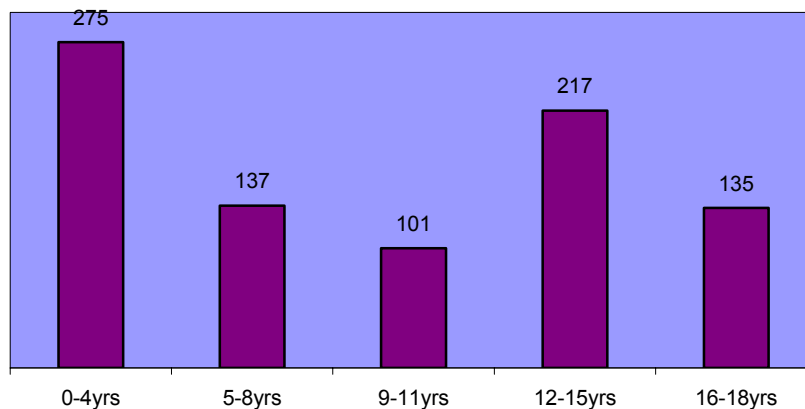
The salaries reported for the "Other Direct Shelter costs" are estimated salaries & benefits based on the positions identified within the EPR unit. The costs are not based on actuals.

The EPR Emergency Placement Desk

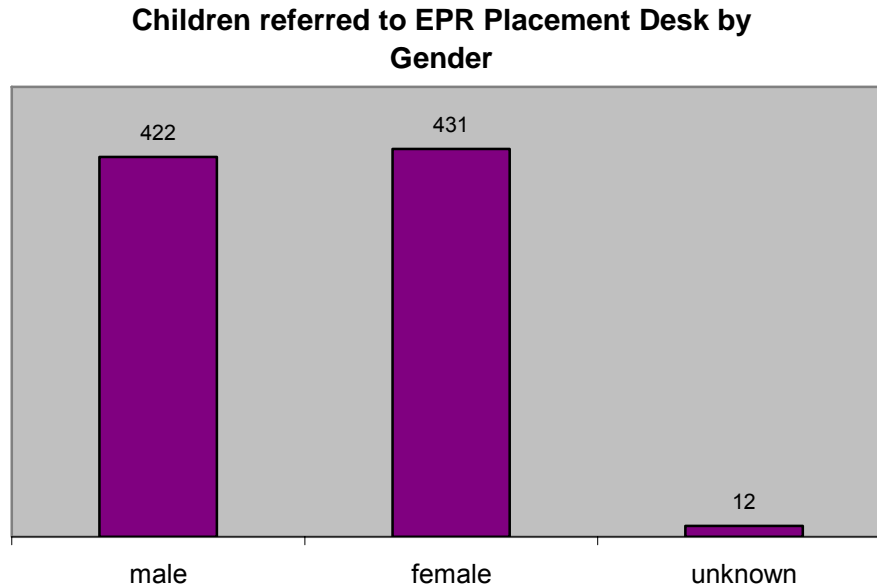
One of the essential features of the WCFS EPR unit is the emergency placement desk, which serves as the first point of entry for referrals to the emergency placement system. The placement desk operates during daytime working hours and accepts referrals for the emergency placement of children from all agencies providing child and family services in the city of Winnipeg and the All Nations Coordinated Response Unit (ANCR). When no other placement option is available, the placement desk facilitates appropriate placements of children/youth into one of several emergency placement options in Winnipeg including; the EPR Shelters, emergency foster homes operated by B & L Homes and the CLOUT program, hotels, and external emergency placement facilities.

This review examined the number of admissions of children to the EPR placement system by reviewing the day-to-day admissions facilitated by the Emergency Placement Desk for the 7-month time period from July 31, 2007 until Jan 31, 2008. A total of 865 referrals for emergency placements were processed during this time period. The age categories of children and youth at first admission to the EPR system varied from under one year of age to a maximum of 18 years. The most frequently recorded ages were less than one year of age and 15 years of age. The actual number of children referred to the EPR placement desk by age categories follows.

Children referred to EPR Placement Desk by Age Categories



As can be seen above, referrals of children under the age of 11 made up 60% of the total number of referrals to the EPR Placement Desk. More than half of these children, 32%, were under the age of 4 years. These findings support previous reports by the OCA that the EPR Shelter system services primarily younger children.

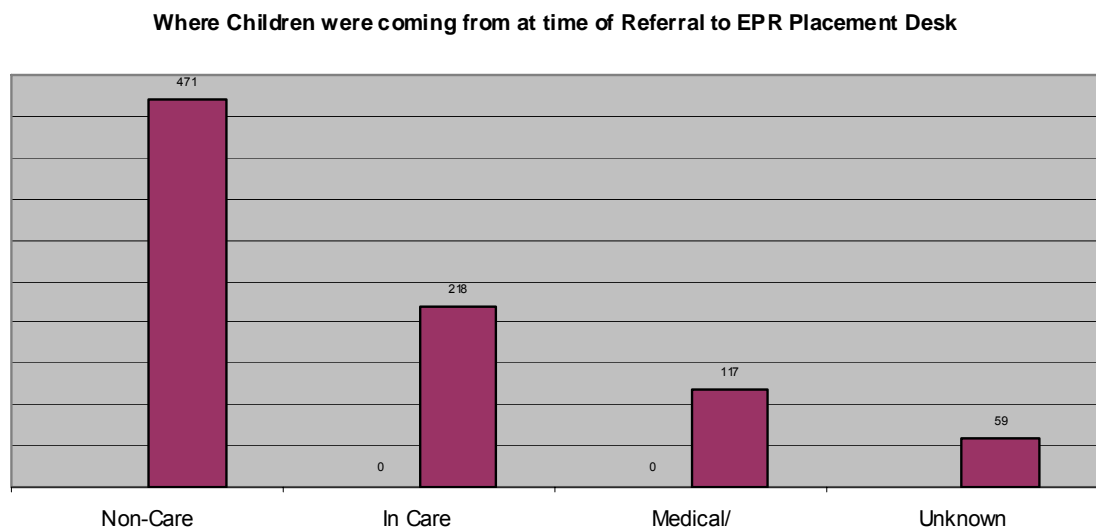


Male and female children were fairly equally represented in the referral data gathered through the EPR Placement Desk, while the gender for 12 children was not documented.

The primary intent of reviewing EPR admission information is to determine where children are coming from when they are referred to the EPR emergency placement desk and where emergency placement resources are located for them. The records maintained by the EPR placement desk include daily admission reports. It is important to note that some children move within a couple of days from one emergency resource to another and may be included in the records of the EPR Emergency Placement Desk on more than one occasion. As a result, rather than determining the number of children requiring emergency placements during this seven month time period, this review focused on the number of referrals for emergency placements that came to the attention of the EPR Placement Desk.

Previous reviews found that a significant number of children and youth requiring emergency placement in the EPR system were already in the care of a CFS agency but needed to move because of a placement breakdown. To verify this finding, the review examined the EPR Placement Desk reports to determine where the children and youth requiring emergency placements came from. Four categories were established:

- i). Non-care. Referrals of children coming from their own home, relative placements, or other non-care facilities such as safe houses,
- ii). In-Care. Referrals of children coming from foster homes, places of safety (POS), hotels, independent living, treatment group homes or facilities, or other EPR shelters,
- iii). Medical/Justice system. Referrals from the Manitoba Youth Centre (MYC), Hospitals, or the Crisis Stabilization Unit (CSU). These resources were separated from the rest because it is unknown whether the children referred from the above facilities were in care or not in care at the time of referral, and
- iv). Unknown. Placement information on the child is unknown or the child left (AWOL) before placement occurred.



More than one half (54%) of the children referred to the emergency placement desk came from the non-care sector. Of the 471 children admitted from the community, most of the children (458) came from either their own home or that of a friend or relative, while the remaining 13 children came from non-care community facilities such as the Youth Resource Centre on Mayfair. One-quarter, or 25%, of the children were placed in other care resources prior to a referral to the emergency placement desk. Of the 218 referrals in this category, 78 children came from foster homes, 48 came from a place of safety (POS), 12 were in hotel placements at the time of referral, 37 were in another EPR Shelter, 41 were in other paid group or facility care prior to referral for an emergency placement and 2 were in independent living. In 117 referrals, or 14% of the total number of referrals, the children came from a medical or corrections system setting. In almost one-half of these referrals, the child was previously residing at the Manitoba Youth Centre (MYC) and discharged to CFS care. In the remaining referrals, the children were being discharged from a hospital or the Crisis Stabilization Unit (CSU). In 7% of the total number of referrals, the child's previous residence was unknown either because the child left (AWOL) before placement plans could be completed or the information was not documented.

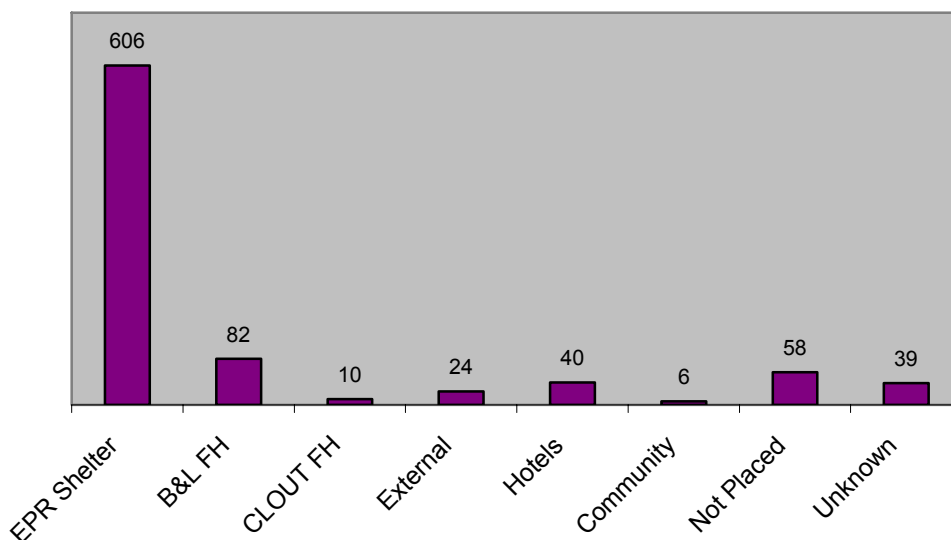
Given that 25% of children referred to the EPR Placement Desk were in care, and the status of the children in 21% of the referrals is unknown, there is sufficient reason to be concerned that a significant number of children referred for emergency placement are already in care. This supports previous findings by the OCA that the EPR shelter system supports and augments the Child and Family Services substitute care system. In the Shelter Review (2004), the OCA found that an alarming 51.5% of children in EPR placements were living in some form of foster care prior to their admission to the WCFS emergency placement department. Although the percentage is lower than that reported in the initial Shelter Review, the scope of this review was limited only to the number of referrals to the EPR Placement Desk in a 7-month time period.

The EPR Placement Desk is primarily responsible for locating a placement for the children referred to the program. Several emergency placement options are available to the Placement Desk depending on variables such as age of the child, the number of children in a sibling group, the degree of emotional and behavioural stability,

the availability of bed space and the cooperation of the child. Placement options were divided into seven categories;

- i). EPR Emergency Shelters,
- ii). B & L Foster Homes,
- iii). CLOUT Foster Homes,
- iv). External emergency placement facilities. This included the Eagle Nest facility in Selkirk, Manitoba and the Southern Authority's emergency placement resource on Edmonton St. in Winnipeg.
- v). Hotel Placements,
- vi). Community safe houses, such as Ndinawe and the MYS Youth Resource Centre
- vii). Not Placed. This category included children who were returned to family or went AWOL before a placement could be located, were not able to be placed because there was no placement resource available for them or the placement location was not reported.
- viii). Unknown. Missing information made it impossible to determine the placement outcome.

**Child Emergency Placements as Reported by the EPR
Placement Desk**



Most referrals resulted in a placement at an EPR Shelter. Seventy percent (70%) of referrals to the EPR Placement Desk resulted in children being placed in one of the EPR shelter facilities. A smaller percentage of children were placed in an emergency foster home, with 9% placed in the B & L emergency foster homes and approximately 1% placed in the CLOUT emergency foster homes. Approximately 3% of the referrals resulted in a placement in an external emergency facility with the Southern Authority's Emergency Facility, *Golden Eagle*, on Edmonton St. in Winnipeg receiving seventeen of the children and the MCFS Emergency Facility, *Eagles Nest*, in Selkirk, Manitoba receiving seven children. Approximately 4.5% of children referred to the EPR Placement Desk were placed in hotels while .5% were sent to community safe houses such as N'Dinawe and the Youth Resource Centre on Mayfair. Another 7% of the referrals were not placed because the children either returned home with family members, were admitted to hospital, left before placement can be secured or were told that there was no placement available for them. According to the EPR Placement Desk reports, 25 children were not placed because of "no placements" available. There is no further information on what happened to these children. In approximately 4.5% of the referrals, no information was available to indicate whether the child was placed in an emergency facility or not.

7. The Reflections of Shelter Support Staff

Child care support staff provide basic care to children and youth in shelters, maintain the day to day household functions, provide basic observations of behaviour, social and medical needs of the children and youth and report and document specific information related to each child. They are an integral part of the emergency shelter system and, as a result, were asked for their insight and input on several issues related to this review. Shelter staff participated in the initial OCA review of the operations of the WCFS EAPD emergency shelter system. Through a random selection process 10% of the total permanent and casual shelter staff were selected for an interview. Every 10th staff person on the alphabetical EPR staff roster was selected. In addition, a letter was sent to all EPR shelters advising staff of the review and inviting staff that wanted to participate to notify the reviewer. Participation in an interview was voluntary. Three staff were away on leave, one was attending an educational facility outside the province, one

had just resigned and five chose not to participate. Interviews were held with 16 shelter staff using the same questionnaire that was used during the previous OCA shelter review. The reflections of shelter staff pertaining to the care of children are reported in this section.

Admissions to Shelter Care

The EPR Home Manual contains an admissions policy and procedures and all shelter staff that were interviewed were familiar with the admissions process. Admission Reports, containing demographic and contact information on the child, a list of medical contacts, medication the child is using, an inventory of clothing and personal items and a brief summary of risk factors, placement plans and short-term goals are to be completed at the time a child is admitted into shelter care. This report should be completed with the caseworker for the child to ensure that all information is accurate and a short-term plan is developed for the child. Shelter staff participating in an interview reported that obtaining information on a child at admission is difficult because caseworkers are not the people bringing children into a shelter. More often the child is brought by a Driver or by an After Hours worker. In response to the question, “Who normally brings a child to the shelter?” shelter staff reported as follows:

| Caseworker | After Hours Worker | Driver | Other |
|-------------------|---------------------------|---------------|--------------|
| 23% | 41% | 34% | 2% |

Generally, Drivers and After Hours Workers have little information on a child at admission. As a result, shelter staff are required to try to reach the caseworker for the child in order to obtain the necessary information. This in itself, according to a majority of the staff is a challenge. Almost all the staff reported that it was difficult to reach the caseworker after a child was admitted. Admission conferences provide the venue for the gathering and sharing of information about a child and developing a short-term plan for the child. However, according to shelter staff, who participated in an interview, these conferences rarely occur. Some indicated that attempts were made to schedule an admission conference but the caseworker kept cancelling it. The remaining 7% of shelter staff indicated that admission conferences are held after vigorous attempts by the coordinator to schedule them. EPR shelter coordinators also reported that it was difficult

to arrange an admission conference because caseworkers were too busy to attend. Intake workers, who frequently use the EPR shelter system, don't want to attend admission conferences because their involvement is short-term and they transfer the case to the appropriate child and family services agency caring for the child. Having information on children is vital to their care, particularly if a child has medical needs or is on medication. One staff advised that a child was in a shelter for one week before the caseworker advised staff that the child had a life-threatening medical condition that required regular medication.

Shelter staff reported that an equal number of children are admitted to an emergency shelter from the community and from foster homes. A few are admitted from another emergency shelter. Children and youth are not always well matched as placement often occurs based on the availability of bed space. Accordingly, bed space is identified by age and gender. Bed space availability is provided to the After Hours Services on a daily basis. If there are requests for bed space for special needs children, the After Hours unit can match the availability of the bed space to the needs of the child. The reality, however, is that there is not much available bed space and limited choices when an emergency placement is needed. On-call supervisory staff are provided with lists outlining some of the special needs or high needs of children/youth in the shelters that have available beds and use this reference when approving shelter admissions after hours. Although attempts are made to match children and staff in placement facilities, shelter staff reported that matching was not always successful and discussed caring for youth from two different street gangs placed in the same shelter, and mixing children of difference age groups.

Consistent with the issues raised by staff during the initial shelter review, the lack of information on children and youth upon admission to a shelter and the inadequacy of proper matching of children/youth in shelters were once again reported as concerns by shelter staff. In the last year, on-call supervisors approve all after hour admissions which would require a variance.

Rights and Grievance Procedures

Staff reported that children and youth receive a general orientation to the shelter, including rules, routines and grievance procedures upon admission. The responsibility

for this process is that of the support worker on shift at the time the child is admitted. None of the staff referred to the EPR grievance procedures listed in the EPR Home Manual, but advised that children/youth are told about the Office of the Children's Advocate. Some of the staff stated that they have called the OCA on behalf of children in shelter care when they found that a caseworker was not providing the services that were required. Others stated that they use the threat of calling the OCA when caseworkers are not responding to a child's needs.

Approximately 83% of the staff stated that they observed a fair application of rules and routines in the shelters. This differed somewhat from the first review where it was found that rules and routines were not applied consistently and fairly to all children in shelters. The role of the OCA, as an advocate on behalf of children, appears to be now firmly entrenched in the philosophy of the staff working in emergency shelters. They see the role of the OCA as a valuable resource for themselves as well as the children and youth in care. Staff report that information on the OCA is visible and easily accessible to children and staff. This reviewer found that information on the OCA was visibly posted in all the shelters that were visited. However, few staff knew about VOICES: Manitoba's Youth in Care Network, and did not inform youth in care about this resource. This information was brought to the attention of the Program Director for Voices and discussions occurred on a process for providing information such as posters and brochures to the shelters.

Contact with Caseworkers

There are no restrictions to when a shelter worker can access the caseworker for a child and most staff report having to access caseworkers for a number of reasons such as to report an incident, obtain permission for school or medical activities or issues, report disclosures or behavioural concerns or ask questions. The exception to this are the staff that work only night shifts. These staff rarely have contact with caseworkers but report their concerns to coordinators or communicate their concerns to day staff who contact caseworkers. Almost all the staff reported that it is difficult to access the caseworker, with the exception of one staff person who indicated that with persistence the caseworker is accessible. In general, shelter staff reported that caseworkers don't readily return telephone calls, rarely have contact with the children in shelters and don't

attend to the needs of the children. Comments such as, “few workers see the children”, they almost never have in-person contact with the children”, and “some workers, you don’t hear from at all, they just drop the children off and you don’t see them”, was not uncommon.

Shelter coordinators are the intermediaries between the children in shelters and child and family service caseworkers. They are responsible for arranging case conferences and sharing information about a child with the caseworker. There is no clear delineation when a shelter staff should call a caseworker directly or do this through a coordinator. Shelter staff may try to contact a caseworker, but turn it over to the coordinator if they are not readily successful. Like shelter staff, coordinators also report that caseworkers do not have regular contact with children once they are placed in shelter care. These findings concur with that of the OCA during the review of the shelter system in 2002/03.

School and Formal Programming

All children and youth are expected to attend school programs during the day and, according to the staff interviewed, the majority of the children in shelter care were in school programs. Exceptions were older youth who were either suspended from a school program or were refusing to attend. Shelter staff reported that school attendance is encouraged and transportation is arranged to try to keep children in schools that they attended prior to being admitted to a shelter. This may include transportation by an agency Driver, EPR Support Driver, shelter staff or a taxi service. Staff accompany children in taxicabs. If children cannot attend a previous school, registration into a new school may take several weeks, as the enrolment process has to be facilitated by the child’s caseworker. Staff report that it generally takes a month or two to get a child enrolled in school. Once a child is enrolled, staff report that the teamwork between the child and family services and schools is not good. Communication is poor and children are suspended too easily. There are few daytime alternatives available for children and youth who do not attend school. Day programs are rare and several day programs used previously by shelter staff have been cancelled. Staff report that youth who do not attend school have too much time on their hands and are at increased risk of getting involved in criminal and gang related activities or become vulnerable to exploitation.

Since the last Shelter Review, geographic boundaries between school divisions have become flexible so children in care can continue to attend the school they were in prior to admission to a shelter. In addition, transportation is provided by agencies to ensure children can continue to attend school. These issues were raised in the Shelter Review (2004) and attempts have been made by the EPR program to address the transportation issues that previously prevented children from continuing attendance at the same schools they were in prior to placement.

Shelter staff were uncertain what formal programming meant and reported on one-to-one activities with children such as going to movies, watching television, playing board games, recreational activities or doing crafts. Apart from these types of activities, there is no regularly scheduled programming in most shelters. Recreational activities are not consistent in all shelters and vary depending on the staff on duty. Some shelters focus on recreational activities, while others only occasionally provide recreational opportunities. Although the EPR Home Manual encourages recreational programming as required in the Child Care Facilities Standards, not all shelters can provide this activity. Shelter staff cited examples of shelters with sibling groups of different ages. Young children make it difficult for staff to participate in recreational activities with older children. Other limitations include the high behavioural needs of children making it too difficult, and unsafe, for some shelter staff to take the children out. On the other hand, some shelters emphasize recreational programming and devote considerable time to ensuring all the children or youth are involved in structured activities. These shelters tend to be staffed by child care support workers who value recreation by virtue of their own involvement either professionally or by interest in recreational fields. There is no consistency between shelters in the amount and quality of recreational programming that is available to children and youth.

Family and Peer Contact

Shelter staff report that a majority of children and youth in shelter care have visits with family members outside the shelter. Visits inside shelters are permitted in accordance with the Facility Standards: Part 3, Section 58 – 63, which states that “the licensee permits or restricts visits, at any reasonable hour, in accordance with Agency

instructions”, and that “the licensee permits the children to receive visitors in keeping with family/home programs or routines and in considerations of the child’s needs”. Whether visits inside the shelters are permitted is largely a discretionary responsibility of the coordinator. With the exception of the occasional visit between siblings, few staff reported family visits in the shelters because of concern that family visits may compromise other children who don’t have visits with family. One shelter staff reported, however, that she worked in a shelter where family visits occurred in that facility. This was only heard once through out this review, and such exceptions must be approved by both the caseworker for the child and the supervisor with the EPR.

Generally, telephone contact with family members is permissible unless the caseworker indicates otherwise. According to shelter staff, most children and youth have regular contact with family members over the telephone. Occasionally, limits are set for the length of time a child can use a telephone. Many shelters do not allow children to bring peers to the home but children communicate with their peers over the telephone. Unfortunately, as peers are not allowed in the shelters, children bring their friends over and must play outdoors in the yard. This limits events such as birthday parties to locations outside the shelter.

None of the shelters have computers or Internet access for staff or children at this time. However, in this changing time, more children are now coming into care with computers and Blackberries and can access the Internet through wireless connections. This creates a challenge for staff to monitor appropriate and safe usage.

Basic Care Provided to Children and Youth

Most shelters follow a food plan based on the Canada Food Guide and involve the children in meal planning and shopping. Meal plans are developed for a three to four week period and then rotate. Special attention is given to children who have allergies or intolerances or are on special diets. Staff report that personal hygiene is monitored and children are encouraged to follow a regular schedule of bathing and brushing teeth. As children often come into shelters without a lot of clothing, some shelters maintain a clothing supply for emergency use. If there are no emergency clothes that fit a child, it is often a process to obtain new clothes for them. Initial clothing allowance has to be

issued by the caseworker and the process may take several days or weeks. Staff report that they may buy the child essential items from the shelter budget then replace this with the initial clothing money. When issued an initial clothing allowance, older children are accompanied by staff and allowed to shop for their own clothes. Staff are required to take children of any age shopping, ensuring their choices are appropriate and financially prudent and are accountable for submitting receipts back to the Agency.

All children/youth receive a personal allowance of anywhere from \$4 to \$10 a week. Each shelter seems to have a different standard for the amount children receive. Children can also earn more allowance by doing extra chores, keeping their room clean and showing good behaviour. In shelters for older youth, up to \$20 a week can be earned.

With the exception of children under the age of 8 and sibling groups, children in shelters have their own bedrooms, closet space and dresser space. In many shelters, door alarms are placed on bedroom doors and night-shift staff make regular inspections during the night. House rules state that children are not allowed to go into another child's bedroom and doors must remain open during the day when a child is in their room. Staff report that older children/youth are asked to empty their pockets, roll down their socks and their bags are examined for lighters, matches, weapons, drugs or other dangerous items when they come in from being out in the community. Any dangerous items are seized. Staff also reported seizing cigarettes from youth, but doling them out upon request if the youth smoked outdoors. Youth in shelter facilities are allowed to smoke outdoors.

As reported in the Shelter Review (2004), the basic physical needs of children were adequately met in the shelters. Food appeared to be sufficient and nutritionally sound. Personal hygiene was encouraged and the shelter environment was clean, adequately furnished and comfortable.

Safety

Shelter staff were asked to rate how safe shelter care was for children and youth. On a general level, all staff rated shelters as being anywhere from safe to very safe.

Yet, the next question asked shelter staff whether residents can place one another at risk and 83% of the staff responded that they could. Risk included physical or sexual aggression, rough play that would result in a physical altercation, and leading children or youth into criminal activities, gang involvement, substance use or prostitution. The most common risk to children, by their peers inside shelters, was verbal and physical threats, and physical assault. Once outside the shelter the risk to the child/youth increased significantly. Several staff expressed concerns about the location of shelters and reported that children have been threatened, have had jackets stolen and have been assaulted while walking to or from the shelter. The location of some shelters presented a safety risk to staff as well as children. Staff reported being afraid to walk to the shelter in the dark, risking their cars being vandalized or stolen and dealing with intoxicated people coming to the door at all hours. Staff were asked if they felt safe working in the shelter. In their response, 25% stated that they felt safe, while 75% stated that they didn't feel safe in the shelters. In addition to concerns raised about the location of some of the shelters, several other reasons for feeling unsafe included the fact that many youth have issues with authority figures, get easily angered and respond through violence, poor matching of staff and youth, new staff are not trained to deal with violent youth, and the neighbourhoods were unsafe, with gang houses or "crack houses" in visible proximity to some shelters.

Staff were asked if a resident had ever assaulted them and 78% of the staff responded affirmatively. Assaults included being punched in the chest, kicked, pushed and having objects thrown at them. One staff reported requiring medical attention after an implement caused a facial laceration. Almost all the staff reported that they had been threatened by a child/youth. Most staff indicated that assaults are taken seriously by the EPR and action follows such as police involvement, removal of the youth, or reassignment of the staff to another shelter. On the other hand, a couple of staff did not feel supported and stated that they didn't bother reporting assault threats because nothing would be done anyway.

When asked if they had ever seen other shelter staff engage a resident in a manner that caused an escalation of a violent or aggressive behaviour, 83% of the staff reported that they had. Staff reported that they observed other staff making offensive comments to a child, calling them names, shouting at them, and standing in front of them

to block them from exiting the door. Several staff discussed the concern about a large number of inexperienced staff who don't know how to respond to an aggressive child and "get in their face" rather than calming them down. When asked how they dealt with such observations, most staff reported that they tried to speak with the other staff and provide some guidance on how to approach aggressive children. Several staff notified their coordinator about the incident. According to shelter staff, risk to staff can be reduced with more training, and "refresher training" in non-violent crisis intervention available on a regular basis.

Since the last shelter review, more staff reported being assaulted. 78% of staff reported being assaulted by a resident compared to 72% in the previous shelter review.

Behaviour Management

All the staff were familiar with the EPR policy and procedures on behaviour management and most staff reported managing behaviour by removing privileges, using time out techniques, logical consequences and changing the course of events before behaviour began to escalate. The use of physical restraint was reported by 67% of the staff and involved children ages 8 years and up, only because there was risk of harm to the child or another child in the room. Every time a physical restraint is used, staff complete an incident report and fax it to the coordinator. Additionally, 50% of the staff reported witnessing another staff person using physical restraint on a child.

In the last shelter review, 68% of the staff reported using physical restraint on a child compare with 67% reporting the same in this review.

Discharge Planning

The discharge planning process has not changed much since the previous shelter review. At that time staff reported on the thoughtless process of discharging children from shelter care. They advised that there was inadequate notice to staff and children regarding discharges. Sometimes the children would not be told till the day before that they were moving. Similar concerns were reported in the present review. Notifications of discharges were too short, with examples provided where children were

told in the morning that they would be moving later that day. According to staff, the caseworker does not always adequately prepare the child for discharge and may not be there to move the child. Rather, caseworkers inform the staff and child that “someone” will be coming to pick them up. The staff report that children become anxious and worried when they learn that they are moving and may have questions for them that can only be answered by the caseworker. The short notice and lack of preparation of the child for moving does not provide an opportunity for the child to have closure with the staff and other residents. Not only does this rob the child of a chance to have a meaningful departure it interrupts a significant relationship process, that of closure.

Several staff discussed the formidable way in which children are moved in and out of shelters. Many are not adequately prepared and don’t understand why they had to leave their home or foster home and don’t know the caseworkers plan for them. Most children arrive with their belongings in a garbage bag and leave the same way. It should be noted that this practice is so deplorable to some staff that they make efforts to collect suitcases and have them available for children to pack their belongings when they leave. Staff report that many children are not adequately prepared for their next placement and many are not included in decisions about them. Shelter staff found that while most children go to foster homes when they are discharged from a shelter, a smaller number return home and a few move to another shelter or a residential child care facility.

8. The Voice of the Children and Youth in Shelter Care

The Office of the Children’s Advocate operates on the premise that the thoughts and feelings of children are best represented through the children themselves in their own words. To facilitate interviews with children in shelter care, the OCA contracted with Marie Christian, the Director of Voices: Manitoba’s Youth in Care Network to obtain the views of children in shelter care using the same surveys used in the initial shelter review. Ms Christian describes the process that was used to select children in shelter care for personal interviews.

“Selection

For the purpose of this review, 13 children and youth living in the EPR system were interviewed between April and June 2008:

1- 6 year old

3- 8 year olds

1- 10 year old

2- 11 year olds

2- 12 year olds

1- 15 year old

3- 17 year olds

11 male; 2 female

For a random sampling, the names of all children and youth living in the shelter system as of April 2008 were divided according to age (6 -10 years, “children”; 11-18 years, “youth”) and pulled from a hat. The names of 8 of the children and 16 of the youth were pulled first. Initial phone calls to set up times for interviews found that a significant number of the youth had already moved from their shelters, whether returned home, to another shelter, to a foster home, or to the youth justice system. One of the youth refused to be interviewed. Six youth (11 – 18) were interviewed from the first draw. All of the children selected had been moved or their shelter staff did not return the calls to set up an interview. Zero children (6 – 10) were interviewed from the first draw. Another draw was made, and by this time, even more of the youth who had been living in the EPR system as of April 2008 were moved. However, one more youth was interviewed. Once again, shelter staff did not return calls to set up interviews with children. Zero children were interviewed from the second draw. The interviewer obtained an updated list of EPR shelters, and after identifying which shelters housed children ages 6-10, interviews were arranged by calling random shelters and asking a) if there were children between the applicable ages living there currently and b) if the interviewer could set up time to interview the children. 5 children and one youth were identified and interviewed from the third draw.

Process

The interviewer would introduce herself to the children and youth at the beginning of every interview, explaining that she is representing the Office of the Children’s Advocate, and explaining the role of the OCA. She would explain how important it is to the OCA to have their voices included in the writing of the report about shelters. She would explain

that their words would be private, so they could be very honest, and that if there was any question that they did not want to answer, they could say, “skip” and they would move to the next question.

The interviewer explained that she would try to write down exactly what they said, and they could look at what she was writing.

Exclusions

As mentioned above, children and youth who had already moved to another placement (whether returned to family, to another home, to another shelter, or to another system) were disqualified from participating in the interviews. One youth was disallowed to participate in the process because it was felt that she posed a serious risk to the safety of the interviewer. Youth who declined to be interviewed were not pressed to participate: two children were very shy, and did not want to continue with the interview, but they did acknowledge that they knew about the Office of the Children’s Advocate (the interviewer showed them a picture of the OCA mascot and asked if they had ever seen or heard of it before. The children showed her where they had seen the figure before- on a poster in the hallway).

Treats

As a thank you, all youth who completed an interview were given a candy bar. Children were given a Ring Pop and a sticker. All were given information about the youth in care network, and the children received a copy of “Moving In, Moving On, Moving Out: a guide to living in care written by youth-in-care for youth-in-care”, produced by Voices: Manitoba’s Youth in Care Network.”

Most of the children and youth interviewed had been living in a shelter for a period of time ranging from 3 – 8 months. Four children/youth were part of sibling groups residing together at a shelter with 69% of the children interviewed being in care previously. Most of the children/youth reported at least one to five previous admissions to care.

The majority of the children/youth knew the names of their caseworkers. They were asked to comment on the frequency of contact with their caseworker and reported as follows; “3 times since Nov”, “not very often”, “once a week”, “once a month”, “none”,

“only saw him once”, “I wish she came more often”. This indicates that a higher percentage of children and youth report seeing their caseworker less frequently than on a monthly basis as required in the child and family service standards. In the previous shelter review, 63% of children/youth indicated that they had monthly contact with their caseworker. Most of the children/youth reported having 1 – 2 workers since they came into care. One youth reported having more than three caseworkers.

The Admission Process

When asked where they resided prior to admission to a shelter, 46% of the children/youth reported living with parents or relatives, while 54% reported living in a foster home or a group facility. This differs from the previous shelter review that reported only 38% of children and youth were living with a parent or relative prior to admission to a shelter. Children/youth were asked who told them that they would be coming into a shelter and three reported being told by their caseworker, one by an After Hours worker and three were not told at all. Others reported being told by a parent, a police officer, a big brother and a babysitter. Most interviewees reported that they weren't told how long they would be staying in a shelter.

Upon arrival at a shelter, youth reported that they were “shown around”, “told about rules and responsibilities”, “met other residents”, “met staff” and “told who the primary worker was”. When asked how they felt about being in a shelter, children and youth reported, “scared”, “confused”, “nervous”, “kinda happy, kinda sad”, “lonely”, “sad” and “angry”. Younger children were more explicit, “I cried all night”, “I missed my mom and dad”. For seven children and youth, the present admission was the first time they had been in a shelter. Two youth made comments about the shelters, “It's pretty good here”, and “I wish someone did stuff to make me feel better”.

Grievance Procedures

Questions on the grievance procedures were asked of youth only. Four youth reported that they had been told about the grievance procedures while three said that they hadn't. Most youth did not remember what they were told about the grievance process, although one youth recalled being told, “Just that I'll be safe”. When asked who

they would go to if they had a complaint, three youth said they would call their caseworker, other youth stated that they would tell a coordinator, a staff or a friend. When asked if they were told about the Office of the Children Advocate, two youth stated that they had been while five youth said that they hadn't. None of the youth had been told about Voices: Manitoba's Youth in Care Network.

Programming

Children/youth were asked about the programming available to them in shelters. Some of the responses included, "weekend outings", "go to the Y", "movies, bowling, buying Slurpees at 7 – 11". Another youth reported going to the park and another stated that independent living classes are set up to prepare youth for living on their own. These responses are very similar to those obtained in the previous survey. At that time children and youth indicated going to movies and playing video games. One youth stated that independent living classes were offered at the shelter the youth was residing in.

School Attendance

Most children/youth, 85% of those interviewed, reported that they attended school prior to coming into a shelter. One stated that he dropped out of school just before coming into the shelter. Only 69% of the children and youth were currently attending school. The others were not in school or registered in a day program. One child stated that he spends his days playing with his brother; while older youth reported spending time with friends. When asked if they liked school, the majority of the children and youth reported that they did. One said it was boring and another stated that he would like it better if it weren't so difficult. These results closely resemble the responses to the same question in the previous review. At that time, 82% of children and youth attended school prior to admission to a shelter and only 66% were attending at the time they were interviewed by the previous review team. During the previous review, alternative day programs were available and 4% of the youth attended day programs. At this time, no children/youth attended any alternative day programs and reviewers were told that no day programs were available.

Peer Contact

Almost all the children and youth reported having contact with friends but unable to bring friends into the shelter. When asked why they couldn't bring friends into the shelters, youth reported that, "those are the rules", "its suppose to be a safe house", and "staff don't know them". During the previous review, approximately 33% of children and youth were able to invite friends to the shelters. When asked if they would invite friends to the shelter if they could, about 80% of the youth said they would. All the children/youth reported telephone contact with peers.

Basic Care

All children/youth reported that they are provided with enough food and can eat whenever they felt hungry. When asked if there are times when food is withheld, four children/youth answered affirmatively; "yes, but it hasn't happened", "at bedtime", and "if you don't get home on time". Almost all the children/youth described the food as "good". Only one youth said the food was, "blah. Pizza is my favourite". Bagged lunches are provided for youth who are away from the shelter at lunchtime and one youth stated that he received money to purchase lunch. When asked what happened when youth miss a meal, they responded, "then you eat when you're hungry", "ask, then get our own food", "eat later", and "they put it in the fridge". Youth reported that staff shared meals with them and were then asked what is discussed during meal times. The youth reported, "whole bunch of stuff", "we just joke around", and "whatever". Most youth stated that meal time was relaxing although one youth stated that, "I like sitting by myself because its nice and quiet". This information is consistent with the responses obtained from children and youth in shelter care during the previous shelter review.

Clothing and Personal Items

All youth reported that they were provided with personal items and received clean and appropriate clothing. No one had any concerns about clothing. During the previous shelter review, 44% of children/youth responded that they did not receive adequate clothing.

Allowance

All children and youth reported that they received an allowance. The amount ranged from \$4 a week to \$15. Youth stated that they received, “minimum \$4 a week – more if you do chores”, “about \$15 depends on how much chores you do”, “\$10 a week”, “\$6 every Friday”, \$10 every Saturday”, and “depends if rooms are dirty all week - \$4, if clean \$10, with chores \$15”. Allowances were contingent on doing chores, keeping rooms clean and showing good behaviour. The previous Shelter Review (2004) reported that only 90% of children/youth received an allowance, part of which was conditional upon chore completion and acceptable behaviour.

Health

Youth were asked if they had seen a doctor, dentist and optometrist while at the shelter. 71% reported seeing a doctor, while only 43% reported seeing a dentist and 43% reported seeing an optometrist. In the previous review, 85% of children/youth had seen a doctor.

Chores

Youth were asked if they completed chores in the shelter and 43% reported that they had while 57% reported that they don't do any chores. According to the youth, a chore list is posted in most shelters and youth are either assigned a chore by the staff or can choose what chores they want to complete from the list.

Routines, Outings and Celebrations

Most children/youth reported a regular mealtime, bedtime, curfew and free play times as well as routines that included showers, brushing teeth, having a bedtime snack and some children reported that a bedtime story was read to them. Youth reported that they went out by themselves without staff, but also participated in activities with staff. Youth reported going to movies, shopping, swimming, shooting pool, playing basketball and archery and going to the park with staff. Some activities included a group of youth. Most of the youth reported that they participated in decisions about activities and

outings, although two youth stated that the staff make those decisions. Youth were asked to comment on routines and outings and two youth had the following comments, “I wish I had more allowance.” “Longer curfews.”

Children and youth were asked what happens at the shelters when there is a birthday or whenever there is a special holiday. All reported that birthdays are recognized by celebrations including, “cake”, “food and songs”, “presents”, “games”, “outings”. Children and youth also reported that special holidays are celebrated and provided examples of having “Easter baskets”, “Chocolate”, “big dinner”, “presents”, “painted Easter eggs” and “we went ‘trick or treating’ at Halloween”.

This information compares favourably with the responses of children and youth in shelter care during the previous shelter review. At that time, all the respondents reported that special occasions were celebrated.

Privacy

Youth were asked for their view of privacy in the shelters and all reported that they had their own bedrooms and a place to store their belongings. Although one youth stated that there was no place to store personal belongings. Only two youth reported that they were able to lock their personal belongings away. Six youth stated that they had never experienced any of their belongings stolen, but one youth reported that items such as “smokes”, “lighters” and “socks” were stolen. All youth reported that they had adequate private space to bath, shower and change clothing and were able to use the telephone privately. More than half of the youth reported that staff searched their rooms occasionally. In the previous review, 37% of children/youth reported that their rooms were searched and 59% reported that they have had personal items stolen.

Safety

All children and youth stated that they felt safe in the shelters but did make comments that showed some discrepancy with their responses. “I feel safe most of the time. I just don’t want another resident to steal my stuff.”, “I feel unsafe because of ---- (another resident).” “I feel safe when staff pick me up at school.” Children and youth

were asked when they felt unsafe and they responded, “when lies are told about me”, when another resident is “mad at me”, “at night”, “when its dark”, and “outside, neighbours are drunk”. The children and youth were asked what would make it safer for them in a shelter and they responded, “if there weren’t any thieves”, and “if ----- (another resident) wasn’t here”. In the previous review, only 72% of children/youth stated that they felt safe in the shelter.

Younger children were asked if they liked the other residents in the shelter and 85% of the respondents stated that they did. This is considerably more than the 58% who reported that they liked the other residents in the shelter when interviewed during the previous shelter review.

Family Contact

Children and youth were asked if they had contact with their family and 85% of the children interviewed responded that they had contact with either a biological parent, a foster parent or a stepparent. This is considerably more than the 69% who reported contact with family members during the previous shelter review. Most contact occurred in the community with the older youth arranging their own contact with family to a large degree while younger children visited with family in Agency offices. One child advised that visits occur in the shelter. Family contact occurs anywhere from once a week to once a month to “whenever I want – every couple of months”, and “everyday if I want to”. Most children and youth reported that family visits couldn’t occur in shelters. Children and youth were asked who determines when they should have contact with family and 7 responded that that decision is made at the agency level by their caseworker or the supervisor, while two children stated that the family makes that decision and four youth reported that the decision is theirs. Only two youth stated that they were asked if they wanted contact with their family. Therefore, 85% of the children/youth were not asked if they wanted family contact. This is a larger percentage than the 52% who responded that they were not asked if they wanted family contact in the previous shelter review. Most children and youth reported that they were in favour of the current visitation arrangements. One youth reported that the caseworker was not aware of the family contact he was having. In the previous review, almost one half of the youth reported unsanctioned contact with family.

Peer on Peer Violence

Children and youth were asked if they worried about being hurt in the shelter they were at. Nine reported that they weren't worried about this while four stated that they were worried. A younger child commented that "kids are rough, throw things, jump/play too hard". Older youth stated that "most of the girls are nice", "staff looks out for everyone", "I'm the oldest", and "they never hurt me". The children and youth were asked if they had witnessed any other resident being subjected to hurtful experiences and they advised that the major threat was verbal harassment by peers including general name calling, insults, put downs, racial comments, comments regarding sexual orientation and one-on-one fighting. One youth was concerned about threats to do physical harm and sexual harassment. Another youth worried about theft of personal property and money. When asked what they would do if the above occurs, one youth stated that staff would be informed and another youth stated that he would handle the matter himself. Only 50% of the youth stated that they would tell staff. As one youth puts it, "I'm not a rat – I'll deal with -----". If staff were aware of the situation, youth thought that they would "interfere and give out consequences". In the previous shelter review, 52% of youth stated that they would report any violence toward them to staff.

None of the youth interviewed reported being part of a gang, and only one youth knew of another resident that belonged to a gang. This youth saw a problem with gangs at the shelter and stated that they "try to intimidate with stories of shootings and stuff".

Interactions with Staff

All the children interviewed stated that they liked the staff who worked in their shelters because they "give me food", "take me to the park", "are easy to talk to", are "really nice" and "take us out for supper". One child reported that staff brought video games for the children to play. Older youth spoke favourably about staff as well describing them as "nice", "fun to be around", "pretty cool", and appreciated that the staff "joke around", "listen well", "don't force you to do anything", and "give you choices". The children were also asked what they didn't like about the staff and the following comments were heard, "sometimes they tease me but they're just kidding", "when they send me to

my room”, “when they yell at me when I do something bad”. A six-year-old boy stated “they get madder and madder when I don’t eat”. “One hit (my brother)”, stated another child. Yet another child stated, “A male staff hit me. Mom is filing reports. Spoke to regular staff, made an incident report”. A child referring to purchased service staff made the following comment, “The new ones don’t know what they’re doing and they don’t know none of the rules, and they’re lazy”. Older youth had no concerns about staff. They stated that there was nothing about staff that they didn’t like. Most youth reported having a primary staff who did activities with them, talked to them on a one-on-one basis and was someone that the youth trusted and could talk to. One youth received outside counselling. Most youth knew what a case conference was and about half of the youth participated in a case conference about themselves.

Behaviour Management

Children and youth were asked what rules they had to follow in the shelters. The responses were as follows:

“Respect everyone, don’t steal, and come home by curfew, don’t go AWOL”

“Show respect, honesty”

“Respect your boundaries, others, do your daily chore, no swearing, no fighting, respect other’s property, clients are not to enter staff space”

“Clean your room”

“No friends, no food in rooms, rooms have to be cleaned daily, empty your pockets before you come in the house, smokes and lighters given to staff.”

The children and youth were also asked what happens when rules are broken and they responded as follows:

“Grounding, lose TV or phone”

“Don’t get allowance, TV and electronics taken away”

“Early bed, no video games, warning first”

“Get in trouble, get grounded, and lose your stuff, like toys for not listening. I lost my Play station. It’s in the basement. I don’t know when I’ll get it back.”

“Allowance gets docked”

“Time-out”, “Quiet time”

Youth were asked whether they had ever been subjected to more intrusive disciplinary measures. One-half of the youth reported having been given time out in their room once in a while to “almost every day”. Two youth reported that physical restraint was used on them because, “I was angry and yelling” and “I was running away”. Once this restraint was administered by a police officer and the child was placed in hand cuffs. In the previous shelter review, 59% of children/youth reported the use of time out, 22% reported having been physically restrained.

Approximately 45% of children/youth stated that staff spoke to them following an incident. This compares to 59% of children/youth who reported the same in the previous review. Children/youth responded that staff talked to them following an incident, “when I calm down, they explain what happened”. Both children and youth were asked to respond to the following question:

Has staff ever threatened you?

| Yes | No |
|-----|-----|
| 62% | 38% |

The children and youth reported threats of physical restraint, time out, contacting the police and removal from the shelter. Only one youth reported being swore at and no youth reported being put down or humiliated by staff. A total of 33% of children and youth reported feeling humiliated and put down by staff when interviewed during the previous shelter review. No children/youth reported that they had experienced any humiliation or were put down by staff in this review.

When asked if they had ever witnessed another resident being swore at or put down, one youth answered that he witnessed a staff swearing at another youth on one occasion. About one half of the younger children reported that they had witnessed staff yelling at children. One child stated that name calling and hitting was observed. This was the same child who said a staff person hit him.

Resident Violence Against Staff

Youth were asked if they had ever witnessed another youth hurting a staff member and 15% responded affirmatively. One youth stated that she observed, “one girl was hitting a staff”. Another youth stated that he “heard threats”. The same percentage of youth reported witnessing another youth hurting a staff person in the previous review. When asked if they had ever hurt a staff, 30% of the youth stated they had, “when I get really mad”, and “I pushed a staff”. During the previous review 19% of the youth admitted assaulting a staff.

Running Away

Children and youth were asked to respond to the following question:
While at the Shelter, have you wished you were somewhere else?

Three didn’t respond, four responded ‘Yes’ and six responded ‘No’. The four who responded affirmatively stated they would rather be:

“With my friends”

“Regina, Saskatchewan with family, like for spring break I was supposed to go for 2 weeks, but my social worker didn’t reply”

“At my foster mom’s house”

“Back with my step mom in -----, closer to my friends”

Younger children were asked if they liked living at the shelter. They responded as follows:

“Yes”

“Yes, It’s fun here”

“Yes, because they’re really nice and they let you do lot’s of stuff”

“Yes, because there’s video games, and it feels safe here”

“Yes, I want to go home now”

“Yes, because you get to do fun stuff and play with staff”

Similarly, children and youth were asked if they had ever run from the shelter they were currently at and four said they had while nine said they hadn’t. Those

that ran commented “only once – overnight”, “once or twice”, “I was really mad, had to get away”, and “the cops brought me back, the staff worry about me”. Youth were asked if they had ever run from a past shelter placement and four youth said they had because “my aunt called the cops and told them I was abusing her. I was scared so I left”, “I didn’t like it”, unhappy”, “I didn’t like it – stressed”, and “I didn’t like it, -----(staff) was being a complete asshole”.

Medication

Youth were asked whether they were administered medication. Two youth reported taking Risperidome. “Risperidome, controls anger so you don’t go into a state of rage. Happened a lot when I lived with my aunty (taking Risperidome was a condition of staying at aunt’s)” “Risperidome for anger, stomach meds because the Risperidome gives me ulcers”.

Discharge

Both children and youth were asked if they knew how long they would be staying in the shelter. One youth, who was preparing for independent living, reported, “until I get an apartment”. Other children/youth made comments such as “6 months”, “No, I don’t know”, “I forget”, “4 minutes”, “till Christmas”, and “I’m supposed to be out soon”. Most children and youth did not know where they would be living after the shelter.

“Maybe (home community). I’ll tell you tomorrow.” (Social worker visit expected)

“Back home on ----- or might go to a foster home before Christmas”

“Go back home at Christmas. Might go to a foster home soon.”

“At Sherbrook”

“No”

“My mom’s finding a house”

“My own apartment”

“At my step-mothers”

“Back home or in a foster home”

“Home”

“Another shelter”

Children and youth were then asked where they wanted to live.

"On my own, closer to school."

"In my own place"

"I don't know. Somewhere in Winnipeg, so I can catch the bus and get to my family."

"I don't know"

"At ---- (step mom)"

"My mommy"

"Besides home, at -----, my best friend."

"Home."

"At home"

"My mom's house."

"Where my family is"

Most youth reported that they were asked where they wanted to live by shelter staff, parents, a foster parent, a caseworker, or a shelter coordinator. Only one of the younger children interviewed reported being asked about where she wanted to live. That child was asked by her mother. Most children reported that they weren't asked where they wanted to live. One child stated, "my social worker will tell me". Another child stated that, "I don't care where I live as long as it's with family". Less than half the youth were aware of the case plan for them. Those that were indicated that their case plan was "just get an apartment", "live with -----, go to school, finish school".

Overall Experience with the Shelter

Both children and youth were asked what they liked about the shelter. They responded as follows:

"They have good food and the staff are nice."

"Everything. Recreation day."

"Everything"

"I get my allowance, and going out for supper, going to the park"

"People aren't complete assholes. ----- is the only one I trust"

"My staff"

"I can play on PS2, watch TV, and there's cable. There's no cable at home anymore."

"They have lots of good food here."

"Go to the movies. Staff."

"Playing"

"The nice staff, the video games and staff"

At the same time, children and youth are also asked what they disliked about the shelter. They responded as follows:

"That there are thieves and that it's far from school."

"Nothing"

"Going to bed early"

"No more threatening to call the cops"

"They lose your cigarettes and lighter sometimes"

"Bugs"

"That I have to go to timeouts, eat at the table, and that when I'm bad, I don't get to play on the PS2"

"I don't like that I can't go outside on my own."

"The freaky stuff upstairs at night time. I saw a shadow go by."

"I don't like the (purchased service organization) and (purchased service organization) staff"

Children and youth were asked to respond to the question, what do children/youth need to know about this shelter to help them in their stay here? The following responses were received:

"Follow the rules"

"Show respect and honesty"

"Don't be bad or you won't get your allowance or activities. You can earn your allowance back."

"Keep your room clean and be good to get allowance"

"Don't talk to (another resident)"

"They're (the staff are) very nice."

"To be good."

"You have to listen to the staff."

"Don't cry. He's crying because he wants to go home."

"It's fun with (staff person). Meet new kids next door."

“I dunno”

All the interviewees were asked what they would change or improve at the shelter if they had a chance to. They responded:

“The garage- make it into a weight room, so we don’t have to go to the Y”

“Later bed, because I’m not in school”

“Going outside to the park or somewhere else”

“Me on the PS2 whenever I want”

“If staff didn’t have to take you everywhere (walk you to and from school, outside).”

“I dunno”

And finally, children and youth were asked if there was anything else that they wanted to share that was not asked of them. Only a few took this opportunity to be heard.

“This Shelter is really good”

“Not really”

“(I) Need to visit my mom and sisters more”

“I want my mom.”

Through the words of the children in shelter care; we are able to get some insight into their lives. On the positive side, shelter care seems to adequately meet several basic needs of children including physical care, the need for a safe place to live, and some element of social well-being through positive relationships and interactions with staff. However, children and youth in shelter care face isolation from their families and are not kept well informed on plans affecting their lives. There is clearly not enough contact between the children/youth and their caseworkers where they might be kept informed on decisions that affect their lives and that of their families. This takes away any control that they may have over their lives and leaves them solely dependent on others to make decisions affecting them.

9. The Broader Emergency Placement System

In the Shelter Review (2004), the OCA provided an in-depth review of the history that led to the development of the WCFS EPR system. As mentioned, this resource developed in response to a demand for emergency placements, and, due to the urgent nature of the service, emerged rapidly and outside the regular provincial placement system. As a result, it emerged without a vision, policy and program model. Although there was no question that the need for an emergency care system serving children in Winnipeg was essential, the OCA called for changes to integrate the existing system into a continuum of care that would reflect a progression of services and provide policy and a program model for the EPR system. At the forefront of the OCA concerns was the fact that demographic information appeared to suggest that a large number of children using the emergency care system were already in foster and residential care placements and moved to emergency shelter care because of placement breakdowns. If the emergency placement system was operating within a coordinated out-of-home placement system, then a capacity for systemic resource development based on the needs of children requiring emergency placements can be developed. As a result, the OCA recommended that a centralized office be established by the four Authorities within the DFSH to develop a continuum of integrated in-home, community and out-of-home family support and placement options.

With the restructuring of the child and family services system in the province, responsibility for all aspects of service delivery were transferred to Child and Family Services Authorities and provided by 25 child and family service agencies in the province. The responsibility for resource development is an agency function, overseen through policy developed at the Authority level.

The issue of emergency out of home care, and the use of hotels as placement resources for children, was addressed by the Standing Committee in 2006/07. This resulted in a policy statement outlining when children can be placed in hotel placements, followed by a protocol for children in need of emergency out of home care. The Southern Authority provided an example of their “Protocol for Children in Need of

Emergency Out of Home Care”. As each Authority operates somewhat differently, this protocol does not apply to child and family service agencies outside the Southern Authority.

Part 1 – Agency Responsibilities

- a). Contact the following to locate an appropriate bed for the child/youth in need of placement:
 - 1. Extended family members
 - 2. Community members
 - 3. Internal agency foster homes and potential places of safety
 - 4. Other Southern Authority agencies
 - 5. Emergency Placement Resources (for shelters)
 - 6. External service providers
- b). Consult with the Southern Authority designate to identify further alternatives and/or solutions.
- c). In the event that all of the above options have been exhausted, the placing agency will immediately provide the Southern Authority with a completed Southern Authority Hotel Placement Request (SAHPR – 1) Form.
- d). Agencies require Southern Authority approval to proceed with a hotel placement.

In addition, the Southern Authority developed an *Emergency Foster Care Manual* directing that:

“Agencies are now required to develop additional foster homes with the necessary skills to provide for children coming into care on an emergency basis. Agencies within the Southern Authority are in the process of developing an Emergency Placement Resource System to provide for children entering care in emergency situations”.

Placement in an emergency foster home would be short-term with an expectation that children move from emergency bed spaces to more permanent placements leaving regular availability of emergency bed space. Special training is provided to foster parents who care for children in emergency situations and there is an expectation that

they maintain daily documentation. The rate for emergency foster placements is \$100 a day. A retainer fee is paid to ensure bed space is available when needed.

In addition to implementing a policy on hotel placements, committees were established to work along with agency representatives on the task of developing new placement resources and recruiting and retaining foster homes. At this time, most child and family service agencies have Resource Departments and staff responsible for recruiting foster homes and developing any other placement resources as may be needed to appropriately service the client population of that agency. Resource Development staff, within each Authority, provide assistance and support to agencies in developing the emergency placement alternatives that are best suited to the needs of children that they are responsible for.

Discussions with child and family service caseworkers confirm that extended family, as a place of safety for children, is the most commonly used emergency placement option. Some agencies report having Kinship Care programs. Manitoba does not have legislation specifically for Kinship care, but some communities such as Garden Hill rarely use resources outside their community for emergency placements. In general, staff with child and family service agencies in rural and northern communities confirm that locating extended family, or placing children in already established places of safety in the community, are the most common responses to securing emergency placements for children who come into care or have to be moved from another placement resource because of a breakdown. However, locating emergency placements for older children or youth with high needs or behavioural difficulties is more challenging and, often, these youth are transported to Winnipeg for placement in the EPR shelter system.

With hotel placements being prohibited with few exceptions, recruiting and retaining emergency bed spaces in foster homes has been the focus for resource development and placement departments of child and family service agencies. Emergency bed spaces in foster homes are located where the need for this is greatest. For example, the Kinosao Sipi Minisowin (KSM) and the Nisichawayasihk Cree Nation (NCN) child and family service agencies, providing the majority of child and family services in the northern part of the province, have developed an emergency foster home

in Winnipeg where the agencies share the emergency bed spaces. Recruiting foster homes has been the focus of all child and family service agencies in the province, supported by the province-wide Foster Care Recruitment Strategy. This strategy has added foster homes to the child and family services system, however, according to staff working with child and family service agencies, the added foster homes have not made a difference when placement resources are needed for larger sibling groups and children or youth with high needs and behavioural challenges. This population of children and youth tend to make up a significant portion of children in the care of child and family service agencies.

New Emergency Placement Resources

Because of their high needs or special challenges not all children or youth can be placed in a foster home or with family members. As a result, child and family service agencies are moving toward the development of emergency facilities in different parts of the province to care for children and youth who may not be able to reside in a foster home or family residence. These agency-operated facilities are staffed by hired foster parents who reside in the facilities, or by child care staff who work shifts to care for children in these facilities. Some facilities have both foster parents and paid staff and several emergency and non-emergency facilities are shared between child and family service agencies with different Authorities. The Metis Child, Family and Community Services agency is the Designated Intake Authority (DIA) for Parkland Region and is responsible for intake and after hours services to all children and families in the region. All agencies providing child and family services in the region share placement resources with the DIA according to a set of collaboratively developed principles and protocols that state:

1. Culturally appropriate emergency placements, and in particular emergency foster homes, are a priority for children in crisis, and
2. No child should be denied an available emergency placement; emergency resources submitted to the DIA should be considered available as shared resources.

The following protocols apply when a child is in need of an emergency placement:

1. The emergency resources belonging to a child's culturally appropriate Authority/agency (if known) will be considered as a first resource for the child.
2. If no suitable placement is available, or, if the child's cultural affiliation cannot be determined, non-agency specific resources will be considered.
3. If a suitable placement is still not available, placement of the child into any available agency specific resource will be considered.

In partnership with the Southern and General Authorities, the MCFCS has developed two emergency placement facilities for children and youth in the Parkland Region, in addition to shared emergency foster bed spaces.

Sunrise House is a 4-bed co-ed facility for 12 – 17 year old youth located in Swan River. The facility is also used for sibling groups. This facility is staffed by direct service workers (DSW) who work 8 – 12 hour shifts. Placement is to be short-term.

Four Winds is also a 4-bed co-ed facility but licensed for 0 – 12 year old children and is located in Dauphin. Like *Sunrise House*, this facility is staffed by direct service workers who work shifts from between 8 to 12 hours. The placement facility is intended to be short-term.

In the Interlake Region, the Metis Child, Family and Community Services (MCFCFS) agency operates the *Eagles Nest* facility in partnership with the General Authority. Currently located in Selkirk, Manitoba, this facility has 8 – 10 bed spaces for male youth and two of the bed spaces are designated for emergency placements. Unfortunately, the facility will be moving to two separate locations later in the year. One facility has been confirmed in Winnipeg and a search is underway for another location in the Eastman/Interlake Region of the province. It is unclear whether the capacity to allocate emergency bed space will still be there after the move.

The Southern Authority added 10 emergency bed spaces for youth in Winnipeg through the development of the *Golden Eagle* facility on Edmonton Street. Operated by

Project Neechewan, this facility accepts admissions of youth for short-term placements. The maximum stay is 15 nights and placing caseworkers are expected to provide a case plan within 24 hours. The facility can accommodate 5 male and 5 female youth.

The majority of child and family services in the northern part of the province is provided by agencies responsible to the Northern Authority. The Nisichawayasihk Cree Nation (NCN) Child and Family Services operate two Receiving Homes in Nelson House. One facility is a 4-bed unit for children ages 0 – 3 years and the other is a 4-bed facility for children ages 11 – 17 years. The Receiving Homes are agency-operated but staffed by live-in foster parents who are able to provide specialized services for children with FASD. The facilities allow for children to remain for longer periods of time and, as a result, bed space is not always available for children requiring an emergency placement.

According to reports from caseworkers, most child and family service agencies across the province refer children to the WCFS EPR emergency placement desk, at one time or another, when an emergency placement is required in Winnipeg. In fact, agencies in northern and rural communities have stated that, due to the lack of placement options for youth with high needs; arrangements are made to transport the youth to Winnipeg for placement.

Emergency placement resources, other than foster homes and extended family residences, are needed in other centres through out the province to accommodate the placement needs of children and youth who cannot manage in a family-based placement resource. Clearly, reports of youth transported to the EPR system in Winnipeg calls for similar placement options in closer proximity to the youth's family and community.

In order to obtain current information on the state of emergency placement options, staff responsible for resources at the four Authorities, as well as staff working in placement services in several agencies, participated in personal or telephone interviews with the reviewer. Staff reported that several new placement facilities, both for emergency placement and longer-term care, are in various stages of development in various locations across the province. The staff working on developing and establishing these resources also report frustrating delays and complications due to a wide number of reasons.

Conditions of Manitoba Housing Units

Vacant Manitoba Housing units were identified as possibilities for establishing resources for child and family services including emergency placements for children in several locations in the province. Staff working on exploring this possibility found the conditions of the housing units alarming. Requests to upgrade the conditions of the homes take months to process and more delays occur before any work is done on the housing units. While two agencies have developed sound programs that would provide emergency care and family reunification services to children and families in the Interlake Region, they have been waiting months for the facilities to be upgraded to a standard that would make them habitable.

Staff Shortages and Workload Size

Authority representatives reported that a shortage of staff to meet the workload demands of child and family services, left little time for the task of developing emergency resources. Most of the time is spent in supporting existing placements because of the complex needs of children in care. An Authority representative reported that four possible sites for an emergency placement facility were located, but existing agency staff just did not have the time to develop these sites.

Shortage of Qualified Foster Parents for Agency-Operated Facilities and Shortages in Child Care Support Staff

Most Authority representatives noted the lack of qualified individuals to operate emergency facilities and provide quality care to youth. There is a province-wide shortage of residential child care workers and this is particularly evident in rural and northern communities. The work is difficult and child care staff in residential settings face numerous personal risks including threats and potential physical assaults. Furthermore, the wages paid for staff to live-in or work in agency-operated youth facilities are not sufficient to encourage people to accept these types of working conditions. As a result, agencies are having difficulty in finding qualified staff who are willing to work in agency-operated child placement facilities. Several representatives

reported that residential care staff are not offered adequate training and are not adequately compensated for the work they do.

Lack of Funding

Some prospective residential facilities are ready to develop once funding is approved. Other prospective placement facilities are on-hold due to the lack of available funding. Representatives questioned what happened to the money from the hotel use reduction strategy, in that it was understood that this money would be available for resource development. Some representatives suggested that the funding distribution was not equitable and more support is available for emergency placement development in some areas of the province than in others.

Resource Development Strategies and Ideas

As indicated earlier, several sound projects are proposed or already in development. Some of these projects are inclusive of family preservation and reunification services, youth assessment services and the emergency placement needs of children and youth across the province. Each Authority is working on several projects either with their agencies or in partnership with other Authorities and their agencies. Resource development is not limited to out of home placements for children but includes preventative and family capacity-building programs. Some of the proposed resources include:

- a) *Ahsanook*, a residential placement and assessment facility for children and youth, which combined with coordinated family programming, aims at reunification of the children/youth with their families. Based in Winnipeg, this facility should provide placements for 10 youth. The building has space for other programs and services.
- b) *Daawin*, a partnership between the Southern and Metis Authorities, this program will develop nine 4-bed facilities and a Resource Centre in the community of St. Laurent. Both the Southern and Metis Authorities will develop the resource according to the specific needs of their client population.

- c) Still unnamed, a facility on the Brokenhead First Nations will be converted into a residential facility for 4 pregnant young mothers and, another 4 young mothers and their infants. This facility is proposed by the Southern Authority and is still in the planning stage. In addition, a private proposal to convert an apartment block in Winnipeg into 5 suites for youth in semi-independent living, and two suites for youth in independent living is currently under review.
- d) The Southern Authority is also working on developing a four-bed treatment unit on the Fisher River First Nations.
- e) The Northern Authority has located a facility to develop a 4-bed emergency placement resource in Ashern. It is currently waiting for the Licensing Branch to complete the approval process.
- f) The Northern Authority, along with the Cree Nations CFS, is working to develop 4-bed emergency placement group homes in Snow Lake, Lynn Lake and Leaf Rapids.
- g) The Northern Authority had discussed partnering with an external residential care facility to develop emergency resources in The Pas and Thompson.
- h) The Metis Authority is involved in the relocation and restructuring of the *Eagles Nest* facility in Selkirk to two separate 4-bed facilities for youth and developing a third facility, particularly for female youth.
- i) The Metis Authority, along with the MCFCS agency, is considering developing an emergency placement facility in Brandon and obtaining approval to proceed with program development in St. Laurent.
- j) The Metis Child, Family and Community Services agency has developed a proposal, in partnership with the DFSH Employment and Income Assistance (EIA) program and Manitoba Housing, for a Family Enhancement Program where Manitoba Housing Units will be converted into agency-operated placement facilities providing care to children. This program encourages families to develop

the capacity to provide care to the children by enabling them to move into the homes and develop the skills needed to resume parenting their children.

- k) The General Authority continues to have responsibility for the WCFS EPR unit and develop resources required to meet the current placement demands. This has resulted in developing 6 additional emergency shelters, and increasing emergency foster bed spaces.

Improving the Emergency Placement System

Throughout the review process, child and family service managers and staff were asked for their views on the emergency placement system and their ideas for improving this system in the province. Their responses were collected and condensed into the following thoughts and suggestions.

Few longer-term placement options are available

Concerns were raised about the availability of longer-term resources that children may be able to move into. Some of the children in emergency shelters and foster homes have high and multiple needs that cannot be managed in foster care and require a specialized placement resource. Bed spaces in existing residential care resources are limited and the children are placed on a waiting list.

Provincially funded residential treatment facilities are selective in the children/youth they accept

Several staff indicated that provincially funded residential care facilities were too selective in the children they accepted and passed by children with serious behavioural issues or a proneness to violence.

Limited placement options for larger sibling groups

Most foster parents can only accommodate one or two children at a time, and sibling groups of three or more have to be placed in hotels which is not an acceptable placement for them. They end up staying too long because there is little possibility of a

foster home able to accommodate the group. Sibling groups often end up being separated eventually because they can only stay in a hotel for so long. Appropriate longer-term placement resources are needed to ensure the emergency placement system works as intended.

No system in place to monitor the reporting of available bed spaces

It was suggested that child and family service agencies were slack in providing a list of available placement resources to the emergency placement desk. By supplying foster bed vacancies to the desk, children can be moved from emergency bed spaces into the vacant foster bed space. As there is no accurate and consistent tracking and compliance system in place to ensure information about vacant foster bed space is shared between agencies, agency placement coordinators fill any available foster bed spaces with requests from their agency and “protect” available foster bed space for their own use. Without having access to available foster bed spaces in the system, children in emergency care end up staying there.

High workloads and untrained caseworkers result in low priority given to moving children in stable emergency foster homes or shelters

The workload and inexperience of caseworkers was suggested as another reason why children are not moved if they are in a stable emergency foster home or shelter. This is not considered a priority for the caseworker and is not attended to. Some new workers do not even know where to look for longer-term placements. Referrals result in placements of children on a waiting list. Staff agreed that an improved, centralized tracking system that accurately tracks the availability of bed spaces in foster homes and residential facilities, and updated on a daily basis, is imperative to managing the turnover of placements from emergency care to stable, longer-term care.

Final Thoughts

The present state of the emergency placement system has taken a different direction from the recommendations made by the OCA. In the Shelter Review (2004),

the OCA recommended a centralized office to develop specific standards for emergency care, identify emergency placement needs, establish appropriate resources and regulate the emergency care system in the province. With the restructuring of the child and family services system responsibility for all services involving children and families was transferred to four Authorities, each providing services through child and family service agencies to specific target population groups. The child and family service agencies are responsible for all service delivery aspects including the development of resources to meet the placement needs of children in care. The Standing Committee serves as the regulating body to ensure fair and equitable practices are in place through policy development and distribution of resources.

The hotel reduction strategy in 2006 was effective in dealing with the use of hotels for emergency placements for children, a concerning practice in child and family services and, at the same time, provided an incentive for agencies to begin developing emergency and other placement resources that would meet the specific needs of their client population. By redirecting the money saved from costly hotel placements, agencies could develop the resources that would make most sense for their specific client needs. In keeping with the strategy to eliminate hotel use, three committees were established with representatives from all four Authorities to work on moving children from hotels, developing alternative placement options and recruiting foster homes. The collaborative nature of the committees progressively waned as work increased between Authorities and their respective agencies. According to staff with Authorities and agencies, at this time most of the resource development work is internal to each Authority and the agencies responsible to it. The consensual model of decision-making adopted by the Standing Committee provides a framework for collaborative working models between Authorities and agencies; however, according to staff, collaboration is articulated but not necessarily practiced. The absence of a centralized regulating body that monitors placement resources, including available bed spaces, across the system does not encourage the sharing of resources between child and family service agencies. How does one agency know whether a suitable bed space is available for children in a foster home managed by another agency if the other agency wants to keep that bed space vacant for an anticipated admission of their own? In the restructured child and family services system, the process of locating placements for children in care is not an efficient or effective process and, although the intentions are well meaning, the system

does not allow for access to placement information that is essential in locating suitable placements for children. The lack of longer-term bed spaces for children and youth is a concern that has been stated by a number of child and family service staff, including staff working in the area of resource development. However, the fact that 370 children and youth were moved from hotel placements, within a six-month period, into longer-term placement resources when absolutely required to do so, suggests that there may be more placement options out there than reported. Through the work of a committee that diligently worked to plan for each child in a hotel placement, longer-term resources were located. The issue in question is whether there is actually a lack of placement resources or the absence of an effective communication system that accurately advises on bed space availability and accessibility. This issue is beyond the scope of individual child and family service agencies and it is up to the Authorities to recognize the value of a centralized tracking system that would generate information on placement availability across the system. Without having the information to move children out of emergency placements, the few emergency placement spaces across the province will continue to be filled with children who have nowhere to move.

In keeping with the direction set out by the Standing Committee, a variety of placement resources have been developed or are in the process of planning and development at this time. Although there is little doubt that new placement resources are required; once again, they are being developed in an ad hoc manner and outside a systemic, regulatory process, somewhat like the way emergency shelters in Winnipeg developed in the 1980's. The resources are developed on the basis of perceived need without the benefit of evidence-based research to support the need. Some are developed without a program model, stated goals and objectives and the ability to measure outcomes. Compliance mechanisms, accountability and adherence to standards are not included in the design of some resources while others have very concrete and detailed plans.

Most concerning, however, is the fact that so many of the new placement resources identified to serve children that were previously in hotel placements are on hold while agencies are waiting for licensing approvals, funding approvals or physical renovations and upgrades to make facilities habitable. Through interviews with staff, it was evident that many issues exist. As the hotel reduction strategy became effective,

Authorities and agencies were encouraged to begin the process of developing resources to replace hotel usage. Committees were established with the understanding that funding from the reduced hotel usage was available to pay for actual development of new resources. Many resource staff were not prepared for the complications associated with developing resources. Such factors as a shortage of qualified foster parents for agency-operated facilities, shortage of child care staff, conditions of housing units, expectations of provincial child care residential facility standards, by-law and zoning regulations, public health standards and fire safety codes were not familiar to individuals who came from a background in human services. As a result, the challenges encountered in the process of developing resources were significant and discouraging to many staff. As many proposals sit waiting for some type of approval or action from outside sources, staff are asking where the support and finances that were offered at the onset of this process are today and what are they suppose to do with the children and youth who would have previously been in hotel placements.

The experience with the process of developing resources, in itself, speaks to the mayhem that can occur without a systemic planning process. The Hotel Placement Policy has been in effect for almost a year and, with the exception of the continuous and progressive development of emergency bed spaces in the WCFS EPR unit, very little increase in emergency bed spaces in facilities has been evident across the province. This raises the question of whether a centralized office, specifically concerned with the emergency placement resources may have prevented the frustrations encountered in developing resources and ensured a fair distribution of funds and an equitable allocation of emergency bed space across the province.

10. Findings

Several considerations are taken into account in determining the findings in this review. Firstly, one must look at the issues from the point of view of societal standards and expectations of how the child and family services system should function. In this situation, consideration was given to the image society has of an alternative care system for children and youth who cannot live with their own family. What society believes is happening and what children in care are entitled to, is balanced with what is currently

being provided. When children are removed voluntarily, or through enforcement, from their home and family, it is expected that they will be provided with the highest quality substitutional care and treatment planning. Children in care have the right to expect a high level of care whether they are placed in a hotel, shelter or foster home. It is the responsibility of the child and family services system to ensure that substitutional care is equal to or better than the level of care the child was receiving prior to entry into the child and family services system.

Equally important is adherence to a body of knowledge, through which a general acceptance of principles has been established and embodied in statutes. Findings are made in response to developments at various junctures in keeping with provincial child and family service standards, other provincial legislated policies and acceptable “best practice” in child and family services at this time. The definition of best practice is intended to include what is done or should be done when comparing it to acceptable knowledge within the profession of child welfare at similar times in any Canadian jurisdiction. Accepted best practice is constantly adjusting to new ideas and research on an international level.

The challenge in this review was not as much to make new recommendations, but to achieve a balance that would facilitate implementation of new recommendations, while recognizing that there is a mature system in place that needs to be maintained. It is imperative that recommendations to relieve a struggling short-term, emergency placement system are afforded without jeopardizing the health of the long-term child and family services child placement system.

Findings from the Hotel Reviews (2000)

In 2000, the Office of the Children’s Advocate completed two reviews on the use of hotels as placements for children and youth in care. Both reviews were requested as a result of public concerns and complaints about children in care living in hotel rooms. Along with recommendations for changes in the quality of care to children in hotel placements, the OCA, at that time, called for an end to the use of hotels as placements for children in care. Six years later, the Hotel Reduction Strategy and the Hotel Placement Policy followed making a significant impact toward reducing and regulating

hotel use. However, in the six years following the OCA recommendations, hotels continued to be used as emergency placements for children and youth in care. The OCA found that:

- 1. During the seven years following the first hotel reviews, a total of 4806 children and youth in care were placed in hotel rooms. This averages to 687 children and youth every year.**
- 2. These children and youth used a total of 53,729 days in hotel placements.**
- 3. Over 30% of the children and youth were readmitted to hotel placements on three or more occasions.**
- 4. While 62.5% of children placed in hotels were under the age of 12 years, 33% were under the age of 5 years.**
- 5. The per diem cost of children in hotel placements increased from \$305 in 2000 to \$562 in 2008.**

It was not until 2006 that the issue of children in care living in hotel rooms was addressed.

The Hotel Reduction Strategy

- 6. The Child and Family Services Standing Committee introduced a hotel reduction strategy in November 2006, with the intent of ensuring that all children were removed from hotel placements by the end of July 2007.**
- 7. The hotel reduction strategy created three Committees with specific responsibilities for moving children out of hotel placements and developing resources to replace future hotel use.**

- i. The Hotel Reduction Team was established for a short time period to identify, track and work with child and family service agencies to locate suitable placements for all children in hotel placements.
- ii. The Resource Development Team was established to develop resources that would reduce the use of hotels as emergency placements for children in the long term.
- iii. The Foster Care Recruitment and Retention Team was established to increase the number of existing foster care bed spaces in the province for children.

8. The Child and Family Service Standing Committee introduced a Hotel Placement Standard, effective August 1, 2007, prohibiting the placement of children in hotels with some exceptions.

The Hotel Placement standard allowed hotel placements only in exceptional circumstances, to be monitored and approved by the CFS Authorities. These exceptions included:

- i. in the case of flood, fire, other natural disasters or community crisis that require the evacuation from the residence to ensure the safety of children; or,
- ii. in the case of a public health issue that requires quarantine, restricted movement of affected individuals, or removal from an affected area, to prevent the spread of disease or other serious health conditions; or
- iii. in the case of sibling groups where there are three or more children and there is no other option available to place the children together.

The latter exception was later amended to remove the number of children that make up a sibling group. (Appendix I)

9. The hotel reduction strategy was successful in removing all children from hotel placements in the province by July 31, 2007.

Children/Youth in Hotel Placements

- 10. Two specific groups of children and youth are largely represented in the hotel population; children that are part of large sibling groups and high-risk youth with multiple special needs including aggressive and violent behaviours.**

a). **Large Sibling Groups**

In 2004, the DFSH introduced a policy to keep sibling groups together when placed in care. Because most foster homes do not have the bed space to accommodate large sibling groups, hotel placements are used in order to keep the siblings together upon admission to the child and family services system. Large sibling groups account for the high number of very young children in hotel placements. The DFSH recognized the limited placement options available for large sibling groups and, as a result, has left hotel placements as exceptions for this group of children in the Hotel Placement standard. The OCA supports the DFSH policy for keeping sibling groups together but cautions that hotel placement is not a suitable option and that appropriate placement alternatives must be developed for this group of children.

b). **High-Risk Youth**

The Hotel Placement standard has prohibited the use of hotel placements for this group of youth, who have been significantly represented in hotel population statistics for years. Although hotel placements are not supported for any child or youth, there are limited placement options available for some high-risk youth. Caution must be exercised that high-risk youth are not without a place to stay due to the Hotel Placement Policy. Careful consideration must be given to the fact that it is difficult to find placements for high risk youth for several reasons:

- a). Foster care is not a feasible placement option because safety risks are not always preventable when caring for high-risk youth.

- b). Residential care facilities are hesitant to accept youth with violent behaviour and high-risk youth may themselves jeopardize placement plans by not meeting the criteria and expectations set for admission to the facilities.
- c). Some youth have conditions placed on them by the criminal justice system requiring 24 hour supervision because they are at high risk of causing harm to themselves or to others. The child and family services system becomes responsible for providing this supervision if the child is in the care of a child and family services agency. In order to minimize risk of harm to other children in care, youth with high-risk behaviours, such as a tendency to act violently toward others or at high risk of sexually offending, are not placed with other children/youth in the WCFS emergency shelter system. The availability of shelters, where high-risk youth can be the only residents are rare, therefore, hotel placements become the only options for some high-risk youth.
- d). Placement in long-term residential facilities is not always successful due to such issues as the youths own lack of cooperation, leaving without permission (AWOLS), and admissions to a correctional facility or a stabilization unit. The provincial standards limit the number of days that bed spaces can be held in a child's absence to 10 days. If the absence is planned and the youth will be returning, an Absence Policy Waiver can be submitted for approval to hold a bed space longer. However, in many situations, when youth run from a placement facility, or are admitted to a correctional facility, there is no plan, and after 10 days absence and the youth's whereabouts cannot be established or release date set, it is only reasonable that the bed space is given to another youth.

The complexity of locating placements for this group of youth was a common theme that emerged in this review. Several high-risk youth are placed in shelters where they are the sole resident and require more than one staff person to provide the supervision that is required. As entire shelter facilities are devoted to single youth, the cost factor is significant. This is neither a practical nor affordable solution. Anecdotal reports of high-risk youth being placed in hotels, in contravention of the Hotel Placement standard, were not uncommon.

The fact that actions are in contravention to policy is an indication that the policy is not feasible. Changes cannot be made without consideration given to the impact of the changes. Although the OCA does not endorse hotel placements for any youth, the circumstances in this situation requires that a step be taken backwards and that the actual needs of the youth in hotel placements be assessed and suitable placement options developed before a total prohibition of hotel placements for high risk youth.

Alternative Placements for Children/Youth in Hotels

To implement the hotel reduction strategy, approximately 365 children and youth in hotel placements across the province were moved to alternate placement accommodations in a short period of time raising questions about the swiftness of the move and the appropriateness of the placements. Of concern was the fact that there was no evidence that a comprehensive review of the needs of the children and youth in hotel placements was conducted to ensure that suitable placements were found for each child or youth. As a hotel placement tends to be “a last resort” for the most difficult to place children and youth, the haste in moving these children out in hotels raised doubts about the suitability of alternative placements to meet the needs of these children and youth. The OCA found that:

- 11. Of the 365 children and youth in hotel placements between November 2006 and July 2007, 38% were moved to other residential care facilities; 21% were moved into foster homes; 20% moved back home, with a relative or into independent living in the community; 7% moved into a Place of Safety; 3% went into a facility operated by Manitoba Justice or Manitoba Health; and information on 11% of the children and youth was not available.**

An attempt to track the current whereabouts of a sample of the children and youth that moved from hotel placements, using the CFSIS database, was for the most part unsuccessful. File information on many of the children and youth was absent, limited or simply not updated. Several previous reports have identified concerns about the efficiency of the CFSIS database as an instrument to track children in care. This was again evident largely due to the lack of data input.

Nevertheless, the OCA was able to find information on a few youth who had been in a hotel placement for more than 30 days prior to moving from the placement as a result of the hotel reduction strategy and followed their placement history for a period of one year following discharge from the hotel.

12. Not all the youth who moved from hotel placements, as a result of the hotel reduction strategy, fared well.

Nine youth who had each spent a minimum of 30 days in hotel placements in the six-month period between January and July 2007 were followed to determine how they fared after leaving the hotel placement. Four high needs youth were moved to emergency shelters and community placement resources such as N'Dinawe and the Youth Resource Centre (YRC). Another four youth moved into foster home placements and one went into a shift-staffed residential care facility. In less than one year after they were moved from a hotel placement, seven youth were in foster home placements or external residential care placements that broke down, five were placed on at least one occasion in an emergency shelter facility, six of the youth were in the Manitoba Youth Centre (MYC) on at least one occasion, and eight incidents of AWOL involving the above youth were reported. One youth was returned to a hotel placement in February 2008 and the whereabouts of four of the youth were unknown according to the child in care information on CFSIS obtained in May 2008. It is unlikely that had these youth remained in a hotel placement the above would have been preventable. These youth are severely traumatized, have very high needs and are, for the most part, uncooperative with treatment attempts. This information is, however, important to an awareness of the types of needs and subsequent behaviours that are common in a group that had been in hotel placements for long periods of time. It also shows that there are not sufficient placement options for these youth and that appropriate resources are required to address the placement needs of these children.

Ongoing Hotel Placements

The hotel reduction strategy and the Hotel Placement Standard has significantly reduced the use of hotels as placement facilities for children and youth, but has not eliminated this entirely. It is a commendable first step in addressing this very complicated issue. The OCA supports this first step but cautions that this is only a beginning in continued work to reduce and eliminate hotel placements for children in care. As this report indicates, hotel use continues for sibling groups and, in contravention to the standard, for high-risk youth where there is absolutely no other placement option.

The hotel reduction strategy introduced some regulations governing hotel placements. These have the benefit of ensuring that other placement resources be explored to the fullest before a decision is made to use a hotel placement and regulating the number of days a child or youth can stay in a hotel placement. The success of these regulations is associated with the availability of other resources to move children to. This work has to continue.

Acknowledging that hotels continue to be used as placement facilities for children and youth, several other findings from this review should be taken into consideration as work continues to ensure that adequate placement alternatives are available to replace hotels.

- 13. Hotel placements are not regulated by provincial licensing standards and, as a result, there is no monitoring of care provided to children in hotels, outside of the agency that has arranged the hotel placement.**

Hotel placements are allowable through provincial place of safety standards. These standards generally apply to the use of family residences for placements of children, but include facilities such as women's shelters, apartments and hotels. When a child is placed in a family residence, a home study is completed

on the family after 30 days. If a child is placed in a shelter facility, the provincial licensing department monitors the quality of care. There is no provision for this if a child is in a hotel.

- 14. Under the provincial place of safety standards, there are no policies or guidelines that pertain specifically to the quality of care for children in hotels or on managing care costs for children in hotel placements.**

While most family residences or external facilities such as women's shelters have established structures that guide the activities and events that occur on a daily basis, hotels, on the other hand, have absolutely no structure. No programming is available to children in hotel placements and day-to-day activities are solely the responsibility of the staff caring for the children. As hotels are being used for child placements, a quality of care standard specific to child placements in hotels is essential.

The application of provincial funding guidelines to hotel placements is limited to information on billing the province for the costs of Level V children in hotels rooms. Other funding issues specific to children in hotel placements are not addressed. Unlike foster care, where child specific expenses such as personal and recreational allowances, are included in the foster care rate, these are not included in the cost of hotel placements. Agencies must separately access these expenses from their child maintenance budgets. According to senior DFSH staff, not all agencies are aware of this process. As a result, children in hotel care may be missing out on recreational opportunities, camp experiences, etc. because there are no formal guidelines for agencies and caseworkers on managing care costs of children in hotel placements.

- 15. In Winnipeg, children placed in hotels by the WCFS EPR program, and occasionally by other child and family service agencies, tend to be cared for by purchased-service care providers from private home care and health care organizations.**

Although these service providers have basic training, including CPR/First Aid Training and may have Non-Violent Crisis Intervention training, their levels of skill and experience working with children vary. Because these staff are not employees of child and family services agencies, their competence and abilities are not assessed by the agencies that leave children in their care. Unfortunately this group of care providers are responsible for some of the most challenging and difficult to care for youth in the province. By itself, this issue is enough to question the quality of care provided to children in hotel placements. Other child care support staff report concerns working with purchased service staff, primarily due to their lack of knowledge of the child and family services system, lack of knowledge of the needs of the children in care and questionable skill levels, perceptions and practices. At the same time, the DFSH Licensing Branch reports that a majority of incidents in shelter facilities, where inappropriate behaviour toward children was documented, involved purchased service staff.

16. Many high-risk youth placed in hotels are concurrently involved with several systems at once, such as the child and family services system, the criminal justice system and/or mental health services.

In earlier reviews of the emergency placement system, the OCA reported on the lack of collaboration between systems that children and youth are concurrently involved with. Many youth in the child and family services system have multiple needs and are involved with many systems, such as justice, education, health and child and family services. However, most of these systems work in isolation from each other and the outcome is that children and youth are shuffled from one system to another, where one specific need may be addressed but the other needs remain unresolved. Recommendations for an integrated, multi-system, child-centred service delivery approach for children with high needs and special needs have been previously made by the OCA in both the Shelter Review (2004) and again in the report *Strengthening Our Youth: Their Journey to Competence and Independence* (2006). Collaborative strategies have the benefit of building shared value systems, improving communication between systems and providing a “team” of knowledge and support to more effectively respond to the multitude of needs common in high risk children and youth.

17. The hotel reduction strategy has contributed to the urgent state of emergency placements for children in the province.

Unintentionally, this strategy has only intensified the already urgent issue of finding emergency placements for children and youth in this province. Hotel placements offered the benefit of time to locate or create suitable placements for children. Now, bed spaces have to be located or created immediately in an existing system where the majority of bed spaces are full most of the time. The consequences of this strategy have been evident on several fronts;

- i. Reports of emergency shelters are being hastily set up under the Place of Safety designation and operate before they are inspected and licensed.
- ii. Children are placed in emergency shelters before they are inspected to ensure that they meet health and safety regulations.
- iii. Children and youth from rural and northern communities are transported to Winnipeg for emergency placement.
- iv. High-risk youth are placed in hotels in contravention to the Hotel Placement standard.
- v. Anecdotal reports of family places of safety having as many as eight children were made to the OCA.

Findings from the Review of the Operation of the WCFS Emergency Assessment Placement Department (EAPD) Shelter Review Report (2004)

Approximately 83 recommendations were made to the DFSH and the WCFS in the Shelter Review (2004). Both the DFSH and the WCFS, now a Branch of the DFSH, made a concerted effort to respond to the recommendations. A total of 78 recommendations were reviewed in this report. Some of the recommendations were so similar that they were combined, while other recommendations included more than one required action and, therefore, were assessed as two parts to the recommendation. A detailed status report on the recommendations can be found in Appendix II. All recommendations were assessed for action taken using the following criteria:

- i. Completed – the recommendation or portion of the recommendation was completed in full and no further action is necessary,
- ii. In Progress – the recommendation is being addressed but has not been fully completed.
- iii. Ongoing - the recommendation is part of a larger context or a series of actions that are currently being addressed.
- iv. No Change – the recommendation has not been addressed and policy and practice continues as it did prior to the recommendation.
- v. Rejected – the recommendation was reviewed and a decision was made to reject the recommendation.

With respect to the progress made on the recommendation in the Shelter Review (2004), the OCA found that:

19. Twenty recommendations, or 25% of the total recommendations, were completed at the time of this review.

This included the following:

- A province-wide community assessment of out of home care was completed in 2005.
- An additional Investigator was added to the Provincial Abuse Investigators unit in November 2004. Since then the PAI unit had doubled to four.
- A second Provincial Licensing Specialist was added to the DFSL Licensing Branch in October 2004. A posting to hire a third Licensing Specialist was issued in September 2008.
- The scope of investigating abuse allegations was expanded for the PAI unit to include investigations of questionable child management practices.
- Alleged incidents of abuse by purchased service staff working in licensed residential facilities is now being investigated by the PAI unit.
- An internal financial audit was completed on WCFS in 2005.

- As recommended by the OCA in the 2004 Shelter Review, the EPR program is managed by the WCFS, which is a Branch of the DFSH until it is transitioned to the Southern Authority.
- The WCFS developed the Emergency Placement Resources (EPR) Home Manual in 2005. This manual is a combination of policies, procedures and step-by-step guidelines and relevant information for EPR program shelter staff.
- The WCFS developed the Systematic Tracking of Emergency Placements (STEP) database in 2005.
- The management structure in the EPR program was strengthened with a clear designation of responsibilities for the program manager, the addition of a supervisor position, and the continued assistance of a seconded position from the DFSH.
- Supervisory responsibility of shelter coordinators has been designated to a management team consisting of the program manager, and two supervisors. Shelter Coordinators provide direct supervision to shelter staff.
- Shelter coordinators complete site inspections in shelter facilities on a monthly basis.
- Non-Violent Crisis Intervention (NVCI) training is mandatory for all staff who work in EPR shelter facilities. This includes regular, casual and purchased-service staff.
- Two positions were added to the WCFS Human Resource Department that support the EPR shelter staff; A Labour Relations/Compensation Coordinator and an Employment Equity Coordinator.
- Variance Orders are posted in shelter facilities.
- 24-hour shifts were eliminated.
- Information on the Office of the Children's Advocate was visible in all shelters that were attended.
- Fifty emergency foster bed spaces were created for children under the age of 8 years in Winnipeg in 2005. These had increased to 165 in June 2008.
- Increases in foster home rates were announced in 2007 and implemented over a two-year period.

- A province-wide foster home recruitment strategy was developed and implemented in 2008.

20. Twelve recommendations, or 15% of the total recommendations, were currently in progress of being completed by the time this review ended.

This includes the following:

- The DFSH and the Four Authorities, through the Alternative Care Sub-Committee were working on the standardization of special rates for foster homes, and a standardized classification system for placement resources in the province in 2008.
- Integrated service planning for high needs children and youth was recommended in the Shelter Review (2004) and was a common theme in several other reviews on child and family services. In 2008 the Standing Committee created the Interim Child Welfare Intersectoral Committee (CWIC) to develop a work plan for addressing intersectoral working relationships.
- The High Risk Youth Committee was established in 2006 with representatives from the DFSH, RCMP and Winnipeg Police Services, Child and Family Services and the Manitoba Association of Residential Treatment Resources (MARTYR).
- Funding for an emergency care system is part of the province-wide budgetary process for child and family services. During the review, the EPR program was still in the process of being transferred from the DFSH to ANCR, an agency of the Southern First Nations Authority.
- Analysis of EPR program expenditures was included in the transitional planning process currently underway by the Joint Management Committee for ANCR.
- Budgetary planning is part of the transitional planning process for the EPR program's transition to ANCR.
- The transitional planning process for the EPR program includes an evaluation of operational and programming responsibilities.
- At the time of the review, supervisory access across all shifts has been improved somewhat through flexible working hours by some shelter coordinators, a rotating on-call schedule for EPR managers and an On-Call

Dispatch Service for shelter staff after regular working hours. This process continues.

- Shift configurations in shelters were in the process of changing. 24-hour shifts have been eliminated and new shelter staff are hired for 8 and 10 hour shifts.
- The DFSH and Manitoba Justice were working collaboratively with federal departments to advocate for sustainable funding for organizations providing street shelter services in 2007/2008.
- The DFSH and the Four Authorities were in the process of working on the recruitment and retention of foster homes, foster care standards and foster parent training program.
- A province-wide foster home recruitment strategy was announced in October 2006 with an investment of \$6.1 million to improve the foster care system in the province.

21. Ongoing work continues on approximately 18 recommendations, or 23% of the total recommendations, as part of the larger restructuring and funding process for the child and family services system.

In June 2008, ongoing work continues on 18 recommendations as part of the larger restructuring and funding process for the child and family services system in the province.

- The Standing Committee continues to work on regulatory, service and fiscal strategies for the child and family services system.
- Child and Family Service Authorities and agencies are working on a continuum of care, including Family Enhancement Programs, specific to their target population groups.
- While functionally in place, ongoing work is needed to enhance the capacity of the WCFS STEP database. The information system is limited in its capacity to generate meaningful reports and lacks a dedicated staff position to ensure data entry is kept up to date.
- The capacity of the Provincial Abuse Investigators and the Licensing Branch databases does not allow for accurate tracking of investigation reports and incident reports to determine if residential facilities have complied with

corrective action to ensure that children are not left at risk. The Child Protection Branch is aware of the limitations of the current databases and has requested approval to develop an effective information and tracking system.

- Monthly meetings of shelter staff were not consistent and when the matter was raised with management in March 2008, this issue was noted.
- All shelter staff and purchased service staff are required to be certified in Non-Violent Crisis Intervention (NVCi). This requires yearly re-certification. Progress has occurred to ensure this is available and re-certification is monitored.
- Human Resource standards, policies and procedures continue to be developed in accordance with the collective agreement for shelter staff.
- Shelter Coordinators were provided with training in working under the collective agreement and have access to the Labour Relations Compensation Coordinator for consultations. However, with changes in staff, on-going training in this area is required.
- In March 2008, the WCFS and the staff – management Joint Training Committee was reviewing feasible ways to offer competency-based training to all shelter staff.
- Although it is regular practice to complete annual performance evaluations on all staff, shelter coordinators reported that they are not up to date in completing performance reviews with shelter staff.
- The DFSH created 50 additional emergency foster bed spaces in Winnipeg in 2005, in response to the recommendation that no children ages 0 – 7 are placed in any emergency group care facility. These bed spaces increased to 165. However, children under the age of 7 years continue to be placed in emergency group shelters and in hotel placements.
- Licensing group care shelter facilities is an ongoing process, as shelters are developed to meet the specific needs of children requiring emergency placements.
- Most shelter facilities for youth are gender specific. However, some facilities in smaller communities are licensed as co-ed to provide the flexibility of placing children of either gender when an emergency placement is required. Ongoing work is required to ensure that adequate procedures are in place in these arrangements.

- The development of shelter facilities and foster homes able to accommodate large sibling groups is an ongoing process.
- There is sufficient flexibility in the shelter care system to develop care plans that are specific to special needs children and youth. Shelter facilities are renovated or created to meet specific care needs such as wheel chair accessibility.
- Information was provided that discussions between the DFSH and Manitoba Justice have started to address youth who are concurrently involved with both systems; however no emergency care shelters have been developed specifically for youth leaving correctional facilities.
- While information on the OCA was available in all EPR program shelters, there are no formal standards directing agencies to make children in care aware of the OCA. Continued work is required by the DFSH to ensure a formal process is in place to communicate the information of the OCA to all placement resources in the province.
- At the time of the review, on going support was provided to the Manitoba Foster Family Network (MFFN) by the DFSH for research, foster parent training and advocacy.

22. In June 2008, there were no changes to 23 recommendations, or 29% of the total number of recommendations.

- No change was evident in the recommendations made on restructuring the Provincial Placement Desk.
- The Provincial Placement Desk was not made up of a committee with a consistent multi disciplinary membership. The Desk does not travel to rural and northern communities.
- The Provincial Placement Desk does not track residential care placement breakdowns.
- Communication about residential care facility bed space vacancies was not accessible to child and family service staff through a secure web site.
- The WCFS EPR program did not have a standardized mechanism for tracking and responding to recommendations made by the Provincial Abuse Investigators.

- The Provincial Abuse Investigators database did not have the capacity to track reports to ensure compliance by facilities to recommendations.
- Although some initial meetings were held between the DFSH and the YECSS program, no committee was in place to review the working relationship between the EPR shelter system and the YECSS.
- Experts in residential care had not been consulted on developing a program model for the EPR unit. A program model for the WCFS EPR program has not been developed.
- Shelter Coordinators did not directly supervise purchased service staff.
- Purchased-service staff were not coordinated through one central management position. Purchased-service staff were indirectly supervised by the coordinators of the shelters that they worked in.
- No standards or licensing regulations specific to emergency, short-term care for children have been developed. The emergency shelter system continued to operate under standards developed for long-term residential child care facilities.
- The OCA recommended a needs assessment and a site inspection prior to issuing a variance order. The process for obtaining variance orders has been simplified to include verbal approvals over the telephone without a site inspection and the delegation of authority to the EPR Program Manager to approve variance requests after working hours. The emergency nature of some placements requires immediate action to ensure children are not left without a placement while site inspections take place.
- Funding to cover shifts while EPR shelter staff attend competency-based training had not become a part of the EPR program funding formula.
- There had been no commitment to offer competency-based training to emergency shelter staff.
- There was considerable flexibility in determining staff-child ratios. Child – staff ratios were not limited to one staff for 2 children or youth but were flexible and subject to change dependent on the needs of children/youth. The needs of children were the biggest determinants of staff-child ratios.
- There was no evidence of discussions between the DFSH and Child Mental Health regarding collaborative and integrated approaches to service delivery.

- Working with geographically based multi disciplinary teams was not a consistent or standard practice, but multi-disciplinary teams may be established when required by an agency or a caseworker regarding a specific child or family.
- There was no change to the recommendation to create a Health Specialist for the EPR program.
- There was no change to recommendation to create an Educational Specialist for the EPR program.
- Information on VOICES: Manitoba's Youth in Care Network was not available in all residential facilities.
- Most youth interviewed by the OCA were not aware of Voices: Manitoba's Youth in Care Network.
- A process for communicating information on Voices: Manitoba's Youth in Care Network, to agencies, and placement resources, has not been established.
- There was no province-wide tracking system in place to accurately and reliably monitor foster home breakdowns and maintain information on foster bed spaces.

23. The OCA found that seven recommendations, or 8% of the total, had been reviewed and rejected.

Seven recommendations were reviewed and rejected.

- The recommendation to create a Community Resource Development Office to be housed with the DFSH was rejected by the Shelter Review Implementation Committee (SRIC).
- The DFSH reviewed the implications of the Provincial Abuse Investigators ability to make recommendations regarding the employment status of an individual and rejected this recommendation.
- The SRIC rejected the recommendation that all shelter staff have on-site access to the WCFS internal computer information communication system, because of the cost that would be involved.
- The SRIC concluded that the implementation of competency-based training for shelter staff would neither be practical or cost effective.

- The SRIC rejected the recommendation that Competency-Based training be made mandatory for purchased service staff.
- The SRIC rejected the recommendation that successful completion of Competency-Based training be a part of the licensing requirements for emergency shelters.
- The WCFS management reviewed the OCA recommendation to physically store and maintain all EPR shelter personnel files within the Human Resources Department and decided that this was not feasible as shelter coordinators required regular access to the personnel files.

In the Shelter Review (2004), the OCA noted that, “clearly there are no quick fix solutions and the challenges faced in improving the system are many”. The DFSH and the Child and Family Service Standing Committee have made a commendable attempt to address many of the recommendations and the findings hold promise for continued improvements to the emergency placement system for children and youth in the province. Several other findings emerged that mark developments in the implementation process.

Policy Implications

The OCA recommended that the DFSH, along with the four Authorities, using the information already available in the Shelter Review (2004), undertake a comprehensive analysis of the legislative, policy and resource implications outlined in the review and use these as a guide for developing an emergency placement system that will functionally and effectively resource the newly restructured child and family services system in the province.

- 24. The DFSH responded immediately to the Shelter Review (2004) report in a *RESPONSE AND ACTION PLAN to the Office of the Children’s Advocate SHELTER SYSTEM REVIEW REPORT*, issued on April 7, 2004.**

The response and action plan called the Shelter Review (2004) a “blueprint for developing an emergency care system that has a clear direction and purpose

within the broader context of all services intended to enhance the well-being of children” and presented a comprehensive action plan with four main strategies.

1. Act immediately to create new emergency foster care resources specifically designed for children under the age of eight.
2. Immediately establish an Implementation Committee to address the Advocate’s recommendations for future planning, system design and longer-term resource development.
3. Implement recommendations that will immediately have a positive impact on improving the quality of care in the shelter system.
4. Implement recommendations that will immediately strengthen the system oversight capacity.

The Assistant Deputy Minister of Child and Family Services and the Assistant Deputy Minister of Community Service Delivery were given the responsibility for ensuring that the four action plan strategies were implemented.

25. The Minister of Family Services and Housing established the Shelter Review Implementation Committee (SRIC) in June 2004; to assume the larger task of reviewing the recommendations and developing an implementation plan within a one-year time period.

Comprised of three representatives from the DFSH, an associate professor from the University of Manitoba, and the Chief Executive Officers of each of the four Authorities, the SRIC was given the task of developing a blueprint for building a new system of emergency care for children “in a systematic and organized manner, using an evidence-based approach to planning”. (Response and Action Plan, April 2004).

The SRIC developed terms of reference for gathering the information necessary to formulate a detailed, evidence-based implementation plan within a one year time period. These included:

1. Complete a province-wide assessment of residential care needs for children.
2. Based on the results of the needs assessment, develop a proposed

continuum of care and classification system for children's residential care.

3. Within the context of the proposed continuum of care, develop a vision statement and comprehensive program model for the role of emergency placement facilities and services.
4. Given the proposed program model, recommend standards and training strategy to ensure staff have the qualifications and competence to adequately meet the needs of children in emergency care.
5. Assess the feasibility of implementing the OCA recommendations regarding a centralized office to oversee future resource development, reconfigure the provincial placement desk, external governance of placement resources for children and a strategy for foster parent recruitment.

26. The SRIC arranged for a province-wide assessment of out of home care needs to be completed in 2005.

The First Nations Child and Family Caring Society of Canada (FNCFCS) was hired to complete a literature review of policy and resources pertaining to care needs. In 2005, a comprehensive review, *Literature Review of Key Resources* (unpublished), was completed for the SRIC on out of home care needs of children. Child and Family Service caseworkers and resource workers across the province participated in a survey on out of home care needs of children. The DFSH Policy and Planning Branch reviewed the survey responses.

27. A review of population trends in the province suggested that the number of children in care would continue to rise over the years. As a result, future planning for out of home care resources must be addressed.

A review of population trends showed that Manitoba's population has gone through a boom, bust and echo cycle where a large portion of the population has been moving toward retirement age (boom) and their children are moving into post secondary education and the employment market. The "bust" population, or those born between 1967 and 1979, are beginning to have children. These

children are known as the “millennium kids”. They represent a declining portion of the overall population. However, although this trend is true for the general population, the trend for the aboriginal population of Manitoba differs. The *Literature Review of Key Resources* found that Manitoba’s aboriginal population is considerably younger than the overall population and is growing at a much faster rate, “looking forward, by 2016 the aboriginal population is expected to increase by 36% in the rural part of the province and more than double in Winnipeg”.

At the same time, child in care statistics show that 81% of all the children in care in Manitoba are Aboriginal (CFSIS 2004). If this trend proves to be true, and the population of young Aboriginal children is increasing quickly, then the need to address an increase in the demand for appropriate placement resources cannot be ignored.

28. When its term ended, the Shelter Review Implementation Committee submitted a *Detailed Implementation Plan for the Development of an Emergency and Short-Term Care (ESTC) System (DIP)* to the Minister of Family Services and Housing in June 2005.

The Committee advised that the implementation of the ESTC is highly dependent on numerous other activities that are part of the AJI-CWI and indicated that, “both the OCA and the SRIC have an understanding that changes in ESTC will be implemented in a manner consistent with the AJI-CWI devolution, and respectful of the philosophy and partnerships supporting this important initiative”.

The ESTC DIP appears to be the last formal documentation on the action taken to address the recommendations of the Shelter Review (2004). The Committee made decisions and took action in response to several recommendations, transferred responsibility for some recommendations to other committees or departments and recommended against implementing some recommendations. Details of these actions will follow in findings under specific recommendation categories. Overall, the SRIC added a significant amount of information to the

existing data on emergency care. This information is now available for future planning for a comprehensive emergency placement system in the province.

Provincial Vision for Out of Home Care

The OCA recommended that a provincial continuum of care be re-developed by the DFSH and the four Authorities to include preventive, supportive and supplementary and substitute care services.

29. The SRIC proposed a definition of a continuum of care for the province and transferred responsibility for further development to the Standing Committee.

A definition of a continuum of care was comprised of the following principles:

- the continuum of care must use strategies targeted to “at risk” population groups and communities that are designed to strengthen their capacity to meet the protective and supportive needs of children, young people and their families
- the continuum of care must include prevention and early intervention services that are designed to strengthen families and to protect young people
- the continuum of care must include statutory intervention and ongoing support services designed to meet the protective, care and ongoing support needs of children and young people who have experienced significant harm or who are at risk of experiencing significant harm.
- The continuum of care should include a full range of services such as;
 - enhancing community capacity
 - in-home supports, and
 - out-of-home placements

When it ended, the SRIC reported that the responsibility for developing and implementing an overall Child and Family Services continuum of care rested with the new CFS Authorities, in cooperation with the Child Protection Branch. The child and family service system was reaching the end of a restructuring process which gave responsibility for child and family services to Authorities who ensured

the delivery of services through child and family service agencies to a specific client population group. As responsibility for child and family services was being transferred to Authorities, it was expected that all aspects of service delivery would become the responsibility of the Authorities as well. This would result in different models for a continuum of care because of unique service issues and goals in different Authorities. The proposed principles for a continuum of care were broad enough to be adaptable to different models of service delivery. The principles for a continuum of care were provided to the DFSH and the Standing Committee in a detailed implementation plan.

Out of Home Placement Resource Coordination

The OCA provided a comprehensive report on the historical development of the emergency placement system for children in care and cautioned that, “resources are often built to accommodate crisis”. It was reported that there was no overall vision and system coordination for resource development. As a result, the OCA called for the DFSH, and the four Authorities, to establish the Community Resource Development Office (CRDO) to be housed with the Department and have the capacity to develop resources for youth and children in a systemic and planned fashion. With the implementation of CRDO, the OCA recommended a province-wide, community needs assessment of service providers to determine capacity and resource needs.

30. The Shelter Review Implementation Committee recommended against establishing a centralized Community Resource Development Office (CRDO), located with the DFSH.

The SRIC struggled with the concept of a centralized office in the context of a decentralized child and family services system. At the time, the AJI-CWI implementation plan called for the transfer of existing resources outside the DFSH to Authority control. As the DFSH was transferring services and responsibilities outside the department, establishing an office within the department would have been in conflict with its goals. Therefore, this recommendation would not have been feasible at the time. As a result, the

responsibility for tasks associated with the new centralized office was given to the Standing Committee.

31. Each Child and Family Service Authority is responsible for ensuring the availability of in-home and out-of-home resources specific to the needs of their target client population groups.

In keeping with the structure of the overall child and family services system, each Child and Family Services Authority is responsible for ensuring development and implementation of in-home and out-of-home resources for their client population groups with the Standing Committee providing a governance function. At this time, responsibility for providing in-home and community support programs remains with child and family service agencies, with support from the Authorities. Family centred preventative programs may differ slightly among agencies; however, all child and family service agencies provide some type of in-home support services to reduce the risk of children moving into out of home placements. Family enhancement continues to be strongly reflected in the philosophy and principles of most child and family service agencies. The development of Resource Centres in Winnipeg, through collaborative strategies between Authorities, has increased the availability of preventative services and programs for families that are willing to participate and access these programs. Some initiatives are centrally motivated. The Changes for Children Initiative was given the responsibility for developing a province-wide Differential Response strategy. This strategy aims at providing a preventative and supportive response to families where child protection concerns are not imminent.

While significant progress is evident in family enhancement and support and community programs, placement alternatives to foster care are limited across the province. With the exception of the emergency placement shelter system in Winnipeg, there have been limited increases to residential bed spaces for children and youth in the province. Long-term residential bed spaces are limited and difficult to access for many child and family service agencies as the majority of these resources are situated in Winnipeg. There appears to be a province

wide shortage of placement resources, both foster bed spaces and alternative placement options.

Standardized Resource Classification

The OCA recommended a standardized classification system for all out of home placement resources.

- 32. A review of child placement rates showed notable inconsistencies between special rates paid to foster parents by child and family service agencies, and in predetermined rates for residential care facilities and group homes.**

Without a standardized system of conducting child assessments to determine rates, agencies have developed their own forms for determining special rates to be paid to foster parents. This has resulted in a system of inconsistencies in assessing child needs and in the rates foster parents receive to care for children with high needs. The rate classification system for child caring residential facilities is predetermined and allows for subjectivity in matching the needs of a child to the treatment provided. The inconsistencies in the current rate classification system was identified in the Shelter Review (2004) and, subsequently reported in the *Strengthen the Commitment – An External Review of the Child Welfare System* September 2006. [Strengthen the Commitment - An External Review of the Child Welfare System](#)

- 33. The Standing Committee immediately assumed the task of reviewing the classification system and began to work on redesigning the special rate determination and funding process.**

A project proposal was developed by Standing Committee to identify standardized processes and approaches to the setting of special rates and, subsequently, linking any new processes and approaches to the larger funding model. A survey of the current practices in place by agencies for setting special rates was completed and, based on the results of the survey, the Standing Committee has started working on redesigning the special rate determination and

funding process. The Standing Committee has assigned this task to its Alternative Care Sub-Committee.

Provincial Placement Desk (PPD)

The Provincial Placement (PPD) is an integral component in the out of home placement system for children and youth in care, in that it facilitates placements into longer term, treatment focused residential facilities. The OCA made several recommendations regarding the Provincial Placement Desk in the Shelter Review (2004). Along with concerns that the provincial placement desk does not have a visible presence outside of Winnipeg, the OCA noted that its role was not clearly defined. As a result, the OCA recommended changes to the Desk to include a multi-disciplinary membership, accessibility so caseworkers throughout the province can have the opportunity to present to the Desk, and a restructuring of its function to include tracking of residential care breakdowns. The OCA recommended that information on residential care breakdowns should be shared with Authorities annually and that a secure web site be established; accessible only to CFS agency staff, which lists all residential care bed openings.

- 34. The Shelter Review Implementation Committee determined that a review of the Provincial Placement Desk will be conducted along with decisions related to restructuring the Group 2 Resources (residential care by external agencies). By June 2008, no review had been scheduled on the provincial placement desk.**

Several concerns related to the operations of the Provincial Placement Desk were identified by the OCA in the Shelter Review (2004) and recommendations called for significant changes to the structure and operations of the Desk. However, the Provincial Placement Desk has not changed much since the Shelter Review recommendations were released in 2004.

- 35. The Provincial Placement Desk does not operate as a committee but referrals are screened and placement decisions are made by the Provincial Placement Specialist.**

At one time the Provincial Placement Desk consisted of a committee of child and family service experts who met on a regular and consistent basis to review all referrals for the placement of children and youth in one of the 31 provincially-funded residential treatment facilities in the province. Child and family service caseworkers were required to present their referrals to the committee, and after considering the information the committee made recommendations regarding placement options in accordance with the needs of the child or youth and the ability of the residential facility to address those needs. At some point the committee seems to have ended and the Provincial Placement Specialist assumed the role of screening and decision-making regarding placement options.

- 36. The PPD has limited information and tracking capabilities. Information on child needs, treatment capacity and residential care breakdowns is not tracked.**

While the Provincial Child Caring Facilities Licensing and Standards Manual requires all admissions and discharges from the residential care system to be under the authority of the Provincial Placement Desk, this is not routinely tracked and no data is maintained on unplanned discharges or placement breakdowns.

- 37. The communication system for reporting bed space vacancies in residential treatment facilities to child and family service Authorities and agencies is limited to weekly emails to some Authorities and agencies and faxed information to others. This system requires that the information is distributed further within agencies or between Authorities and agencies. There are many junctures in this system where communication can breakdown before reaching all caseworkers.**

The OCA recommended that residential care bed openings be posted through a secure site for CFS workers. As of June 2008, no such website had been developed. Information on bed openings in residential treatment facilities is shared weekly with child and family service agencies through the fax system or through an email.

- 38. During the review, the Provincial Placement Desk was staffed by one Specialist with responsibility for all aspects of the coordination of the PPD including referral management, case conferences, placement decisions, assigning referrals to vacant bed spaces in residential facilities, relations with both the child and family services system and the residential care providers, child specific consultations to both systems, attendance at meetings of residential care facilities, child and family service agencies and community committees, maintaining data and managing an information and communication system that advises child and family service agencies of bed space vacancies in residential care facilities.**

One staff position was not enough to meet the following responsibilities. The responsibilities assigned to the Provincial Placement Specialist must be reviewed and adjusted. It is suggested that administrative responsibilities for the operations of an information system and a communications system be removed from the duties of the Specialist and assigned to a full time Administrative Assistant for the PPD. This will free the Specialist to work on redeveloping the PPD as a committee, develop guidelines and protocols for caseworkers referring to and working with residential treatment facilities and concentrating on activities related to working effectively with caseworkers and residential care providers on information sharing, consultations, placement breakdowns, and effective working relationships between the two systems.

Provincial Abuse Investigator (PAI)

The OCA recommended an additional staff position to investigate allegations of child maltreatment and called for an expansion of the role of the Provincial Abuse Investigator (PAI) to include investigations of questionable child management practices related to permanent, casual and purchased-service staff working in residential child caring facilities. The OCA suggested that recommendations for corrective action include a person's employee status as it relates to the appropriateness of the person's continued involvement with children and youth, and that investigations include purchased service staff as well as permanent staff. Finally, the OCA recommended that a mechanism be

developed to track all PAI reports to ensure compliance with the recommendations and that PAI reports are copied to all required management personnel. Similarly, a mechanism for WCFS to respond to PAI recommendations, outlining corrective actions and time frames, was recommended.

39. The DFSH increased the number of Provincial Abuse Investigators and expanded their mandate as proposed in the Shelter Review (2004).

As recommended by the OCA, a second Provincial Abuse Investigator was hired in November 2004. Since that time the DFSH has doubled the number of Provincial Investigators from two to four with implementation of the additional staffing complete by the end of May 2008. The addition of Provincial Investigator staff will widen the scope of responsibility, aid in more rapid response times, and increase services with an emphasis on prevention, expert knowledge consultation and recommendations within the child protection system.

In the last few years, the definition of child abuse has been interpreted in a broader sense to include incidents where no physical signs of harm are evident. This allows for a broader interpretation of child abuse and enables the office of the PAI to investigate a range of allegations of mistreatment to children in residential care facilities. According to senior staff with the DFSH, in the last two years the scope of abuse investigations has increased to deal with inappropriate staff behaviours toward children such as investigations of non-observable injuries.

40. Collective agreements and disciplinary procedures prohibit the PAI to make recommendations, resulting from abuse investigations, on an individual's employment status.

. According to a senior manager of the DFSH, recommendations resulting from an abuse investigation do not go as far as recommending that an individual should be discharged from a position, however, recommendations to employers are quite specific, such as, "this staff person should not be working with children under six years of age" or "with teens". The onus remains with the employer to take action to deal with the individual regarding performance issues and

employment status. Because of specific collective agreements and disciplinary action procedures, employers remain responsible for decisions to discharge or reassign an individual to another position.

41. The Provincial Abuse Investigators now investigate abuse allegations involving purchased-service staff.

The PAI unit started investigating abuse allegations involving purchased-service staff that are working in residential child care facilities or group homes in 2005.

42. The Provincial Abuse Investigators' database is limited in its capacity to track recommendations for corrective action and compliance by agencies. Meaningful analysis is not possible.

A shared database for the PAI unit was developed approximately two years ago. Initially, with only one PAI, data was entered and maintained by this individual in a system that she developed. With the increase in staff, a shared database was necessary. The new database has the potential to collect compliance information, but it is not currently set up to track this information. It appears that, in general, the recommendations from the office of the PAI are not tracked on a database and there is no mechanism in place to ensure that there is compliance by agencies and organization with the recommendations.

43. The WCFS EPR unit does not have a consistent mechanism in place to respond to PAI recommendations.

The OCA recommended that WCFS put in place a mechanism for responding to PAI recommendations, outlining corrective actions and stipulating time lines. At this time this is not being done. Although, as stipulated in the Child Caring Facility Licensing and Standards Manual, there is an expectation that agencies report back to the PAI on corrective actions taken in response to recommendations, there is not a formal process for doing so. It is a hit and miss situation. PAI staff report that there is no consistency in the responses from agencies. A WCFS Branch coordinator may get back to the PAI investigator to

report what occurred following a recommendation, or it may be the PAI calling the Coordinator as a follow-up asking what corrective actions were taken with respect to a recommendation.

Integrated Service Planning

Concerned about reports of large numbers of high needs children and youth in the EPR system, the OCA recommended that the DFSH examine the feasibility of creating an Integrated Departmental Services committee that would address barriers created through policy that prohibit continuity of planning for children across government service sectors. Child and youth in care issues cross several government departments providing an opportunity for a coordinated government-wide effort for an effective and efficient response to these issues. Cooperation and coordination must occur across jurisdictions for successful outcomes for children in care. Children and youth in care utilize a wide array of services such as social, educational, medical, none of which are coordinated to operate together. Working together government departments can more effectively address the issues faced by youth leaving care by offering a coordinated response to these issues.

Several recent reviews on child and family services have recommended integrated service capabilities to address various system needs in the child and family services system at several levels. The Changes for Children committee identified this issue for ongoing consideration and an intersectoral committee has been established to make recommendations related to the need for increased collaboration and integration of systems. The terms of reference for this committee are broad and the need for integrated services for high needs and special needs children and youth in care is pressing. It is encouraging that a process to address service integration has begun, however, it is imperative that some action is taken to begin integrated service planning for high needs and special needs children and youth in care.

- 44. Recently, the Standing Committee created the Interim Child Welfare Intersectoral Committee (CWIC), to develop a work plan for addressing intersectoral working relationships.**

An Interim Child Welfare Intersectoral Committee (CWIC) has been created by the Standing Committee to identify and involve key intersectoral partners with expertise related to mental health, addictions, suicide and complex medical needs that affect children. The Committee had its first meeting in September 2007 and is developing a detailed work plan for addressing intersectoral working relationships.

- 45. A critical lack of equity and accessibility to programs and resources across government departments is a concern particularly when services are required for multiple needs children and youth in care.**

Services for children may have to be sought from as many as six different departments or agencies. The current system of departmentalizing services impacts on the provision of equitable and accessible services, particularly for children with high or special needs. As departmental policies are often developed in isolation from each other, responsibility for specific services rests with that particular department. High and special needs children present with a multitude of different needs. Departments providing a specific service lack the flexibility to respond to multiple needs and, as a result, the child must access services from several departments or agencies to address their multiple needs.

- 46. An integrated service plan would consider services to children with multiple needs as a single service system, and have the capacity to develop joint service plans, including coordinated assessments and interventions and target the services needed to meet the needs of the child.**

This would ensure inclusive access for all children to required services. In an integrated service delivery plan, the needs of the child are at the forefront and the required services are accessed to meet the needs. Children referred for integrated service planning are assigned to a caseworker who works to ensure that an assessment is completed, a joint coordinated treatment plan developed and services are provided to meet the needs of the child.

Collateral Service Systems

Both the Youth Emergency Crisis Stabilization System (YECSS) and the Winnipeg Police Services (WPS) have a consistent involvement with the WCFS EPR Shelters in that shelter staff frequently contact one of these services as a resource to assist them in dealing with youth who may be out of control. In the Shelter Review (2004), the OCA made two recommendations following an examination of the role that the Youth Emergency Crisis Stabilization System (YECSS) and the Winnipeg Police Services (WPS) had with WCFS Emergency Shelters. Both recommendations focused on increasing communication with the above systems and required that the DFSH review the information the OCA had obtained and enter into discussions with the EPR unit and the above systems to strengthen and formalize working relationships.

- 47. At this time there is no committee in place to further review the access arrangement and usage of the Youth Emergency Crisis Stabilization System (YECSS) by the WCFS EPR system.**

The YECSS is a 24 hour community-based crisis intervention service for children and youth and their families who are experiencing acute psych/social distress and behaviour difficulties. Staff working in emergency shelters are advised to call the YECSS if they are caring for a child who is exhibiting extreme behavioural or mental health concerns. In the initial shelter review, the OCA noted that the YECSS was not being utilized as it should be for children in shelter facilities and recommended that the DFSH enter into discussions with the Agency and the YECSS to determine if the shelter system is adequately utilizing the YECSS program and ensuring that the system has ease of access to YECSS resources as required. It was reported that some meetings had occurred shortly after the shelter review but have now ended.

- 48. In 2006 the DFSH established the High Risk Youth Committee to formalize access and response policies and procedures between the Winnipeg Police Services (WPS) and residential care facilities in Winnipeg, including the EPR shelters.**

The OCA recommended a coordinated planning and communication capacity between the emergency shelter system and the Winnipeg Police Services. It was recommended that the DFSH take responsibility for establishing and coordinating this function. As a result, the High Risk Youth Committee was established in 2006. This Committee is comprised of representative from several departments of the RCMP, WPS, the DFSH, the WCFS Branch including the EPR department, ANCR, and the Manitoba Association of Residential Treatment Resources (MARTYR). One of the central issues in discussion is the WPS' concern about the high number of calls that they receive in response to issues concerning children in care. As one member states, "CFS kids make up 75% of police work". The workload issues revolve primarily around the high number of Missing Person reports because children have simply walked out of care facilities. Once the children are out on the streets at all hours of the day, involvement in criminal activities and the risk of sexual exploitation increases. The WPS are concerned that the CFS system is not doing enough to prevent children in care from being on the streets. They are questioning why staff do not do more to stop children from leaving child care facilities without permission.

To some extent this issue is being addressed by a DFSH initiative that included hiring four Outreach Workers, based in four residential care facilities in Winnipeg. The Outreach Workers actively search for youth that have run from these facilities. The WCFS EPR unit does not have access to this initiative at the time of this review.

The Cost of Care: A Realistic Program Model

Recognizing that the changes to the CFS system, as a result of the AJI-CWI process, will necessitate the distribution of resources currently part of the residential care system, the OCA proposed that the DFSH create a realistic budget based upon actual costs, days in care and projected needs and use this information to create a formal program model for emergency, short-term care. To begin this process, the OCA recommended that an audit of the financial management practices of WCFS occur and the information used to develop a realistic budgetary process with a funding formula for emergency care based on actual operational costs. Once this information is available,

the DFSH and the Standing Committee could proceed to develop a program model for emergency residential care. In the interim, the OCA recommended that the DFSH assume control and responsibility of the current shelter system until the above is completed.

49. The Internal Audit Unit of Manitoba Finance conducted and completed a financial statement audit of the WCFS ERP unit in March 2005.

This information was included in the review of the entire system of funding child and family services in Manitoba as a result of the implementation of the AJI-CWI. The DFSH, along with the four Authorities, were participating in developing a comprehensive funding model at that time and all financial arrangements pertaining to an emergency shelter system became part of the overall funding discussions.

50. The DFSH maintains control and responsibility of the Emergency Placement Resource (EPR) program through the Winnipeg Child and Family Services Branch as plans continue to transition the program into the All Nations Coordinated Response agency (ANCR), an agency responsible to the Southern Authority Network of Care.

All financial arrangements related to the EPR program are part of the overall transitional funding arrangements that have not been confirmed yet as the Standing Committee and the DFSH continue to work on developing a fair and equitable funding formula for the child and family services system.

The EPR program has been in a state of transition since 2005. Currently, the EPR unit is operated and funded by the DFSH until it is transferred to the Southern Authority Network of Care, as part of the ANCR agency.

Program Development

The OCA made several recommendations on developing a program model, including obtaining the assistance of an independent residential care expert to create

and document a model for the EPR program. Other recommendations included developing a policy and procedure manual, a capacity to track internal incident reports and obtain an analysis of this information.

Although the WCFS Branch has responded to the Shelter Review (2004) recommendations by implementing several internal changes in accordance with the recommendations, there has been almost no work on developing a program model for the EPR. While it is understandable that the Branch would leave this responsibility to the new agency and Authority assuming responsibility for the program, the fact that the transition period has now exceeded three years is alarming. In the meantime, the EPR program has grown in size and responsibility, but operates without a program model that addresses goals, objectives, internal and external operational plans or offers a vision for future development.

51. There have been no changes to the EPR program model as this program has been in a state of transition since 2005. While waiting for transition planning, the EPR program continues to operate as it had at the time of the first Shelter Review.

. While the EPR unit relocated to be in closer proximity to ANCR in 2005, it was not included in the planning for ANCR until February 2008 when the Joint Management Group (JMG) for ANCR started looking at the transition of the EPR unit to ANCR.

52. An independent residential care expert was not retained to develop a program model for an emergency care system.

The responsibility for developing a program model for the current emergency placement system in Winnipeg was left to the Joint Management Group of JIRU, now ANCR. Because the Joint Management Group for JIRU had retained an independent contractor to work on developing a program model for JIRU, it was suggested that this work extend to include the EPR program.

- 53. In response to the recommendation of the OCA for a policy and procedures manual to guide care and programming in shelter facilities, the WCFS developed the Emergency Placement Resources Home Manual, in June 2005.**

This manual is a combination of policies, procedures and step-by-step guidelines and information for shelter staff regarding a variety of issues associated with caring for children in a shelter facility. The Manual is well written, organized and includes references to the Child Care Facility Standards when applicable. An entire section of the Home Manual is devoted to recreational programming.

- 54. The review found that the Systematic Tracking of Emergency Placements (STEP) database, managed by the WCFS EPR unit, is outdated and limited in its capacity to generate meaningful data for outcome analysis. In addition, responsibility for data entry is assigned to the one staff person who is responsible for administrative duties for the entire program.**

Although this database has a tracking capacity, data input is inconsistent and analysis capability is limited.

Coordination and Supervision

Several recommendations were made to improve the coordination of the shelter system and increase the level of supervision across the program. The OCA recommended that the coordination of the shelter system become the responsibility of one position. In addition to a coordinator role, this position would be responsible for supervising all shelter coordinators. Through this position, supervision to shelter staff would increase across all shifts, and include purchased service staff. The OCA recommended monthly team meetings, regular site inspections and an internal computer information system that would include access to the agency information system for staff. It was also recommended that the seconded staff person from the DFSH remain assigned to the shelter system.

- 55. The management structure of the EPR program consists of a program manager and two supervisory positions, responsible for the coordination of the program and the supervision of approximately 15 shelter coordinator positions. Shelter coordinators are responsible for the operation of shelter facilities and supervision of shelter staff working in the facilities.**

At the time of this review, the EPR unit organizational structure consisted of a program manager, two supervisors seconded or reassigned from the DFSH, an administrative assistant, an emergency placement desk coordinator and 15 shelter coordinator positions. The coordination of the program is the responsibility of the program manager while the two supervisory positions provide supervision to approximately eight shelter coordinators each.

- 56. The supervisory model used in the WCFS EPR shelter system fails to ensure that consistent and quality supervision is available to all shelter staff. Casual staff who work different shifts and regular staff who work night shifts are not afforded the same consistency and quality of supervision as staff working day shifts.**

Shelter coordinators are assigned five to six shelters, where each coordinator is responsible for all aspects related to the operations of the shelters assigned to them. This includes supervisory responsibilities for the staff that work in these shelters, including permanent, casual and purchased service staff. This management model has certain limitations, in that casual and purchased service staff in particular, are accountable to a number of different coordinators if they work in more than one shelter. It is not unusual for casual and purchased service staff to work in a number of different shelters to provide coverage for regular staff who are unable to work and to fill in gaps in staffing where needed. Hence, casual and purchased service staff do not have one supervisory person to whom they are accountable but report to the coordinator of the shelters they work in. If they work in three shelters in one week, they may be reporting to three coordinators.

Shelter staff who predominantly work night shifts only have contact with a Coordinator during team meetings if they attend the meetings, or through special arrangements made during day time hours. Few coordinators work varied hours.

57. Shelter staff who work night shifts have access to a 24 hour On Call Dispatch service for consultations and requests for assistance.

The EPR unit operates the On Call Dispatch Service to ensure that 24-hour support and assistance is available to shelter staff after working hours and on the weekends. Two experienced full time child care support staff work from their homes in rotating 24-hour shifts in this position. The rotation involves working five 24-hour shifts during week 1 and two 24-hour shifts during week 2. Both these employees as well as two substitute on-call staff are members of the CUPE bargaining unit. According to a former employee, the two on-call staff, whose job is to provide basic scheduling after-hour, working from their own homes, with no supervisory expectations, earned \$87,344 and \$84,398 the previous year. This doesn't include the cost of two other staff who replace them during sick/vacation time. Conversely, the two on-call dispatcher positions would provide more than \$171,742 in funding to hire four full time coordinators to work after hours. On call dispatch staff are responsible for basic scheduling of replacement staff if a scheduled staff reports sick or is unable to work, addressing requests after hours for emergency repairs to equipment or a window replacement, assigning a second staff to a shift if the staff on duty is having difficulty with a child and providing support in the form of consultations with staff working after hours.

58. In June 2008, Shelter Coordinators were not directly providing supervision to purchased service staff.

All performance and disciplinary issues are dealt with by the organization that employs the purchased service staff. Concerns about inappropriate conduct is documented and reported to the coordinator from the private organization. If the conduct is a result of a lack of training or understanding the system, recommendations are made to the organization that employs the staff person.

59. Most Shelter Coordinators schedule monthly team meetings with the staff that work in the shelters assigned to them.

Each coordinator determines the frequency and method of providing supervision to shelter staff. Most coordinators attempt to have monthly team meetings with the staff working in the shelters they are responsible for. These meetings are not mandatory and occur during the day, making it more difficult for night shift and casual employees to attend. Most coordinators work during the day, although recently at least one coordinator had been working at least one evening a week. Several coordinators indicated that due to their workload demands, monthly meetings do not always occur.

60. Shelter Coordinators perform monthly on-site inspections of shelter facilities.

Using a prescribed checklist, site inspections occur routinely on a monthly basis. Once these are completed they are posted in the shelter. The Health and Safety Committee, a joint staff/management committee, also reviews the checklists at their meetings to determine whether safety-related concerns are occurring.

61. Staff working in emergency shelters do not have access to the internal communication system available to other employees.

In the *Detailed Implementation Report*, the SRIC reported that a review of the cost of providing access to email services at all EPR shelters was determined to be prohibitive and email access was not provided. The EPR unit uses facsimile machines, currently installed in all shelters, as the primary source of communication of formal material.

Training

The OCA recommended that all shelter staff, including purchased-service staff, receive training in the *Child and Youth Care Workers Core-Competency Training* program and that all shelter coordinators and staff, as well as purchased service staff,

are certified in *Non-Violent Crisis Intervention* (NVCi) techniques. The OCA also recommended that all purchased service staff be coordinated through one central management position until the use of purchased service staff can be phased out entirely.

62. The Shelter Review Implementation Committee (SRIC) dismissed the OCA recommendation that all shelter staff receive training in the *Child and Youth Care Workers Core-Competency Training* program.

The *Child and Youth Care Workers Core-Competency Training* is a 30-day in-service training program developed for child and youth care workers in residential placement facilities. The SRIC suggested that the competency-based training program was neither a practical or cost effective option to implement for EPR staff. Rather, it suggested that training for shelter staff become the responsibility of the Joint Management Committee responsible for the implementation of the Winnipeg Intake System (ANCR). The OCA continues to be concerned that child and youth care workers are working with some of the most challenging children and youth in the child and family services system and are not afforded the training that will provide them with the knowledge and skills to address the numerous issues that these children and youth face. This concern only increases as the number of staff from private home care and health care organizations rise. The Child and Youth Care Workers Core-Competency Training program was specifically developed to increase the knowledge base and provide skills to staff working with children and youth in residential care facilities. For the benefit of children and youth, the staff caring for them should have adequate training to address their varied needs.

63. Training in Non-Violent Crisis Intervention (NVCi) was a requirement for all shelter staff, including purchased service staff working in emergency shelter facilities from private home and health care agencies. However, yearly re-certification is not consistently enforced.

The EPR program has established mandatory training in Non-Violent Crisis Intervention. All shelter staff are expected to have completed this training by March 2008. Training in NVCi is offered through private home and health care agencies for staff who work in shelter facilities through a purchased service

agreement. As Non-Violent Crisis Intervention training requires annual re-certification, the availability of regular training and a method of advising shelter staff when re-certification is required, similar to the method used to ensure First Aid/CPR re-certification, must be instituted.

64. Purchased-service staff were not coordinated through one central management position.

Purchased service staff significantly support the emergency shelter system. Shelter staff reported that approximately 40% of the staff working in shelter facilities are from private home care or health care agencies. It appears unlikely that purchased service staff will be phased out in the near future.

A management model, where shelter coordinators are assigned specific shelters and are responsible for all aspects of operations in those shelters is used. This includes supervisory responsibility for permanent and casual shelter staff and on-site supervision for purchased service staff. At the time of this review, Shelter Coordinators were responsible for providing supervision to approximately 25 – 30 permanent and casual staff working in the EPR shelters that they each managed.

While the OCA recommended that purchased-service staff are coordinated through one central management position, the design of the system does not encourage this arrangement. As reliance on purchased-service staff to support the emergency shelter system increases, a review is necessary to firmly establish the accuracy of purchased-service use reports and develop both a short-term strategy for effectively integrating purchased-service staff into the EPR program and a long-term strategy for phasing out the use of purchased-service staff.

Human Resource Administration

The OCA recommended that WCFS expand its human resource program to support the shelter system and move all shelter staff personnel files to the Human Resource Department. At the same time, the OCA recommended that Human Resource standards, policies and procedures, consistent with departmental standards are

developed; and that all shelter coordinators receive training in the current collective agreement and in completing annual performance evaluations.

- 65. Two Human Resource positions were added to the WCFS Human Resource Department in 2004; a Labour Relations/Compensation Coordinator and a Staffing and Employment Equity Coordinator. Both positions provide support to EPR staff.**

The Labour Relations/Compensation Coordinator has been involved in training and supporting shelter coordinators working with shelter staff under the collective agreement.

- 66. After reviewing the feasibility of moving shelter staff personnel files to the Human Resources Department, the WCFS decided to keep the files with the EPR program.**

The WCFS management reviewed the OCA recommendation to physically store and maintain all EPR shelter personnel files within the Human Resources department and decided that this was not feasible as Shelter Coordinators required regular access to the personnel files. As a result, shelter staff personnel files remain with the EPR program.

- 67. WCFS developed a policy to ensure that shelter staff personnel files, stored with the EPR program, were maintained in a proper and secure manner.**

The policy, *Management of Personnel Files of EAPD Support Staff Policy*, dated April 15, 2005, pertained to the safety and securing of personnel files and to file maintenance. This policy was shared with coordinators in an EPR unit meeting on April 20, 2005. Shelter Coordinators are responsible for ensuring that the files are maintained in a proper and secure manner.

- 68. All Shelter Coordinators were provided with training in managing under the collective agreement in 2005.**

Since that time, several coordinators have left their positions and another round of training is needed for new coordinators. The Labour Relations/Compensation Coordinator with WCFS acts as a consultant to shelter coordinators and managers on issues related to the collective agreement.

- 69. According to EPR managers, all Shelter Coordinators have had a recent annual (2007/2008) performance evaluation.**

Performance reviews on all staff should be completed annually.

- 70. Coordinators report being behind in completing performance reviews on shelter staff.**

Shelter Coordinators advise that workload demands tend to push this task to the background. All Coordinators were aware that annual performance reviews should be completed.

Governance

The OCA expressed concern that the WCFS emergency shelter system was operating in a potential conflict of interest as the DFSH provided both the governance, through the Licensing Branch, and the management of the system through the WCFS Branch. As a result, it was recommended that the governance of the new emergency placement system be through a non-mandated organization. As part of the AJI-CWI restructuring of the child and family services system, the EPR program would become a part of the Winnipeg Intake Services and, as a result, transferred to the All Nations Coordinated Response (ANCR) Agency. This Agency would be mandated and monitored by the Southern First Nations Authority. The licensing function would continue to be the responsibility of the DFSH.

The Implementation Plan called for the transfer of the EPR program to ANCR on October 1, 2005 and the program relocated to 835 Portage Ave. to be in closer proximity to ANCR that year. The Joint Management Committee for ANCR worked diligently to establish ANCR as the Intake and 24 hour response system for the city of Winnipeg. ANCR began to operate as an agency in February 2007. The EPR program was not included in the planning and implementation process for ANCR until the spring of 2008. As integration into ANCR proceeds, the EPR program will operate separate from the DFSH.

71. The AJI-CWI Implementation Plan called for the transfer of the WCFS EPR program to the newly created Intake System in Winnipeg (ANCR). Three years later (2008), the responsibility for the EPR unit remains with the WCFS Branch.

The transition of the EPR unit to ANCR is still not complete. While the Joint Management Committee for ANCR addressed issues related to the implementation of the Intake system in Winnipeg, there was little time and attention given to the EPR system. The initial implementation plan for the EPR program was to transition the unit to ANCR to provide emergency placements on behalf of all child and family services agencies in the city of Winnipeg. ANCR would be an independent agency managed by the Southern Authority of Care Network and, as a result, will be independent from the DFSH. Planning for the implementation of JIRU/ANCR took almost 2 years to complete. The agency did not “go live” as an independent agency under the management of the Southern Authority Network of Care until February 2007. Several sources reported that the EPR unit was not discussed during the planning process for ANCR. Only recently have discussions started focusing on the transfer of the EPR unit to ANCR. While in transition, the WCFS Branch maintains responsibility for the operations of the EPR program, but has not been involved in policy and program development. The EPR system continues to operate without the benefit of a vision, mission statement, goals and programming. Limited work has occurred to address sustainability issues and the entrenchment of this system into the larger child welfare system. Pending governance and administrative decisions, the EPR system operates in isolation from mainstream placement services. Because

“ownership” of the EPR program has not been established, several operational issues are unresolved.

1. Two management positions, currently filled by seconded staff, were not included in the initial implementation plan.
2. Several Coordinators have resigned or retired leaving vacant Coordinator positions posted as term positions – some for as short a term as three months. Term positions do not attract qualified individuals looking for security in employment.
3. There are three vacant Coordinator positions and a pending retirement.
4. The shortage of qualified shelter staff has increased the reliance on staff purchased from private home and health care organizations.
5. Training programs for shelter staff are limited. External training programs, such as competency-based training for residential childcare workers are not utilized as the unit struggles with determining how to fill positions while shelter staff attend the training.
6. One dedicated administrative assistant position for the unit is not enough to maintain the database and tracking children in emergency care is not up to date.

Shelter Standards

Using the Child Welfare League of America (CWLA) standards for emergency, short-term care, the OCA, in the Shelter Review (2004), recommended that standards and licensing regulations be developed by the DFSH specifically for emergency shelter care. These minimum standards for the care of children and youth in emergency placement facilities should reflect the CWLA assumptions that length of stay in a shelter should not exceed 30 days, but can be renewed for an additional 30 days, up to a maximum of 60 days.

In addition, at the time, the OCA expressed concern that only one staff person at the DFSH was designated to reviewing and licensing all residential care facilities and recommended that an additional position be added to the Licensing Branch. With additional staff the Branch should ensure that annual reviews are completed on all residential child caring facilities, site inspections occur before variance requests are

approved and that it becomes a requirement that all variance orders are posted in the facility.

72. Specific program standards that address the unique nature of emergency care shelters have not been developed.

Emergency shelters are expected to comply with the regulations and standards developed for long-term residential care facilities and do not address issues that are unique to emergency care. The OCA recommended emergency care standards to establish requirements regarding the length of stay in an emergency facility, structured programming, functional assessments to assist in care planning and transition to longer-term care facilities, routines and rules that promote healthy life and development, regular medical and dental care and attention to special medical needs and the employment of qualified and competent staff.

The DFSH, in the *Response and Action Plan to the Office of the Children's Advocate SHELTER SYSTEM REVIEW REPORT*, dated April 7, 2004, endorsed the recommendation that specific program standards need to be developed for emergency care placements rather than applying the broader residential care standards, that may not completely address the unique environment in the shelter system. The DFSH advised that immediate action will follow to:

- √ Begin developing program standards specific to emergency placement resources.

No program standards or licensing regulations have been developed specifically for emergency shelters. As a result, regulatory standards are absent for many issues that are unique to emergency shelters such as the length of time for stay in an emergency child care facility, programming, functional child assessments and establishing rules and routines.

73. Although some youth are staying in shelters for lengthy periods of time, the overall length of stay in emergency care has decreased.

The average length of stay in an emergency shelter in 2008 was 44 days. This is a significant reduction from the 85 days reported in the Shelter Review (2004).

74. A second Provincial Licensing Specialist was added to the Department of Family Services and Housing Residential Facility Licensing Branch in October 2004. A third position was posted on Sept 30, 2008.

The OCA recommended an immediate increase to the staffing in the Provincial Licensing Branch. At the time of the initial review, one staff position was responsible for overseeing the operations of all residential care facilities in the province. As the EPR shelter system grew, a number of additional facilities were added to the workload of the Licensing Specialist. Each licensed child care facility in Manitoba is assigned to a Provincial Licensing Specialist who is responsible for the licensing and renewal of licenses for residential child care facilities in accordance with standards. The Provincial Licensing Specialist monitors and assesses the compliance to minimum standards for the licensed child care facilities in Manitoba with powers under the Director to take action if and when necessary. The DFSH responded by adding a second Licensing Specialist position in 2004. A third Licensing Specialist position was posted in September 2008.

75. The DFSH Managed Care database is outdated and limited in its capacity to generate meaningful data for outcome analysis.

The Managed Care database is used to track information related to the operations of the provincial child care residential facilities, including incident reports and corrective actions taken to address complaints and concerns. The capability of the Managed Care database to track information relevant to ensuring that incidents breaching the regulatory system for child care facilities are identified, analyzed and corrected is inadequate. Although this database has the capacity to track incidents, it cannot produce a qualitative report that makes analysis possible. Without this capability and the commitment of staff to enter data and maintain the system, the benefits of the information available through the incident reports are lost.

- 76. The process for obtaining variance orders has been simplified to include verbal approvals over the telephone without a site inspection and the delegation of authority to the EPR Program Manager to approve variance requests after working hours.**

When a child outside the age group or gender that the facility is licensed for needs to utilize a bed space when there are no other beds available, variance orders are needed. In the initial Shelter Review (2004), the OCA recommended that the DFSH Licensing Branch review all requests for variances in the emergency shelter program, and complete a site inspection and review each child's needs in the shelter prior to issuing the variance. The Child Care Facilities Standards Manual requires that requests for variances be submitted in writing and states that written approval for the variance will follow. Because of the nature of emergency placements, in order to place children and youth immediately, including sibling groups of different ages and genders, variance requests are frequent. The placement urgency that is unique to an emergency placement system does not allow time for a site inspection. As a result, the standards for residential facilities are routinely breached to make them functional as they apply to emergency placements. The process to obtain a variance order has been simplified to include telephone approvals. Variance requests after working hours are approved by a DFSH staff or the EPR Program Manager as designated by the DFSH Child Protection Branch. Once a variance has been issued it is sent by fax to the Shelter and it has to be posted. Generally variances are approved for no longer than a week.

This is an example of the complications that can arise when a system is regulated by standards meant for a different type of system. Existing residential facility standards were developed to regulate long-term facilities that have the option to plan prior to admissions. This provides ample time for variance applications, site inspections, etc. The urgent nature of the emergency placement system does not allow the benefit of time. Decisions have to be made quickly. A specific set of standards unique to emergency placements would take into consideration these types of unique issues and respond accordingly.

- 77. At the time of the current review, at least two EPR shelter facilities, providing care to children/youth, were not licensed by the provincial Licensing Branch because they did not meet provincial health and safety standards.**

Consistent with similar findings in the OCA Shelter Review (2004), at least two shelter facilities did not meet standards for health and safety and, as a result, do not meet the licensing eligibility required by the provincial licensing branch. According to staff, these shelters are located in units operated by Manitoba Housing. Some are in the process of waiting for repairs. While waiting, these facilities continue to operate as shelters providing emergency care to children and youth. Shelters not approved as licensed child caring facilities operate under the provincial Place of Safety designation. As Places of Safety, these facilities operate outside the provincial monitoring system, therefore, the quality of care provided to children in the unlicensed facilities is not monitored outside the EPR unit. The result is a two-tiered emergency shelter system where facilities can operate with or without a license.

- 78. Reports from staff working in EPR facilities, suggest that repairs to shelter facilities owned by Manitoba Housing are not addressed within a reasonable time frame.**

A large number of EPR shelters were developed in vacant Manitoba Housing units over the last few years as a result of an arrangement within the DFSH to use vacant units for this purpose. Although the initial plan was that Manitoba Housing would repair or renovate the units prior to the placement of children, this did not always occur. While some units were renovated, the urgent need for bed space resulted in children placed in some shelters before they can be repaired or renovated. According to shelter staff, the state of disrepair in several units make them ineligible for licensing by the Provincial Licensing Branch, yet children continue to live in these homes. Staff report that maintenance and repairs to units managed by Manitoba Housing are not being addressed. A coordinator described the state of a Manitoba Housing unit, currently used as a shelter for

children, as deplorable with holes in the walls, broken floor tiles and outdated, irreparable fixtures.

79. Due to the high demand for emergency placements, EPR shelters are developed under the Place of Safety (POS) designation until they are inspected for compliance with standards and licensed by the Provincial Child Care Facilities (Other than Foster Homes) Licensing Regulations.

This issue was raised as a concern in the OCA Shelter Review (2004) and resulted in a recommendation that additional staff be added to the Licensing Branch to ensure that inspections are completed in a timely manner and licenses issued promptly. The OCA was concerned about children placed in an unregulated out of home care system. A POS is defined in *The Child and Family Services Act* as “any place used for the emergency temporary care and protection of a child as may be required under the Act”. The Child and Family Services Place of Safety Standards state that “agencies are authorized to designate and use the following types of places of safety:

- residences of agency's own staff;
- apartments or hotel/motel rooms;
- residences of relatives or friends of the child or his family;
- family residences; and
- women's shelters.”

Establishing emergency facilities under the Place of Safety (POS) regulations allows for a quick response to urgent placement needs for children in care. According to the DRAFT Place of Safety Standards, children can remain in a facility (house) POS for a month or longer if an application has been made to obtain a license under the Child Care Facility (Other than Foster Homes) Regulation. This allows for time for the facility to meet licensing standards. In the meantime, these facilities operate outside the provincial regulatory system and are not subject to the requirements set out in the Child Care Facility Standards Manual. Without a regulatory system in place, quality care to children can be compromised.

This practice clearly evolved as the system responded to emergency care needs without a framework inclusive of standards, policies and procedures that are specific to its unique nature. This two-tier approach developed because of an absence of realistic applicable standards forcing the emergency care system to comply with regulations and standards that have been developed for very different systems with different purposes.

Staff Competencies

In the Shelter Review (2004), the OCA recommended that successful completion of Competency Based training should become part of the licensing process of an emergency shelter as is CPR/First Aid and NVCI training. In order to achieve this, it was recommended that the DFSH build the cost of this training into the funding formula for the emergency shelter system. The OCA suggested that the DFSH review the possibility of obtaining competency based training through a combination of class and computer assisted training.

80. The Shelter Review Implementation Committee (SRIC) concluded that Competency Based training should not be a licensing requirement.

In its report in 2005, the SRIC suggested that professional development plans should be staff specific and a part of the standard human resource management process. The OCA concurs with a flexible training program, including in-house training events, to address specific training needs.

Group Care Model

The OCA, in the initial review of the Shelter system, recommended that no child under the age of 7 years should be placed in an emergency group facility unless the child has exceptional needs and the facility can meet these needs, or is part of a sibling group and the placement would avoid the separation of the sibling group. It was further recommended that shelter facilities be licensed according to gender and age specifics for children over the age of 7 years and, that under no circumstances should licensing variances be provided which mixes age groups and gender.

- 81. To increase emergency bed space for children under the age of 8 years, the DFSH added 50 new emergency foster bed spaces to the emergency placement system in Winnipeg in 2005.**

B & L Homes was selected to recruit, train and support foster parents for 35 new spaces and the Community Led Organizations United Together (CLOUT), a group of community-based organizations including Ma Mawi Wi Chi Itata Centre, Native Women's Transition Centre, Community Education Development Association (CEDA), Andrews Street Family Centre, North End Women's Centre, Ndinawemaaganag Endaawad, Rossbrook House and Wolseley Family Place, was selected to provide services for an additional 15 bed spaces. The new emergency foster beds were included in the emergency placement resources available through the WCFS EPR program and the EPR Emergency Placement Desk coordinated emergency placements into these new foster homes. The number of emergency foster bed spaces has increased over the years. By May 2008, B & L Homes had 85 emergency foster beds and 80 beds in family reunification foster homes and CLOUT had 16 emergency foster bed spaces.

- 82. In spite of the additional foster home bed spaces, children under the age of 8 continue to be placed in shift-staffed group resources.**

Consistently, over the last four years, children under the age of 8 made up 50% of all admissions to the emergency shelter system. With these high numbers, the additional emergency foster bed spaces are not sufficient to end placements in group shelter facilities. The development of emergency foster beds and foster home recruitment strategies, although essential to the child and family services system, are not showing any significant impact on the high number of young children that continue to be placed in shift-staffed shelter facilities. More than 12% of the EPR shift-staff emergency shelters are licensed for children in the age category of 0 – 8 years. Most of these shelters are licensed for four or more children.

- 83. The EPR shelter system operates gender specific shelters for children over the age of 8.**

Exceptions to this structure occur when sibling groups of different ages are placed together in a shelter. A variance order is requested in these circumstances.

Staff – Child Ratio

In the Shelter Review (2004), the OCA recommended that all shelters operate under an 8 – 10 hour shift configuration and that the staff – child ratio be one staff member for every two children/youth throughout all shifts.

- 84. All 24-hours shifts were eliminated in EPR shelter facilities.**

With the expiration of the collective agreement for shelter staff in 2004, an arbitration process resulted in the elimination of the 24-hour shifts. The only exceptions now are the On-Call Dispatch staff; which includes two staff and two substitute staff, who continue to work 24-hour shifts from their homes, on a rotating schedule.

- 85. Most staff work 12-hour shifts, although 8-hour shifts have been implemented in some shelters.**

Approximately 100 shelter staff have guaranteed 12-hour shifts as awarded in their Collective Agreement. The WCFS has given the Union notice of its intention to review the 12-hour shifts. There is opposition to this by existing shelter staff, however, new positions are hired for 8-hour shifts.

- 86. The staff-child ratio varies in shelters depending on the ages and needs of the children.**

As most shelters are licensed for three - four children, one staff working a 12-hour shift is the regular practice. However, depending on the needs of the children, it is not unusual for two staff to be present during a 12-hour shift. In

some shelters only one staff works the night shift while two are present for the duration of, or part of, the day shift. Shelters with older children may require two staff per shift at all times. The shelters licensed for more than three children have at least two staff working at all times. Again, based on the needs of the children in the shelter, a third staff may be required. At the same time, occasionally a shelter with one or two children may require two staff at all times. There is considerable flexibility in determining staff-child ratios and the needs of the children in the shelter at the time are the biggest determinants of staff-child ratios.

Special Needs Children

The OCA recommended, in 2004, that specialized services be developed for children with special needs within the emergency care system. This included shelters with six beds designed to accommodate sibling groups, and specific shelters designed to accommodate physically challenged children and youth. In addition, recommendations were made to the DFSH to enter into discussions;

- √ with organizations providing community based street shelter services to increase the availability of bed space and outreach services,
- √ with Manitoba Justice to develop emergency care shelters for youth leaving correctional facilities and unable to return home.
- √ With the Department of Health to develop emergency care services for youth leaving mental health facilities and unable to return home.

87. A review of the special medical needs of children and youth in emergency shelters shows diligent planning and commitment by the EPR program to ensure that medical needs are being met.

Several children and youth with special medical needs are being cared for in the EPR system. To provide for the medical needs, the EPR program responses have included such steps as renovations and upgrades to shelter facilities, purchasing specialized home medical care equipment, ensuring sole occupancy in a facility or matching the child with others who have similar needs, purchasing the services of health care aides, arranging for specialized training for staff caring

for the child or youth and ensuring adequate staff on shift to ensure that the child/youth receives quality care at all times. Meeting the special needs of the children appear to take precedence over cost factors.

- 88. The EPR program had two 6-bed emergency shelters that are specifically set up to accommodate sibling groups in March 2008.**

Although steps have been taken to accommodate sibling groups, two shelters are not enough to care for the large number of sibling groups that are referred to the EPR program for emergency care. Whenever necessary large sibling groups continue to enter hotel placements.

- 89. In March 2008, the EPR program had one emergency shelter that is wheelchair accessible and can be used to care for children with physical disabilities.**

According to EPR staff, one wheelchair accessible shelter is sufficient. The lease on a second facility is not being renewed.

- 90. The DFSH created four Outreach Worker positions to work with residential care facilities to locate youth who run from the facilities. Consideration should be given to adding an Outreach Worker to the EPR Program.**

The Outreach Workers are connected to four provincially funded residential care facilities in Winnipeg and are not utilized by the emergency shelter system. As 12% of all children and youth in care are in an EPR shelter at one time or another, having an Outreach Worker connected to the EPR program may reduce the reliance on Winnipeg Police Services. Consideration should be given to creating another Outreach Worker position for the EPR program.

- 91. As of March 2008, no jointly funded emergency placement facilities have been developed with Manitoba Justice or the Department of Health for youth leaving correctional and/or mental health facilities.**

- 92. The DFSH has been an advocate for secure federal funding to independent agencies currently providing street shelters and outreach services in the community.**

Multi-Disciplinary Team Planning

In the Shelter Review (2004), the OCA recommended that the DFSH and the four Authorities establish geographically-based multidisciplinary treatment teams to develop care and treatment plans for high-risk children.

- 93. The use of formal multidisciplinary treatment teams to assess and plan for children in care is not common practice, however, the capacity for this exists in the system. It occurs more on a case-to-case basis depending on whether it is seen as necessary or not.**

It was not easy to ascertain whether multidisciplinary teams are used in all agencies to plan for children in care. There really appears to be no evidence of a formal structure of treatment planning using multidisciplinary teams, however, it likely occurs on a case to case basis simply because many children in care are involved with other systems in addition to child and family services. The WCFS Short Term Emergency Placement (STEP) Committee is the formal body used to review emergency placements and make recommendations for children that are in the shelter system. This committee has the flexibility to invite representatives from other systems to participate in case planning. However, this is not frequently done.

- 94. Shelter staff report being frustrated with the isolation that they feel in dealing with some of the most difficult youth in care.**

Staff at all levels of the EPR unit reported, both at the time of the first OCA shelter review and again through the process of the current review, that a significant number of youth are discharged from PY1, a mental health assessment unit for children and from the Manitoba Youth Centre, to be looked after in the emergency shelter system. Staff provided an example where a 17-

year-old child has been in five different shelters in a period of 5 months because of assaults on staff. When Winnipeg Police Services attend, the child is charged, but within a few days released from the Manitoba Youth Centre and in need of an emergency placement again. As no other placement resource is available to him, and he cannot live independently because of a very low level of functioning, the EPR program continues to be required to care for him. Another youth, 16 years of age with severe depression and 3 suicide attempts, was discharged from the adolescent mental health services to the EPR program with the advice that the child is at high risk of suicidal behaviour. The shelter system was charged with the responsibility to ensure that he does not follow through on a suicide attempt. According to shelter staff, there are no other systems available to care for many of the youth who come in and out of the emergency shelter system. They report that other systems that should be involved with these youth tend to become unavailable once the child is in care.

Use of External Specialists

The OCA, in the Shelter Review (2004), recommended that the WCFS, in conjunction with the DFSH, develop two specialist positions; a Health Specialist and an Educational Specialist to provide liaison functions between the health and education systems and the emergency placement system.

95. The Educational and Health Specialist Positions were not created.

There is no indication, at present, that plans are in place to create the above positions within the EPR program. It must be noted that while a Nurse position exists with ANCR, her responsibilities do not include medical services to children beyond the age of 6 years. Although the Nurse may provide consultation services on occasion, this does not substitute for a full time Health Specialist assigned specifically to the Emergency Placement Resource program.

Children's Rights

In the Shelter Review (2004), the OCA found that the majority of children and youth in hotel placements and emergency shelters were not aware of the Office of the Children's Advocate. Because it is the right of every child in care to be able to access the OCA, it was recommended that the DFSH ensure that all children in care are made aware of the OCA. To achieve this, it was recommended at the time that a standard be issued to all child and family service agencies directing that children and youth be made aware of the existence of the OCA through accessibility to information, prepared and authorized by the OCA, and available to children and youth in all out of home placement resources, including foster homes. In addition, the OCA (2004) recommended that the DFSH ensure that all youth (ages 14 – 18) in care are made aware of *Voices: Manitoba's Youth in Care Network*, and that information, prepared and authorized by Voices is available in all out of home placement resources for youth.

- 96. A standard, directing child and family service agencies to inform children and youth in care about the existence of the OCA and Voices was not formally issued.**

The Shelter Review Implementation Committee reviewed this recommendation and reported that the Authorities have committed to reviewing current practices among their agencies for informing children and youth about the OCA and Voices and developing a communication strategy in this regard. Interviews with children and youth in emergency shelters and with shelter staff indicate that although most children and youth and shelter staff were aware of the OCA, very few were aware of VOICES: The Youth in Care Network.

- 97. Information on the Office of the Children's Advocate was visibly posted in all EPR shelter facilities.**

All shelter staff and most of the children interviewed for this review (2008) were aware of the Children's Advocate and posters with information on the OCA were visibly located in all the shelters that were attended. In fact, several staff

reported encouraging children to contact the OCA or calling on behalf of children and youth.

98. No information was available in shelter facilities on VOICES: Manitoba's Youth in Care Network.

Only a small percentage of shelter staff and very few children/youth in shelter care were aware of VOICES: Manitoba's Youth in Care Network. There was no information on VOICES in the shelters that were attended (2008).

The Foster Care System

In the Shelter Review (2004), the OCA found that the majority of children entered the emergency care system from foster care. As a result, several recommendations were directed at improvements to the foster care system at the time. The first recommendation was to implement the recommendations made by Judge Linda Geisbrecht in her report regarding the death of a child in care. These recommendations focused on the need to recruit sufficient foster parents and adequately reimburse them for the value of their work based on the needs of the child and their ability to meet those needs; increase the number of foster homes in northern communities, and provide appropriate supports to foster parents including respite, clinical support and appropriate training. The OCA further recommended a province-wide foster home recruitment strategy and additional emergency foster bed spaces, developed in conjunction with the four Authorities, and community agencies who already provide foster care programs.

It was also recommended that the DFSH support the research endeavours of the Manitoba Foster Family Network to determine what supports are needed to retain and support foster homes and develop a province-wide system to track foster home breakdowns.

99. The responsibility for addressing Judge Linda Giesbrecht's recommendations was given to the Alternative Care Sub-Committee.

At the time of the current review, the Alternative Care Sub-Committee was working on the following activities related to the foster care system.

- Standardization of emergency rates for foster care.
- Standardization of special rates for foster care.
- The recruitment and development of new foster homes
- The development of a funding strategy to strengthen foster care
- Developing a foster parent training program
- Review of foster care standards

100. Foster parents in the province received a 10% foster care rate increase in 2007, and another 10% rate increase in January 2008.

In addition, funds were increased for recreational supports for children in care. As of January 2008, the basic rate paid to foster parents was \$21.57 a day for children under the age of 11 years and \$26.78 a day for youth aged 11 – 17 years. An additional \$2.36 for child specific use is included. Foster parents in the northern part of the province receive a slightly higher basic rate.

101. A province wide foster home recruitment strategy was announced in October 2006 with an investment of \$6.1 million to improve the foster care system in the province.

In November 2006, the Child and Family Service Authorities and the DFSH launched the “Circle of Care”, a province wide foster family recruitment campaign. The goal of this campaign was to develop 300 new foster bed spaces in the province in the next year. In October 2007, the recruitment campaign was hailed as a success when it was announced that 500 new bed spaces were added to the provincial foster care system. As of May 2008, informal reports suggest that almost 900 new foster bed spaces have been created in the province through this campaign.

102. A sum of \$200,000 was allocated by the Changes for Children Initiative in 2007 to develop a competency-based training manual for foster parents.

A committee consisting of representatives from the Authorities, the Manitoba Family Network (MFFN) and the Joint Training Unit, with foster parent representation, has been established to develop this training module.

103. As of June 2008, there is no province-wide tracking system in place to accurately and reliably maintain information on foster bed spaces.

The CFSIS database has not been effective in generating accurate and reliable information on foster homes throughout the province. Some communities do not have the technological capacity to allow its use, others do not have the necessary equipment to run the system or have developed their own information systems. Most concerning is the fact that CFSIS is lacking significant amounts of information and, therefore, is incapable of producing accurate and meaningful data that would be useful in service delivery planning. Recently, the Standing Committee announced a plan for incremental improvements to CFSIS. It is unknown whether CFSIS will have the capacity to reliably track foster bed space across the province in the future, but the inability to track foster bed space is virtually unacceptable in a system as large and crucial as this. Access to information on foster home availability affects the entire child and family services system and may be one of the biggest obstacles to moving children quickly from emergency care foster homes and facilities.

104. The current system of foster home management does not provide for an organized and consistent communication strategy to share information on available foster bed spaces. This system does not benefit children in care who are in emergency placements waiting for long-term care.

Currently foster homes are recruited and managed by each child and family service agency in the province. There is no organized and consistent communication system in place to share information on available foster homes in the system. Most agencies develop foster homes to meet their own child placement needs and may share foster bed space with other agencies upon request. This sharing of bed space is more associated with the degree of communication that occurs between agencies, the relationships that have been established and the willingness to contact several agencies in search of a foster home for a child. The philosophy of sharing foster bed spaces between agencies in the child and family services system for the benefit of children has been established but the practice is too restrictive, unstructured and unregulated. The

current foster home management system does not ensure access to available foster bed space for all children in care does not promote the matching of foster homes with the needs of children and limits opportunities for some children to have a successful foster home placement.

The Current State of the Short-Term, Emergency Placement System

A review of the short-term, emergency placement system in the province not only provided an opportunity to report on progress made on the previous OCA recommendations, it allowed for an evaluation of the current state of emergency placement services in the province. The restructuring of child and family services in the province transferred responsibility for all aspects of child and family services from the DFSH to four Authorities, each responsible for service delivery to a specific client population group, through the work of geographically located child and family service agencies and departments. The restructuring increased the number of agencies providing services to children and families in the province and created a relatively autonomous service delivery system with each of the 25 agencies and regional departments responsible for developing an adequate resource capacity and service system to meet the needs of children and families they are responsible for. The Standing Committee introduced the hotel reduction strategy in 2006, with the purpose of removing all children and youth from the high-cost hotel placements by the end of July 2007. The savings were to be allocated to Authorities to begin working on increasing foster bed spaces and developing emergency alternative placement resources for children and youth who would have been placed in hotels. Three Committees were created to work on moving children and youth in hotels to alternative placements, developing emergency placement resources to meet the needs of children and youth who would have been placed in a hotel, and developing a foster home recruitment and retention strategy.

The work of the first committee was time limited. After moving all children and youth from hotel placements to other resources, the committee's responsibilities ended. Some members from the first committee joined the committee responsible for developing alternative emergency placement resources. This second committee was made up of representatives from all four Authorities and had the broader task of developing specific and shared placement resources for children and youth other than foster homes. Several proposals for emergency placement and longer-term resources for youth were

developed for both the urban and the rural and northern parts of the province. However, while some new facilities were added to the resources available for children and youth in the province, many more did not get off the ground. Staff reported facing numerous challenges and frustrations in developing new resources. Obstacles such as finding the time to search for facilities, developing proposals that meet licensing standards and finding qualified staff to work in these facilities were reported. Reportedly, several good ideas have not gotten off the ground because of zoning and by-law issues, health and safety standards or the availability of qualified foster parents or care providers. Others are on hold waiting for licensing or funding approvals as discouraged staff are asking what happened to the money and support that was initially thought to be available for developing resources to meet the needs of children who would have been placed in hotels. As agencies wait for licensing and funding approvals, they notice the progressive development of additional emergency shelters in Winnipeg, and are frustrated by what is perceived as an unfair and inequitable distribution of funds and resources. Because of the lack of placement resources for youth in rural and northern communities, many have to be transferred to Winnipeg for placement. This is a source of concern for child and family service agencies and the communities that they serve.

As provincial statistics show more children in care every year, emergency placement facilities, other than foster homes, will continue to be an important component of child and family services. At this time, the WCFS Emergency Placement program is the largest and most utilized emergency placement resource in the province, and, therefore, is typically used as the reference for an emergency shelter system. This program has shown the capacity to meet a range of emergency placement needs of children and youth in Winnipeg. The quality of care provided to children and youth with a variety of high needs and special needs is very good. The flexibility inherent in the program capacity, allows for the creative use of facilities and staffing resources to ensure that all children are receiving care in accordance with their needs. To meet the high medical needs of some children, physical upgrades are made to facilities and the services of health care aides are purchased to work along with child care support workers to meet the child's needs. The ability of this system to respond to the varying care needs of children and youth is remarkable. However, the system seems to operate without a financial limit. At the current per diem rate of \$376.85 (2007/08), the EPR system's primary role is to provide quality care to children requiring an emergency

placement. It does not have an assessment and treatment function. Most of the cost can be attributed to the staffing that is required to meet the challenges of children and youth with very high needs. Some of these children/youth are involved with the corrections system and are discharged from correctional facilities into emergency shelters with conditions that may require 24-hour supervision. Additional staff are needed in shelter facilities in response to such conditions. Without doubt, the emergency placement system provides quality services to a high needs population group. The challenge for administrators is to preserve the quality of this system while addressing the cost of this care.

Emergency shelter facilities are needed across the province to keep youth in their own communities when they come into care. More emergency facilities in the province should result in fewer facilities in Winnipeg if youth from rural and northern communities are being transported to Winnipeg for emergency placement. It is imperative that emergency placement facilities are absorbed into the provincial out of home placement system and regulated through licensing regulations and standards that are specific to the unique goals and functions of these facilities. The development of regulations and standards for emergency care facilities will act as guidelines for child and family service agencies developing new emergency placement facilities in the province. The operational requirements of emergency shelters must be expanded to include regular, structured programs, functional assessments to assist in developing treatment plans, and ongoing training for staff in areas appropriate to dealing with children and youth in emergency placements. Most importantly, a quality emergency placement system is contingent on qualified, committed staff and the availability of suitable long-term placement options.

Through a review of reports and other documents, and interviews with staff at several different levels of programming, the OCA was provided with sufficient reports and anecdotal information to conclude that the current emergency placement system in the province requires immediate attention in several areas to advance its capacity to provide consistent, quality emergency placement services and strengthen its investment in meeting the emergency placement needs of children and youth. Until recently short-term, emergency care was not distinguished from longer-term care on the continuum of out of home care resources for children and youth. However, it has become a reality in

the child and family services system and needs to be considered as a separate, yet interrelated, component of out of home placement services. This view is fundamental in the findings that will follow.

105. Short-term emergency care, as distinguished from longer-term placements is a fairly recent concept in child and family services.

As a result, little literature or research findings are available that discuss this dimension in child and family service practice. In the Shelter Review (2004), the OCA provided a definition for an emergency shelter and developed principles on which the operation of an emergency shelter should be based on. An emergency shelter is just one type of placement resource for children. For the most part, children requiring an emergency placement can be placed in a Place of Safety, a foster home or a facility primarily established to care for children that urgently require a placement. Until the Shelter Review (2004), emergency placements were not distinguished from other placements. However, recently, there is recognition that a large number of children are being placed quickly, without the benefit of preparation and planning and are living in emergency foster homes and facilities for long periods of time until they are able to return home or move to a longer-term placement.

106. The WCFS EPR system developed in response to the demand for emergency placements of children and youth who cannot be cared for in the existing foster care and residential care systems.

Several reasons can account for this:

1. A shortage of foster bed spaces in the child welfare system,
2. A commitment to keep sibling groups together when they come into care,
3. The high needs of many children and youth in care could not be managed in foster care,
4. Limited availability of residential child care facilities, and
5. Placement breakdowns in both the foster care and residential care systems.

107. The WCFS EPR system developed outside the provincial regulatory system for residential out of home placement facilities.

The emergency placement system developed in the 1980's in the form of agency-operated 3 – 4 bed facilities with paid live-in foster parents hired to care for children requiring emergency placements. The early facilities were designated as Places of Safety and the live-in foster parents were licensed by child and family service agencies. As shortages of foster parents developed, agencies hired care providers to work shifts in the facilities. It was not until 1999 that the emergency shelter facilities were required to adhere to provincial licensing standards.

108. The provincial Child Care Facilities Licensing Standards do not contain standards that are specific to short-term emergency care.

The provincial Child Care Facilities Licensing Standards were developed for residential child care treatment facilities and do not address specific short-term care issues. In the Shelter Review (2004), the OCA called for specific provincial standards that would address short-term emergency care for children. Although some factors, related to the quality of care required for children living in residential facilities, are addressed in the provincial residential facilities standards manual, many other factors related to the nature of emergency, short-term care are not. These factors include, but are not limited to, regulations regarding admission policies, programming, assessments, length of stay, and discharge procedures.

109. In March 2008, emergency shelter facilities were operating both inside and outside the provincial regulatory system.

The EPR program operated 54 shift-staff emergency shelters with an additional six shelters in development in March 2008. Of these shelters, 43 were licensed while 11 operate as Places of Safety (POS). In the absence of a regulating system specific to short-term, emergency facilities, there is sufficient autonomy to establish new facilities as places of safety, where zoning and by-law requirements are not as rigid as those for facilities operating under the provincial

licensing guidelines. Facilities that are not able to meet zoning requirements are operating as emergency placements for children under the place of safety designation. The result is that a two-tier emergency placement system has evolved. While the Licensing Branch monitors licensed facilities, those developed under the place of safety designation are not monitored in accordance with provincial standards. Child and family service agencies monitor POS facilities.

110. No formal guidelines or standards are in place to define the process of locating an emergency placement for children and youth in care.

While some child and family service agencies have programs designated for developing and monitoring emergency placement resources, others do not. Locating emergency placements for children is not an organized process. Rather it is a scramble for placement resources with little attention to matching the child's needs to the placement capacity, defining the length of the placement, determining the services that need to be provided while the child is in an emergency placement, and outlining procedures for moving the child from the emergency facility. Without guidelines or standards, there is no consistency in managing emergency placements.

111. The WCFS EPR program was providing emergency placements in Winnipeg for children and youth from most of the child and family service agencies in the province in 2008.

There is a shortage of emergency placement bed spaces for children and youth in the province, and, a majority of child and family service agencies report transporting children from rural and northern communities to Winnipeg for placement in a WCFS EPR resource. Approximately 12% of all children in care have been through the EPR system.

112. The WCFS EPR program continues to operate without a specific program model, including a mission statement and specified goals that identify objective and intended outcomes for the operation of the shelter system.

This was identified as a concern in the Shelter Review (2004) and it was recommended that action be taken to review the current system and develop a program model inclusive of a mission statement, goals and objectives and operational standards. The Shelter Review Implementation Committee (SRIC) drafted a mission statement and accumulated information to assist in developing a program model, but turned over this information to the Standing Committee when it completed its term. The responsibility for a program model for the EPR unit was then given to the Joint Implementation Committee for ANCR. As the transition of the EPR unit from the WCFS to ANCR is still in pending, almost no work at all has been done to review and develop a program model for the EPR program.

- 113. According to provincial data (2008), the total number of children in care in the province has increased over 30% in the last five years. The majority of the children in shelter care are youth with high medical and/or behavioural needs and younger children that are part of large sibling groups.**

Although a significant foster care recruitment campaign has reported increases to the number of foster bed space in the system, it is questionable whether this effort will result in reductions in emergency shelter usage when considering that the majority of children in emergency care have very specific needs. Resource development efforts must focus on the needs of the children and youth in emergency care. It is unusual for foster homes to be able to accommodate sibling groups of three or more. More specific recruitment and planning is required to locate appropriate resources to care for these sibling groups. Similarly, youth with high needs require specialized treatment-focused placements. There are reports of waiting lists for existing residential facilities and a rigid selection criterion that exclude a number of the youth presently in emergency shelters.

- 114. The absence of an integrated service system to meet the needs of high-risk youth accounts for the large number of youth staying for lengthy periods of time in emergency placements, or shuttling back and forth**

between the criminal justice system, the mental health system and child and family services.

The ineffectiveness of the present system to address the needs of high risk youth has been reported previously and is a source of concern as many of the youth in emergency care have serious issues that, if not addressed, may follow them as they move into the adult system.

- 115. A national shortage of qualified residential child care workers has increased the use of purchased service staff from private health care and home care organizations to care for children in emergency facilities and hotel placements.**

Shortages of qualified child care staff to work in residential facilities have been reported at a national level. Decker, Bailey and Westergaard (2002) looked at high turnover due to stress among child care staff in a licensed residential care facility. Residential child care staff reported feelings of low personal accomplishment and high levels of emotional exhaustion. Moses (2000) reported that the majority of residential child care workers in his study felt that the conditions of their work were not conducive to long term employment, citing such issues as lack of adequate pay and inconvenient shift schedules. Anecdotal reports at the local level confirm the difficulty in recruiting and retaining qualified child care staff to work in residential facilities. Therefore, to meet the growing demand for staffing in shelter facilities, the services of staff are purchased from private home care and health care organizations.

Internal reports suggest that as much as 40% of the staff working in emergency shelters are purchased service staff from private organizations.

- 116. Purchased service staff are associated with a large number of concerns about the quality of care that is provided to children and youth in emergency facilities.**

A significant source of these concerns are the regular shelter staff who report that purchased service staff are not knowledgeable about the care needs of children and youth in emergency care and lack the experience to effectively deal with the special needs and behavioural challenges that these children present. Many of the staff concerns have been collaborated by shelter coordinators who report inexperience and significant training needs. These concerns are also confirmed by incident reports citing a disproportionate number of purchased staff investigated for medication errors and aggressive, inappropriate behaviour.

117. A significant number of children and youth admitted to an emergency shelter are already in care.

Only 54% of the children/youth referred to the emergency shelter system come from the non-care sector. The remaining 39% children are placed from another placement resource, the criminal justice system or the medical system. Placement prior to admission to the EPR system was unknown for 7% of children/youth.

The Cost of Care

According to information obtained during this review;

118. The cost of caring for children in emergency shelters has risen by 45% in the last five years.

119. Over 85% of the total cost of shelter care is staffing costs.

120. The individual shelter budget for food, household supplies, and children's allowances and recreation, has not increased in five years.

The Quality of Care in EPR Shelters

A total of 13 children and youth living in EPR shelter facilities were randomly selected for an interview to determine their experiences in shelter care. The

interviews were conducted during late 2007 and early 2008 by Marie Christian, the Director of Voices: The Youth in Care Network, using the same questionnaire that was used in the 2004 shelter review. The findings that follow are based on the interviews with children and youth in shelter facilities and interviews with a randomly-selected group of shelter staff.

121. Children and youth living in EPR program shelters are provided with adequate food, clothing and receive good basic care.

The Canada Food Guide is used to plan meals, special diets are respected, and for the most part, children/youth are asked what they would like to eat. Clothing is not available through the shelter program, but staff request initial clothing money from agencies responsible for the child/youth. Routines established in shelters teach good self-care and hygiene practices.

122. For the most part, someone other than their child and family service caseworker brings children and youth for admission into an EPR shelter.

Most frequently, children and youth are brought to shelters by After Hours Workers or Agency Drivers. This is a concern because these individuals don't have the necessary information on the child to assist the shelter staff with the care the child needs. Most concerning is the lack of medical information that is available at admission. Furthermore, children do not know why they are in shelter care, what the plan is and how long they will be staying. Although, in some cases, this is understandable, but the concern is further increased when the child's caseworker does not contact the child or staff within a reasonable time frame.

123. Caseworkers are not seeing children in shelters within the time frame set out in the child and family service standards.

Although there are exceptions to this, both children/youth and shelter staff report that personal contact with caseworkers is limited. According to child and family service standards, caseworkers are required to have face-to-face contact with

care providers and children in care on a monthly bases and prepare a child assessment within 30 days of a placement of a child. Most of the children and youth interviewed had many questions about their case plans, and reported being left out in the planning that occurs for them. Too many of them reported very little contact with their caseworker.

124. Admission conferences on children/youth placed in shelters are not regular, do not occur within a reasonable time frame or just don't happen.

An admission conference, which includes the caseworker, shelter staff and the children/youth (if appropriate), is an opportunity to share information, discuss assessment issues and develop a plan for the child. These must be scheduled within 30 days after a child/youth is admitted to the shelter system as required by provincial standards. Most of the children and youth interviewed did not attend any admission or case planning conferences. Over 90% of shelter staff reported that they had never attended an admission conference. Shelter Coordinators are responsible for setting these up and they report difficulties with caseworkers agreeing to attend a case conference. They report that Intake Workers don't want to attend because the case is in the process of being transferred to a child and family services agency. Caseworkers who just received a case transfer are reluctant to attend because they have just been assigned the case and do not have information about the situation. Reports of caseworkers cancelling scheduled case conferences were heard from both Coordinators and shelter staff.

125. Inside EPR shelters, a standardized admission process is followed for all new admissions.

Children and youth report being shown around the shelter, informed of rules and routines and provided with personal hygiene items at admission to a shelter facility. Shelter staff follow a process that includes a visual inspection of the child, an overview of house rule, routines and expectations, a tour of the facility and a response to immediate needs, such as feeding the child if hungry or taking

the child for medical care. A child's file is open and all relevant information on the child is documented in the file.

- 126. While efforts are made to keep children/youth in the same school placements they were at prior to admission to an emergency shelter, a large number of children do not attend school or a day program. Many are simply out in the community with their peers.**

The EPR program has been diligent in attempting to maintain children and youth in the schools they attended prior to admission to a shelter. Transportation is provided either by shelter staff, drivers employed by the WCFS or other child and family service agencies, or taxicabs. This is not always possible, particularly if children/youth are placed in Winnipeg from rural or northern communities. Registering children in school is a complex process and usually takes several weeks as school records are transferred and meetings are scheduled. While 82% of children/youth in shelter care had attended school prior to admission to a shelter, only 66% were attending at the time of this review. If not in school, there is not much for children and youth to do. Day programs are not available and, often, older youth are left to do whatever they want during the day including being out in the community with their peers.

- 127. Most children and youth have some contact with their families after admission to a shelter.**

Older youth have contact with family in the community while younger children are more inclined to have visits in child and family service offices. Telephone contact between the children/youth and their families is widely practiced with few restrictions in place to monitor this contact.

- 128. While all children receive a weekly allowance, the amount provided and the conditions associated with getting the allowance vary between shelters.**

It appears that there is a standard \$4 allowance provided weekly to all children in shelters. Additional allowance is dependent on compliance with shelter rules and expectations. This can bring the allowance up anywhere from \$5 to \$15 a week. Most shelters provide an opportunity for children and youth to earn additional money by doing extra chores.

129. Discharging children and youth from shelter facilities is random, inconsistent and without process.

There is no formal discharge process for moving children out of shelters. The decision to discharge is made by the child's caseworker, often without conferencing with the child, and shelter staff are provided notification ranging from several days to an hour or two that a child will be moving. In most cases, no information is provided to either the staff or the child on where the child will be moving. The discharge process is inconsistent and completely dependent on the caseworker's management of this. Both children in shelters and staff report that the discharge process is chaotic and confusing and does not always provide an opportunity for the child to have closure before leaving the shelter.

Applying provincial facility standards to the discharge process in emergency shelters may not be feasible. However, the discharge process appears to be an anxiety provoking experience for children/youth. Standards for discharge planning from emergency care facilities are needed.

130. The majority of children in shelter care report liking the staff and being well cared for in the shelter facilities.

Most children and youth reported that they were consulted on food and clothing choices, provided with activities and entertainment and liked the shelter staff that cared for them.

Behaviour Management Practices

- 131. In general, child/youth behaviour management techniques are appropriate and consistent between the shelters when administered by regular shelter staff.**

The behaviour management techniques used in shelters include removing privileges, using time out techniques, logical consequences and changing the course of events before behaviour starts to escalate. These practices appear to be consistent between shelters. Reports of inappropriate behaviour management approaches tend to occur when new and inexperienced staff, often purchased from private home and health care organizations, are providing the care.

- 132. The use of inappropriate behaviour management practices has been associated with purchased service staff.**

Several shelter staff have reported concerns about inappropriate responses to child behaviour issues by purchased service staff. This information has been corroborated by reviews of investigations conducted by the DFSH Licensing Branch and the Provincial Abuse Investigator.

- 133. Physical restraint continues to be used in situations where a child may be at risk of harming himself or herself or someone else.**

In the current review 68% of shelter staff confirmed using physical restraints on a child at some point when there is a risk of harm either to the child or to another individual. This is slightly higher than the 67% of shelter staff that reported using physical restraints during the previous shelter review.

Safety Issues

- 134. Many EPR shelter facilities are located in neighbourhoods that present safety risks to children/youth and staff.**

Reports have been heard about children being assaulted and having belongings stolen while walking to and from the shelters. Staff report “crack houses” in visible distance from some shelters, being afraid walk in the neighbourhood after dark and having intoxicated strangers come to the door at all hours.

135. Shelter staff are at high risk of being assaulted while working in some emergency shelter facilities.

78% of shelter staff interviewed for this review reported being either kicked, pushed, punched or had an object thrown at them by a resident at the shelter. Almost all the staff reported being verbally threatened with physical harm.

Emergency Placement Resources Outside Winnipeg

136. Emergency facilities for children and youth are lacking in most rural and northern locations.

Children and youth with high needs are difficult to place in communities where there are no specific facilities able to provide care to them. Reports of children and youth transported to Winnipeg from northern and rural communities for emergency placement are common.

137. Money available to Authorities from the Hotel Reduction Strategy has not produced a significant number of emergency bed spaces in locations outside of Winnipeg.

Approximately one year after the hotel reduction strategy ended the placement of children into hotels with some exceptions, very few new bed spaces for older youth and sibling groups are available outside of Winnipeg. It is difficult to track emergency bed spaces because, unless children are moved from these bed spaces consistently within a specific time period, they may begin as emergency bed spaces but soon stop being available for emergencies because children placed in those spaces remain there for a longer period of time. At least four bed

spaces in the Northern Region began as emergency beds but have become longer-term placement resources. This review was able to track eight new emergency bed spaces in the Parkland Region, two in the Interlake Region, which continue to operate as emergency resources, and the remainder in Winnipeg.

- 138. Several proposals for placement resources outside Winnipeg, both for emergency and specific longer-term needs, are presently waiting for renovations, funding and/or licensing approval.**

Attempts to establish out of home placement resources has been met with hurdles and delays in several areas. Vacant Manitoba Housing units thought to be suitable options for facility development were found to be in unusable conditions requiring significant renovation work, other available facilities were not meeting zoning and by-law requirements, while several proposals are on hold waiting for funding approvals.

- 139. Agencies trying to develop resources in northern and rural communities face additional challenges due to shortages of appropriate facilities, foster parents for agency-operated homes and qualified residential care staff.**

These challenges are even more pronounced in smaller, more isolated communities.

- 140. A perception that there is an inequitable distribution of funding for resource development is evident among staff.**

Authorities and agencies expecting funding from the hotel reduction strategy to develop new emergency resources are finding that this money is not available. Several proposals are currently on hold waiting for funds to proceed with upgrades and renovations to meet standards. On the other hand, the WCFS EPR unit is proceeding with adding more emergency shelters and emergency foster homes to its roster of placement resources in Winnipeg.

- 141. Developing placement resources requires specific knowledge and skills. Issues such as zoning regulations, health and safety standards and recruitment and training of staff challenge child and family service workers, not trained in developing alternative placement resources.**

While facilities are available in some communities, excessive workloads leave little time for staff, not designated to this task, to work on developing these facilities into placement resources. Staff are also challenged by the lack of knowledge about zoning regulations, fire codes, health and safety measures and the recruitment and training of staff to manage the facilities. Developing placement resources requires specific knowledge and skills. Most staff, working in child and family service agencies, do not have this type of training or experience. For this reason, the task of developing resource facilities is overwhelming.

Future Considerations

- 142. In the six months prior to the hotel use deadline, the majority of the children in hotel placements were moved to foster homes and external residential care facilities. This suggests that there may actually be more long-term placement options available than reports indicate.**

Approximately 51% of the children and youth in hotel placements were moved into foster homes or other external residential care facilities, 5% went to live in a POS while 14% of the children/youth returned to their own home or a friend/relatives home. Another 16% were moved from hotels to emergency foster homes or shelter facilities and the remaining 14% were either admitted to a hospital or correctional facility, went into independent living or were AWOL. This suggests that there may be long-term placement resources available for children in emergency care and the reason children are not promptly moved from emergency care is not due to the lack of available longer-term resources but an inadequate communication system that does not provide information on the availability and accessibility of longer term care options. It should be noted that the Hotel Reduction team worked diligently with staff from child and family

service agencies to move children out of hotels into other placements and were successful in accomplishing this task. Over 175 children/youth were placed in external foster homes or residential care resources.

143. There is no centralized tracking system to collect and maintain data on long-term bed space vacancies in the province.

Outside the emergency placement system, there are four possible sources of bed space for children in care; placement with extended family, sometimes referred to as kinship care, placement in a foster home, placement in a foster home or group home operated by an external organization and placement in a Group 2 resource, which are provincially funded and regulated residential treatment facilities.

Each child and family service agency is responsible for finding extended family and developing and licensing foster homes and other placement resources needed to address the placement needs of the client population they work with. Once the foster homes are developed, they are maintained by that agency. It is also up to the agency to report any foster bed space that may be empty. In the spirit of cooperation, all child and family service agencies are encouraged to share resources for the benefit of children. However, there is no monitoring of this and compliance with this spirit of cooperation is voluntary.

External organizations providing placement resources for children in care each have a system of communicating bed vacancies; although there are some differences between organizations, communication often includes sending out notifications of the bed vacancy to all child and family service agency placement departments. Some organizations may carry waiting lists.

Placements in Group 2 resources are coordinated through the DFSSH Placement Desk, commonly referred to as the Provincial Placement Desk. Notifications of bed space vacancies are sent to all child and family service agencies and referrals are accepted on a specific referral form. Children/youth accepted for a

placement are placed on a waiting list and caseworkers are notified if a bed space becomes available.

Currently bed space availability is tracked by the following systems:

1. All child and family service agencies keep track of their own foster bed spaces, including vacant bed spaces.
2. External placement organizations track bed space vacancies in their own resources.
3. The Provincial Placement Desk tracks bed spaces in all Group 2 facilities.
4. The WCFS EPR unit tracks emergency bed spaces in it's own system, through the Emergency Placement Desk. The Desk also tracks information on available bed space in other facilities in Winnipeg such as N'Dinawee, Youth Resource Centre, the Golden Eagle Facility and the Eagles Nest Facility in Selkirk.

Each of these systems independently track bed spaces and are solely responsible for communicating bed space vacancies to agencies that require child placements. In turn, this communication has to reach one of the hundreds of caseworkers from the 25 child and family service agencies/departments in the province who needs this type of bed space for a child he or she is responsible for. The complexity of this process can easily result in the loss of relevant information that may benefit a child in care.

144. The collaborative Resource Committee, initially established to identify resource needs across the child and family service system, has become Authority-specific and resource development work is centred on the resource needs of the agencies responsible to each Authority.

Each Authority has a committee that is actively involved in identifying needs and developing proposals to address resource needs for the client population that they are responsible for. One example of this is the Northern Alternative Care Network (NACN), a committee of the six Northern Authority agencies which meets monthly to discuss and present issues related to foster care and resource development. Because each Authority and its agencies face unique issues,

resource development is approached differently as a result of geography, community values and availability of basic services needed for resource development, such as contractors, qualified staff, etc.

11. **Conclusions**

Until recently, short-term emergency care was not distinguished from longer-term out of home care for children. As a result, there is very little research or literature on the subject. The OCA Shelter Review (2004) brought attention to the concept of emergency care as a distinct component of child welfare services. Prior to this the continuum of out of home placement resources did not include a clear distinction for short-term, emergency care. The OCA found that a significant number of children were being cared for in hotels and emergency shelter facilities, and not in family-based resources such as foster homes. The Shelter Review (2004) reported that emergency care was not only a requirement for children/youth who were removed from their family homes and required an imminent placement, it was also required by a large number of children/youth who were already in care but had to move because of a placement breakdown. Two specific groups of children and youth were largely represented in the population of children placed in hotels and emergency shelter facilities; youth with multiple and high needs who could not be accommodated in foster homes because of high risk and aggressive behaviour and large sibling groups who should not be separated when removed from their family homes.

As a result, two reviews of emergency placement resources followed. The Hotel Review (2000) recommended that placements of children in hotel rooms should end and the Shelter Review (2004) recommended that a centralized office be established to review and regulate the emergency placement needs of children and youth and develop specific emergency and long-term placement resources, based on an assessment of the specific needs of children using the emergency shelter system.

At the time the OCA presented the Shelter Review (2004), a complete restructuring of the child and family services system in the province was underway which resulted in comprehensive changes that transferred responsibility for child and family

services from the DFSH to four CFS Authorities. The Child and Family Services Standing Committee was created to develop and govern the new child and family services system and provide direction to the four Child and Family Service Authorities and the 25 child and family service agencies and regional offices that provide direct services to children and families in the province. In the midst of planning and implementing the massive AJI-CWI initiative, the DFSH responded to the OCA Shelter Review (2004) by establishing the Shelter Review Implementation Committee (SRIC) to review the recommendations and develop an action plan for addressing them. At the same time, the DFSH provided immediate funding to develop 50 additional emergency foster bed spaces in Winnipeg.

The Shelter Review Implementation Committee (SRIC) was created for a term of one-year to review and develop an action plan on the recommendations of the OCA Shelter Review. During its term, the SRIC completed a literature review and province-wide needs assessment of out of home care needs of children and youth. It developed a “draft” vision statement for an emergency care system, identified principles for a continuum of care, arranged for a financial audit of the WCFS EPR system and identified a number of issues for ongoing action. During the course of its work, several immediate changes were implemented in the DFSH and the WCFS EPR program. When its term ended in June 2005, a Detailed Implementation Plan (DIP) was presented to the Minister of Family Services and Housing, which included further action required on many of the recommendations. The responsibility for these actions was forwarded to the DFSH and the Child and Family Services Standing Committee.

Shortly after the Detailed Implementation Plan (DIP) was presented to the Standing Committee, three additional external reviews involving the child and family services system followed. In response to these, the Minister of Family Service and Housing established a new strategic initiative called *Changes for Children: Strengthening the Commitment to Child Welfare* with responsibility for improving the current child and family services system. A Changes for Children Implementation Committee was created to review the new recommendations and develop an action plan. Shortly afterwards, the release of two additional reviews brought the total to 289 separate recommendations to improve the child and family services system. A consolidated work plan was developed to address these recommendations.

Somewhere in the course of all these changes, the Shelter Review (2004) recommendations were either delegated to other committees or integrated into the existing work of the Changes for Children Initiative because of their close resemblance to some of the recommendations from the five external reviews. Other recommendations were implemented by departmental programs within the DFSH and the WCFS Branch and several recommendations were not addressed at all. The recommendations made by the OCA in the Shelter Review (2004) were not included in the responsibilities delegated to the *Changes for Children: Strengthening the Commitment to Child Welfare* initiative. As a result, in April 2007, the OCA embarked on a progress review of the recommendations from the Hotel Review (2000) and the Shelter Review (2004).

The OCA commends the work of the Standing Committee in introducing the hotel reduction strategy and the Hotel Placement Standard, which has gone far to reduce and regulate hotel use. However, continued work is required to ensure that suitable alternative placement resources are available for the children and youth who would be in hotel placements. Siblings groups are an exception to the hotel placement standard, and, as we already know, make up a large percentage of children in hotel placements. The Hotel Placement Standard does not change this. Although a hotel placement is no longer an option for high-risk youth, there are very few alternative placement resources that can provide care for this group of youth. These youth often cannot reside with other residents because of safety risks and several entire shelter facilities have been dedicated to solely provide care to one youth. At the same time, anecdotal reports of hotel placements, in breach of policy, to accommodate youth when there is absolutely no other alternative are not uncommon. The OCA believes that the action taken by the Standing Committee is only a first step in hotel reduction, and the subsequent elimination of hotel use, and ongoing work is required to develop a sustainable system of alternative placements to hotel use.

The Shelter Review (2004) contained 78 recommendations for changes to the systems that support emergency placement resources for children and youth. The OCA found that 63% of the recommendations were completed, partially completed, still in progress or have become integrated into the ongoing work of the DFSH and the

Standing Committee. However, 37% of the recommendations showed no change or were rejected.

In the Shelter Review (2004), the OCA reported that, “there appears to be no overall vision and co-ordination of resource development specific to residential care for children and youth. System coordination of resource development is required” (p 161). As a result, the OCA had recommended a central office, the Community Resource Development Office (CRDO), based within the DFSH, to determine and identify resource needs and develop a coordinated and systemic plan for in home and out of home resources for children and families. Contrary to the OCA recommendation, this function is currently addressed through internal committees within each Child and Family Service Authority. The OCA was concerned that placement resources for children and youth were developed outside a system to regulate and monitor the quality of care provided to children and youth. A centralized office, located with the DFSH, would be able to regulate resource development, ensure resources are developed to meet the actual needs of children and youth through a fair and equitable process of funding and resource distribution and monitor compliance with new, province-wide standards.

Several other recommendations appear to be outstanding with no plans in place to address them. No specific plans are in place to address recommendations related to improving the work of the Provincial Placement Desk. In its first review of the emergency shelter system, the OCA called for an Educational Specialist and a Health Specialist to assist youth in emergency care to maintain school involvement and receive a consistent response when medical or mental health issues surface. There is no plan in place to consider this recommendation.

Many of the recommendations in the Shelter Review (2004) focused on changes to improve the current WCFS EPR system. Several internal changes were made. The STEP database has been used more consistently to track children coming in and out of the shelter system, the Home Manual, a comprehensive policy and procedure manual for shelter staff was developed, the management of incident reports has improved, variance orders are requested for changes in all provincially licensed shelter facilities, a process is in place to improve the coordination of purchased services by tracking and documentation and shelter coordinators perform regular site inspections. There are

several more areas that have not been addressed. In particular, child care support staff training is limited and does not involve competency-based training, supervision of shelter staff is not consistent and is more likely to occur if shelter staff work day time shifts, regularly scheduled programs are not available in shelters, and the cost of shelter care continues to rise.

Most concerning, however, is the fact that the EPR shelter system continues to be in a state of transition since 2005. In the initial AJI-CWI Implementation Plan, the EPR unit was to be transferred to the All Nations Coordinated Response Unit (ANCR), the designated intake agency for Winnipeg. While ANCR began operating as an independent agency in 2007, transfer of the EPR unit is still pending. In the meantime, as the EPR system continues to grow by developing additional shelters and managing placements in external emergency foster homes, it still operates without a mission statement, goals and objectives, a program model and a process to evaluate its operational and fiduciary effectiveness. Because the EPR unit is transitioning to ANCR, the WCFS is only concerned with interim operational sustainability and the Joint Management Group for ANCR is still involved with issues concerning the intake and after hours functions.

No action has been taken to act on the OCA Shelter Review (2004) recommendations to develop standards and licensing regulations that are specific to emergency shelter care. Existing licensing regulations and standards did not apply to the unique features of emergency shelters and, as a result, only partially guide the system. Standards reflecting the length of stay in emergency shelters, structured programming, functional assessments to assist in longer-term planning for children, provisions of competent and regular medical/dental care, age appropriate routine and the employment of qualified and competent staff with experience and skills in dealing with issues pertaining to children in emergency care were suggested. The OCA also suggested a program model, which would include an integrated service component to address the specific needs of high risk and special needs children and youth that are in emergency care. With the large number of children with high medical needs, mental health issues and involvement in the criminal justice system, the OCA called for an accurate assessment of placement needs for this target group. Also concerned about the large number of children in shelter care under the age of 8 years, the OCA reported

that specific resources to accommodate large sibling groups were required. The OCA expected that the above issues would be addressed through the newly established Community Resource Development Office (CRDO).

The restructuring of child and family services increased the number of mandated agencies in the province responsible for the delivery of child and family services and the development of resources for children in care. The hotel reduction strategy, in 2006, created several collaborative committees to work on developing new placement resources across the province for children and youth who would have been placed in hotels prior to the hotel placement standard. The foster home recruitment and retention committee and the resource development committee, with funding available from the reduced use of hotels, were tasked with identifying resource needs and developing appropriate alternative placement resources and foster homes. While the foster home recruitment committee continues to work on recruitment and retention strategies, the resource development committee has become more of an internal committee between specific Authorities and the agencies responsible to them. The internal committees are very active and have generated several good plans and proposals for out of home placement resources for children. While some plans/proposals include partnerships between Authorities, others are primarily concerned with increasing the number of emergency placement beds for youth in rural and northern parts of the province. Unfortunately, very few of the plans/proposal for alternative out-of-home placements have actually gotten off the ground. Child and family service agencies, inexperienced in developing residential placement resources, face such challenges as zoning and by-law infractions, health and safety standards, and the limited availability of qualified foster parents and child care workers. Other proposals are on hold while waiting for licensing or funding approvals as discouraged staff are asking what happened to the money and support that was initially thought to be available for developing resources to meet the needs of children who would have been placed in hotels. As agencies wait for licensing and funding approvals, they notice the progressive development of additional emergency shelters in Winnipeg, and are frustrated by what is perceived as an unfair and inequitable distribution of funds and resources. Because of the lack of placement resources for youth in rural and northern communities, many have to be transferred to Winnipeg for placement. This is a source of concern for child and family service agencies and the communities that they serve.

As provincial statistics show more children in care every year, emergency placement facilities, other than in foster homes, will continue to be an important component of child and family services. At this time, the WCFS Emergency Placement Unit is the largest and most used emergency placement resource in the province, and, therefore, is typically used as the reference for an emergency shelter system. This program has shown the capacity to meet a range of emergency placement needs of children and youth in Winnipeg. The quality of care provided to children and youth with a variety of high needs and special needs is very good. The flexibility inherent in the program capacity, allows for the creative use of facilities and staffing resources to ensure that all children are receiving care in accordance with their needs. To meet the high medical needs of some children, physical upgrades are made to facilities and the services of health care aides are purchased to work along with child care support workers to meet the child's needs. The ability of this system to respond to the varying care needs of children and youth is remarkable. However, the system seems to operate without financial limitations. At the current per diem rate of \$376.85 (2007/08), the EPR system's primary role is to provide quality care to children requiring an emergency placement. It does not have an assessment and treatment function. Most of the cost can be attributed to the staffing that is required to meet the challenges of children with very high needs. Some of these children are involved with the corrections system and are discharged from correctional facilities into emergency shelters with conditions that may require 24-hour supervision. Additional staff are needed in shelter facilities in response to such conditions. Without doubt, the emergency placement system provides quality services to a high needs population group. The challenge for administrators is to preserve the quality of this system while addressing the cost of this care.

Emergency shelter facilities are needed across the province to keep children and youth in their own communities when they come into care. More emergency facilities in the province should result in fewer facilities in Winnipeg if youth from rural and northern communities are being transported to Winnipeg for emergency placements. It is imperative that emergency placement facilities are absorbed into the provincial out of home placement system and regulated through licensing regulations and standards that are specific to the unique goals and functions of these facilities. The development of regulations and standards for emergency care facilities will act as guidelines for child

and family service agencies developing new emergency placement facilities in the province. The operational requirements of emergency shelters must be expanded to include regular, structured programs, functional assessments to assist in developing treatment plans, and ongoing training for staff in areas appropriate to dealing with children and youth in emergency placements. Most importantly, a quality emergency placement system is contingent on qualified, committed staff and the availability of suitable long-term placement options.

The extensive review of the emergency placement system in the province not only provided an opportunity to review the progress made on the previous recommendations on hotel use and the emergency shelter system, it allowed for an assessment of the current state of emergency placement services. Through a comprehensive process of documentation reviews and interviews with staff at several different levels of programming, the OCA was provided with sufficient information to conclude that the current emergency placement system in the province requires immediate attention in several areas to advance its capacity to provide consistent, quality emergency placement services and strengthen its investment in meeting the emergency placement needs of children and youth. As a result, the OCA continues to support the recommendation made in the Shelter Review (2004), that the capacity for community resource development, both in-home and out-of-home, be developed through a centralized office created by the DFSH, with the Child and Family Services Authorities, and located within the Children's Resources Office of the Child Protection Branch. The tasks and responsibility of this office, will include, but not be limited to:

1. Assessment of current in-home and out-of-home resources for children and youth.
2. Assessment of in-home and out-of-home resource needs of children and youth.
3. Developing and maintaining a tracking system of resources and child/youth needs.
4. Developing a strategy for intersectoral communication and treatment planning for children with multiple needs.
5. Developing standards and regulations for emergency, short-term care.
6. Linkage between government departments and programs.
7. Linkage between external resource facilities and child and family service agencies.

8. Providing support and direction to the Hotel Reduction Team and other committees working on specific terms of reference related to services to children and youth.
9. Providing logistical support to agencies developing in-home and out-of-home resources.
10. Ensuring an equitable distribution of financial resources based on need.
11. Bringing services in line with “best practice” standards through quality assurance.
12. Regulating and monitoring services for children and youth.

12. Recommendations

For the most part, while many of the recommendations made in the Shelter Review (2004) have been addressed or are in the process of being addressed, there continue to be several critical aspects that remain outstanding and new issues emerging from the recent changes to the structure of child and family services in the province. Recognizing short-term, emergency care as a continuum of substitutional out of home placement resources for children and youth is a necessary next step. Existing licensing regulations and standards do not apply to the unique features of emergency shelters and, as a result, only partially guide the system. Standards reflecting such factors as the length of stay in emergency shelters, functional assessments to assist in developing appropriate longer-term care plans, provisions of competent and regular medical/dental care, programming to meet emergent needs, age appropriate routines and the employment of qualified and competent staff with experience and skills in dealing with issues pertaining to children in emergency care are necessary. In the Shelter Review (2004), the OCA suggested a program model, which would include an integrated service component to address the specific needs of high risk and special needs children and youth that are in emergency care. With the large number of children with high medical needs, mental health issues and involvement in the criminal justice system, the OCA called for an accurate assessment of placement needs for this target group. Also concerned about the large number of children in shelter care under the age of 8 years, the OCA reported that specific resources to accommodate large sibling groups were required. The OCA expected that the above issues would be addressed through the newly established Community Resource Development Office (CRDO).

The Shelter Review Implementation Committee (SRIC) rejected the development of a specialized office in the DFSH in favour of transferring outstanding matters related to the emergency shelter system to the Standing Committee. The SRIC announced that the Standing Committee would assume the tasks of the CRDO. Five years later, the state of emergency placements in the province is in a state of disarray. The hotel reduction strategy, although successful in removing some children from hotel placements, did not include sufficient alternative placement options for sibling groups and high or special needs youth, resulting in child and family service agencies contravening policy in a desperate effort to find emergency placements for special and high needs youth. The haste in implementing the hotel reduction strategy without planning for the special needs of the children and youth placed in hotels created an urgency in the emergency shelter system resulting in new emergency shelter facilities operating under Place of Safety designations because, according to representatives with the EPR department, the licensing and regulating systems could not keep up with the rapid development of the shelters. While emergency shelter facilities increased in Winnipeg, staff in rural and northern locations experienced significant challenges to developing emergency facilities, other than foster homes, due to unavailability of suitable facilities, shortage of staff dedicated to developing alternative resources, lack of live-in foster parents or qualified residential care workers, unfamiliarity with zoning, and health and safety standards and limited experience in developing and coordinating placements in short-term facilities.

In response to the hotel reduction strategy, child and family service Authorities and agencies moved promptly to develop new resources for children in care, counting on the money that would be available through hotel use reduction. Information provided by representatives from various authorities and Agencies indicates that , approximately one year later, several very thoughtful proposals based on sound planning are on hold waiting for renovations to facilities and funding approvals. While several emergency shelter beds were developed in Winnipeg, very few similar additions were found in rural and northern communities.

At the same time that the EPR program is adding shelter facilities and coordinating emergency foster home bed spaces in Winnipeg, it continues to operate in a state of

transition, since 2005. As the demand for emergency placements increase and per diem costs escalate, the findings in the current report shows that the EPR continues to operate without a vision, program goals and objectives, operational standards, and a functional tracking system that allows for needs assessment and evaluation. There are no operational standards that are specific to the emergency placement system in the province. Agencies attempting to develop new emergency alternative placement facilities are doing so in compliance with a set of regulations and standards that were developed for longer-term residential treatment facilities. These standards do not address many issues that are specific to short-term emergency care.

In view of the fact that emergency care has become a reality in the child and family services system and children/youth are staying in emergency care facilities for significant lengths of time because of limited longer-term placements and treatment resources, the need for a centralized monitoring and regulatory system for in home resources and out of home placements is essential. The OCA continues to support the recommendation made in the Shelter Review (2004):

1. **That the capacity for community resource development, both in-home and out-of-home, be developed, regulated and monitored through a centralized office created by the DFSH, with the Child and Family Services Authorities, and located within the Children's Resources Office of the Child Protection Branch. This centralized office will interrelate with the existing centralized services provided through the Provincial Placement Desk (PPD), the Child Caring Facilities Licensing Branch, and the Provincial Abuse Investigators (PAI). The tasks and responsibility of this office, will include, but not be limited to:**
 - Improving the continuity of care, coordination and accountability in the provision of in home and out of home services to children and youth and their families.
 - Assessment of current in-home and out-of-home resources for children and youth.
 - Assessment of in-home and out-of-home resource needs of children and youth.
 - Developing a coordinated system of alternative care network with all Authorities, designated Intake agencies (DIA), child and family service agencies and provincially funded Group 2 resources, and with the external organizations that offer child/youth placement resources.
 - Developing and maintaining a tracking system of resources and child/youth needs.
 - Developing a strategy for intersectoral communication and treatment planning for children with multiple needs.

- **Developing standards and regulations for emergency, short-term care.**
- **Reviewing standards and regulations for residential facilities in the province.**
- **Linkage between government departments and programs.**
- **Linkage between external resource facilities and child and family service agencies.**
- **Providing support and direction to the Hotel Reduction Team and other committees working on specific terms of reference related to services to children and youth.**
- **Providing logistical support to agencies developing in-home and out-of-home resources.**
- **Ensuring a fair and equitable distribution of financial resources for in-home and out-of-home resource development across the province based on need.**
- **Developing, regulating and monitoring hiring standards and training strategies for child and youth care workers in residential facilities.**
- **Bringing services in line with “best practice” standards through quality assurance.**
- **Regulating and monitoring all in-home and out-of-home services for children and youth open to child and family service agencies in the province.**

Developing a Consistent Emergency Care Program in the Province

While the majority of children and youth requiring emergency placements will enter the foster care system or move into homes of extended family, there will continue to be a group of children and youth who are unable to live in foster care or with family members. This group includes children that are part of large sibling groups and difficult to place youth with multi needs and challenging behaviours. In Winnipeg, the EPR program provides this service. In the rest of the province, alternative emergency placement resources are scarce. Encouraged by the prospect of funding available from the hotel reduction strategy, Authorities and agencies attempting to develop appropriate alternative emergency placement resources were met with numerous challenges including the unavailability of suitable facilities, and shortages in qualified live-in foster parents and staff to work in the facilities. While some alternative facilities got off the ground, many were faced with obstacles that could not be resolved. A couple of emergency placement resources began as such but, in the absence of policies and guidelines to manage the short-term nature of the emergency facilities, quickly became long-term resources, as children placed in the facilities simply stayed there. Several other promising proposals are on hold waiting for renovations to buildings and funding

decisions. There is no question that the child and family services system can no longer simply depend on foster parents and extended family to care for some of the high needs children and youth that either enter care or are already in care. Furthermore, the practice of removing children and youth from their communities to place them in emergency facilities in Winnipeg is unacceptable, unless placement in a residential treatment facility is the case plan for the child/youth. The importance of ensuring that appropriate services are available to children and youth in their own communities was discussed in the report following the death of Tracia Owens. (Tracia Owens Inquest: Released Jan 16 / 08). Winnipeg is a haven for unsavoury experiences that may be avoided for many youth, if they can be accommodated in smaller communities near their homes. A network of emergency alternative placement resources is required in several areas of the province with consistent policies and standards that guide operations, fiscal management, and the quality of care to children and youth in the facilities. In addition, a network of longer-term placement facilities with varying capabilities to meet specific needs of children and youth are essential.

Through the centralized office for resource development, assistance must be provided to agencies in rural and northern communities in the form of logistical support, adequate funding arrangements and the use of expert resources to ensure that adequate and sustainable licensed facilities are developed. In addition, minimum standards for short-term, emergency care must be available through a set of standards specific to this. It is suggested that standards of short-term, emergency care include, but not be limited to the following:

- An admission policy
- Inclusion and safe keeping of medical information
- A process for completing functional assessments
- Contact with caseworkers
- Recreating programming
- Day programming for children not in school
- Transfer of special needs educational funding
- Child/youth participation in treatment planning
- Visitation arrangements
- Educational outcomes
- Discharge process

Admission Policy

Because of the random and short-term nature of emergency placements, a specific admission policy and corresponding standards are required. These should allow for the flexibility of children/youth moving in and out of facilities quickly, while ensuring that they are informed and involved in the processes that affect them. Similarly, children/youth are brought to facilities at all hours by intake and after hours workers who may not know the child/youth well enough to have immediate information on medical or other needs. A process should be in place that prioritizes access to essential information on the child and that this information is communicated to staff as soon as possible. The numerous concerns about children/youth not being seen by a caseworker must be addressed. Standards already exist to ensure contact between children in care and child and family service workers is regulated, yet, from all reports the standards are not consistently followed. This may be a workload issue, and if so, it needs to be addressed to ensure caseworkers are able to provide services to children and families in keeping with provincial standards. It is suggested that minimum standards for admission to a placement facility include the following:

- the preparation of a child/youth for entry into an emergency facility by a caseworker or Intake worker.
- a requirement that staff in emergency facilities are provided with essential information, particularly on the medical needs of the child/youth, at the time of placement or immediately thereafter.
- a process for communication between the assigned caseworker and shelter staff.
- a scheduled contact, by the caseworker, with the child/youth within a week following the placement
- a planning conference within 30 days of placement, if the child remains in the facility for that length of time.

Functional Assessments

Individualized functional assessments reflecting a current understanding of a child/youth's circumstances by listing strengths and deficits with measurable outcomes are useful in providing information on the child/youth to guide caseworkers in developing

realistic case plans. The assessments are based on observable behaviours and can be easily completed, after some brief training, by facility staff. It is suggested that children and youth are provided with initial and ongoing functional assessments to identify strengths and needs and to develop individualized, coherent and consistent treatment plans. The DFSH may have to hire an expert to develop an appropriate assessment tool and train staff in using the tool and entering the information into an on-site database that recognizes and takes into account behaviours related to trauma/crisis.

Direct Contact by Caseworkers

Both staff working in emergency shelters, and children and youth, report limited contact with caseworkers after admission to an emergency shelter. Child welfare caseloads have long been considered too large, and more often than not, caseworkers reported that they cannot consistently meet the accepted standards established by the province for child and family services. In addition, changes to the nature of casework have resulted in the wake of increased focus on accountability and documentation, reducing the time available for face-to-face contacts, or relegating it to a lesser importance. Shortages in child and family service caseworkers to fill vacant staff positions create overwhelming responsibilities for the remaining caseworkers to manage unrealistic workloads at a time when confidence in and support for the child and family services system is at a low point. In 2008, a worker from a rural community reported that she was the only caseworker left out of four positions in a community sub-office. She was managing a caseload of 170 while waiting for new staff to be hired. While the DFSH has introduced a workload management strategy in the child and family services, with increased funds to hire more staff, many positions simply remain vacant due to shortages of qualified applicants. A concerted recruitment and retention strategy is needed to develop an adequate workforce in the child and family services system in the province. While existing standards require contact between child and family service caseworkers and children in care to occur at least once a month, information obtained from staff working in emergency facilities and from a sample of children living in emergency facilities in Winnipeg in May 2008, suggests that this does not always happen. As a result, direct contact between caseworkers and children in care needs to be strictly regulated for compliance.

Educational Outcomes for Children in Care

It is a well known fact that children/youth in care fare below their non-care counterparts in achieving positive educational outcomes. Many leave school before completing and, as a result, are generally unprepared to be competitive in a workforce that requires a high school diploma for most jobs. Although the majority of children/youth in the emergency placement system in Winnipeg were attending school, a significant number were not. Registering children in school is a complex process and usually takes several weeks as school records are transferred and meetings are arranged. A survey of a sample number of children in EPR emergency facilities in May 2008, shows that while 82% of the children/youth had attended school prior to admission to a shelter, only 66% were attending at the time of this review. Reasons cited for this was the rigid admission process that required a caseworker to register the child and attend a conference prior to the child's admission. Because of the workloads of most child and family service caseworkers, this process may delay actual school attendance for weeks. In addition, staff reported that youth were too easily suspended for lengthy periods of time and that an attitude of adversity was detectable when school officials were advised that a child/youth was residing in an emergency shelter. On the other hand, educational professionals report a lack of understanding and communication between the two systems. Overall, the relationship between the child and family services system and the educational system is not one that seems to benefit children in care. The OCA, in the Shelter Review (2004) recommended that the WCFS, along with the DFSH, develop a position of Educational Specialist to act as a liaison between the educational system and the emergency care program. The Shelter Review Implementation Committee (SRIC) deferred this recommendation to the Joint Management Committee for ANCR. As of June 2008, it had not been addressed. The OCA reviewed this recommendation again, and, in view of the ongoing concerns between the emergency placement system in Winnipeg and the educational system, combined with the fact that too many children/youth in emergency care are not attending school, is in full support of adding the position of Educational Specialist to the new specialized, centralized office within the DFSH. The Educational Specialist would act as a liaison between the educational system and the emergency care programs. The Educational Specialist should have a background in education and policy administration to assist with transitioning children to schools, responding to concerns and issues

associated with the educational system and assist with the development of educational planning and funding applications where necessary. Through this position, it is suggested that the DFSH and Department of Education launch a review of the poor educational outcomes for children/youth in care and make recommendations for improving these outcomes. The Educational Specialist should work with the Office of the Standing Committee to develop a practice standard that promotes educational achievement as a priority for children/youth in care and support this by providing practical assistance such as educational assessments, tutoring, counseling, learning aids and tools and assistance with learning.

Recreational Programming

For the most part, recreational programming for children and youth in the EPR shelters is left entirely to the staff in each shelter. As a result, there is no consistency in the quality or quantity of recreational programming. Some shelter facilities do not engage in any recreational programming at all. Involving children and youth in recreational programming is an essential part of healthy growth and development and is required in accordance with standards for licensed residential facilities. Children and youth must be provided with consistent recreational programming in all emergency, shelter facilities. This may require adding a Recreational Specialist to the new specialized, centralized office within the DFSH. A Recreational Specialist can work to develop standards for suitable recreational programs and assist placement resources in developing structured, regularly scheduled appropriate recreational opportunities for children/youth.

Discharging or Moving a Child/Youth from an Emergency Facility

There is no formal discharge process for moving children out of emergency shelters or between shelters. Because the nature of emergency placements requires a specific policy to regulate discharges, applying the provincial facility standards to the discharge process in emergency shelters is not feasible. The decision to discharge or move a child from a shelter can be made by the child's caseworker as part of the case plan, or a child can be moved between shelters to allow for a sibling group or another

resident who may be better matched for the shelter. This process is disconcerting to a child/youth, especially when a move is random and made without conferencing with the child. Both children/youth and staff in shelters report that the discharge process is chaotic and confusing and does not always provide an opportunity for the child to have closure before leaving the shelter. A discharge policy that is specific to the unique nature of short-term, emergency placements should be developed to regulate the process of moving and discharging children/youth from emergency shelters.

2. **That the service capacity of the Provincial Placement Desk (PPD), Provincial Abuse Investigators (PAI), and the Residential Care Licensing unit within the Children's Resources Office of the Child Protection Branch, be reviewed, strengthened and enhanced to align with the specialized, centralized office for community resource development.**

Provincial Placement Desk (PPD)

The Provincial Placement Desk is an integral part of the out of home placement system in that all placement referrals to provincially-funded residential treatment facilities are coordinated through the Desk. These facilities are vital to addressing some of the special treatment needs of children and youth who are in the emergency care or foster care system. The Provincial Placement Desk is the link between child and family service agencies seeking placements for high needs children and youth and the appropriate residential facility that can meet the needs. Several recommendations were directed at changes to the structure and operations of the Provincial Placement Desk in the 2004 Shelter Review. None of the recommendations were addressed and no changes have occurred in the operation of the Provincial Placement Desk to improve awareness, accessibility, tracking capacity and communication. In fact, the same concerns prevailed and additional concerns were noted:

- a). Not all child and family services caseworkers understand the role and function of the Provincial Placement Desk.
- b). The Desk no longer operates as a Committee but referrals are screened and placement decision are made by the Provincial Placement Specialist.
- c). The information system is limited. There is no formal tracking of child needs, treatment capacity and placement breakdowns.

- d). The communication system between the PPD and CFS agencies is dependent on distribution of the communication material at several different levels from Authorities to agencies and within agency offices. There are many junctures where communication can breakdown before reaching all caseworkers for whom the information is intended.
- e). The responsibilities of the position are too excessive for one staff person with limited administrative assistance.

The state of the PPD requires immediate attention. Despite plans to include the PPD in a review of all Group 2 resources, some issues cannot wait. Although the OCA supports a complete review of the PPD, the following issues should be addressed immediately.

- A communication strategy for the effective communication and sharing of information between the Provincial Placement Desk and all child and family service Authorities and agencies. The communication strategy should contain:
 - i. A summarized information package on all provincially-funded residential treatment facilities
 - ii. Guidelines for caseworkers considering a referral through the PPD
 - iii. A description of the referral process
 - iv. Protocols for caseworkers on working with residential treatment facility placements, expectations, communication, admission process, discharges, etc.
 - v. Easily accessible Referral Form and Social History templates attached to the communication package and accessible through a provincial web site.
 - vi. Listings of residential treatment facility bed space vacancies that are updated on a weekly basis, and accessible by child and family services staff in the province through a secure provincial web site.
- An effective information and tracking system with analysis capabilities to generate useful and meaningful data. This tracking system should be a part of a larger departmental managed care database with information on all children in care in the province.
- A full-time Administrative Assistant to the Provincial Placement Desk with responsibilities related to, but not limited to, coordinating the communication and information systems.
- Remove administrative responsibilities for the communication and information systems from the Provincial Placement Specialist and include responsibility for

redeveloping the PPD as a multi-disciplinary committee to review referrals and assist with developing treatment plans.

- That the Provincial Placement Desk Committee be composed of representatives from the four Child and Family Service Authorities, the child mental health system, the youth corrections system and the education system, as well as representatives from the residential care system.
- The Provincial Placement Specialist's responsibilities should include supporting the committee, developing related guidelines and protocols for the PPD, and continuing to provide information, education, support and both general and case-specific consultations to child and family services agencies, residential care providers and community organizations.

Provincial Abuse Investigators (PAI)

The PAI unit has grown in both staffing and responsibility, increasing the range of allegations that are investigated in licensed residential facilities across the province. In 2008, the PAI reviews all investigations of abuse or questionable child management practices in foster homes. The work of the PAI unit is limited by its information keeping system. The expansion in staff and responsibilities requires access to a database that can be shared between PAI unit staff and that has the capability to track recommendations that are made for corrective actions. This feature is not available in the current database, which, by the way, is not connected to the larger Managed Care database. Without the ability to track changes and corrections resulting from abuse investigations, the system fails to ensure that corrective responses are taken and concerns appropriately addressed to prevent future abuse incidents involving children/youth in care. The DFSH must address the issue of information keeping in all programs to ensure that the quality of service provided to children in care is constantly monitored and changes implemented as needed to prevent ongoing or repetitive incidents of abuse or inappropriate conduct by care providers toward children in care.

It is suggested that immediate attention be given to developing an effective information and tracking system for the PAI with the capability to track recommendations within an appropriate time frame and have the capabilities to generate useful and meaningful data that can be used to identify trends and provide analysis to strengthen

and improve services provided to children in care. This tracking system should be a part of a larger departmental managed care database with information on all children in care in the province.

Residential Care Licensing Unit

The Licensing Unit has grown from one position at the time the initial Shelter Review (2004) was completed to a total of three positions at the time of this report. As the number of residential child caring facilities increase, the workload for Licensing Specialists has increased as well.

The new emergency child placement facilities in the province are subject to the same assessment, licensing and monitoring standards as longer-term residential treatment facilities. These standards were developed specifically for residential treatment facilities where placement and treatment planning was of a longer-term nature. The standards were not developed to consider the unique features of emergency care such as placement urgency, short-term lengths of stay, sibling groups consisting of different ages and genders, frequent mobility, accommodation of children and youth with varying and multiple needs and the preparation of a child/youth for longer term treatment planning. Although some of the standards apply to short-term, emergency facilities, others require adaptive measures in order to apply to emergency care. The short-term, emergency care system has become a reality in child and family services, and it is necessary that attention be given to regulating that specific system. Using the existing licensing standards and regulations as a framework, a set of new standards specifically targeted at licensing and regulating the short-term emergency care system is required. In order to do this, an additional position must be added to the provincial licensing unit to work on developing standards and regulations for short-term emergency residential facilities.

Additionally, like the PPD and the PAI programs, the Licensing Branch is limited by an ineffective information system. The Managed Care database is used to track information related to the operations of the provincial child care residential facilities, including incident reports and corrective actions taken to address complaints and concerns. The capability of the Managed Care database to track information relevant to

ensuring that incidents breaching the regulatory system for child care facilities are identified, analyzed and corrected is inadequate. The database lacks the capacity to produce qualitative reports that make analysis possible. Without this capability and the commitment of staff to enter data and maintain the system, the benefits of the information available through monitoring and incident reports are lost.

The Licensing Branch is an integral component to a centralized office responsible for community resource development. It is suggested that the Licensing Branch responsibilities include establishing minimum standards, including policies and procedures for the operations of short-term, emergency placement facilities, other than foster homes, in the province. In order to achieve this, the Licensing Branch capabilities should increase as follows:

- An additional position be added to the Licensing Branch to research and develop specific regulations and licensing standards for short term, emergency placement facilities. The standards should be based on best-practice principles, such as those recommended by the Child Welfare League of America. This position would continue to provide regulatory and monitoring services to the short-term, emergency placement system, and
 - An effective information and tracking system be developed for the provincial Licensing Branch with the capability to track recommendations within an appropriate time frame and have the capabilities to generate useful and meaningful data from incident reports that can be used to identify trends and provide analysis to strengthen and improve services provided to children in care. This tracking system should be a part of a larger departmental managed care database with information on all children in care in the province.
3. **That the DFSH, along with Manitoba Justice, Education and Health, begin developing terms of reference for a coordinated and integrated services delivery system for children and youth with multiple needs that ensures fair and equitable accessibility to treatment programs, services and resources that meet their needs.**

Integrated Services Planning

A critical lack of equity and accessibility to programs and resources across government departments is a concern. This is particularly evident when services are required for multiple needs children and youth in care. Concerns about the challenges in obtaining services for this group of children and youth have been evident throughout this

review. Caring for special needs and high needs children and youth is an isolating experience without the benefit of the knowledge and expertise available in other systems. Children and youth in care utilize a wide array of services such as social, educational, medical, none of which are coordinated to operate together. Presently, services for children may have to be sought from various service agencies and government departments, such as health, addictions services, education, justice, children's mental health, etc.

An Integrated Service Plan would consider services to children with high needs as a single service system, and have the capacity to develop joint service plans, including coordinated assessments and interventions and target the services needed to meet the needs of the child. This would ensure inclusive access for all children to required services. In an integrated service delivery plan, the needs of the child are at the forefront and the required services are accessed to meet the needs.

With respect to integrated services, the OCA suggests that

- A child-centred Integrated Service Model be developed, where the needs of the child/youth are determined through an assessment and the required services be accessed to meet those needs,
 - That children and youth referred for integrated service planning be assigned to a case manager who is responsible for assessments and, along with a committee of experts, developing service plans to address multiple needs and ensure that the services the child/youth requires are provided, and
 - That children and youth are provided with support and treatment efforts earlier and at critical junctures in life, to assist them in building the capacities necessary to live safely and function independently in adult life.
- 4. That the Standing Committee reconvene the Hotel Reduction Team, or create another team, to continue working on the hotel reduction strategy with the centralized office for resource development, and in accordance with the proposed terms of reference.**
- **A historical review of hotel placements, including child-specific information on children and youth placed in hotels, to obtain a comprehensive assessment of their needs.**
 - **Program standards establishing a criteria for admissions to hotel placements, programming and quality of care for children/youth in**

hotel placements and management of child specific costs for children in hotel placements.

- **A strategy for intersectoral communication and treatment planning for children and youth involved with multiple systems.**
- **A tracking system to compile hotel placement data that is connected with the needs of children/youth and is effective in developing treatment and care plans for them.**
- **An action plan for developing appropriate short-term, emergency resources adequately suitable for high risk-youth and large sibling groups.**
- **Recommendations for long-term placement alternatives for high-risk youth.**

Hotel Placement Exceptions

A significant step was taken to regulate hotel use in the last two years and a reduction in both the number of children placed in hotels and the length of time they are staying in hotel placements is evident. According to information provided to the OCA, the Hotel Reduction Team, established by the Standing Committee, was successful in moving all children in hotels throughout the province into alternative placements and regulating ongoing hotel placements. Although the significance of this cannot be understated, the consequences of this action on a group of youth frequently utilizing hotel placements and on the child and family services child placement system must be considered. Changes cannot be made in isolation and without consideration of the impact of these on the broader system. A review of the current state of the emergency placement system, particularly in alternatives to emergency foster care, suggests a lack of appropriate alternative placement resources for a group of children and youth that were previously placed in hotel rooms, breaches to the hotel placement policy because of no other options and a lack of suitable, long-term placement resources to move children from emergency settings. It is clear that additional work is still needed to address issues related to hotel placements. Both immediate short-term actions are needed to allow some flexibility in situations where there are no other options but hotel use, and a longer-term framework is required to structure efforts to identify and develop resources that will eliminate hotel use completely. To this end, it is suggested that high-risk youth be included as an exception in the Hotel Placement Standard, subject to a definition of high risk, as the specific needs of these youth are reviewed and appropriate

placement resources developed. Additionally, efforts should be directed to specific recruitment of foster homes that can accommodate up to four children.

5. **That the DFSH, the Child and Family Services Standing Committee, the General and Southern Authorities and the Joint Management Committee for ANCR carefully consider the recommendations that follow to strengthen and sustain the Emergency Placement Resources (EPR) in Winnipeg.**

Sustaining the Winnipeg Emergency Placement Resource (EPR) Program

The Winnipeg-based EPR Program is the largest emergency placement system, other than foster care, in the province and, for the most part, it operates efficiently and effectively through the efforts of dedicated and experienced management staff and coordinators and some very loyal shelter staff who are committed to the program. It is a large program with many complexities, compounded by the fact that governance is unsettled and operating policies and procedures are limited. The program staff, through experience, sheer vigilance and flexible funding arrangements, provide a quality emergency placement program. As indicated earlier in this report, the emergency placement needs of special and high needs children and youth are adequately met through a reasonable standard of care by the EPR program, but at an exorbitant cost. This in itself is the dilemma. The challenge will be to maintain the level of care and reduce the cost of care of the shelter program.

One of the most concerning factors is that the transitioning of the EPR program from the WCFS Branch to ANCR is taking such a long time. Along with impeding program development, the slow process has affected human resources making it difficult to hire new staff to fill vacant positions. Because of the ongoing transition process, vacant staff positions are posted as term positions, some for only three months, others for six months; deterring applications by individuals seeking permanent employment. As a result, in May 2008, the EPR program had several vacant shelter coordinator positions, increasing workload demands on the existing staff and creating an incapacity for completing all job tasks. As shelter coordinators assume additional tasks due to vacancies, critical tasks such as consistent staff supervision and performance evaluations are impacted.

Any recommendations involving the EPR program must begin with the acknowledgement that short-term, emergency placement resources are a necessary fact in the child and family services system. Situated at one end on a continuum of out of home placement resources for children and youth, other than foster homes, short-term, emergency placement resources must be distinguished through a unique set of standards that define and guide its purpose. There is a fine line between short-term, emergency placement resources and longer-term placement resources. The success of one is dependent on the effective operations of the other. Short-term, emergency facilities can quickly become longer-term facilities without standards that ensure movement and the availability of appropriate longer-term placement resources for children and youth to move to. In order to promote successful outcomes, the same criteria afforded to longer-term residential placement resources, cannot apply to short-term, emergency resources. To achieve an out of home placement system that has the capacity to effectively meet the emergent as well as longer term placement needs of children and youth, a coordinated, systemic approach to meet this goal is required. The pending transition of the EPR program has delayed any progress to developing a vision, goals and objectives, operating policies and procedures and program planning for the current system. The EPR shelter system continues to operate as it did at the time of the 2004 Shelter Review. As a result, **the OCA makes the following recommendations:**

- **That the Committees proceed in completing the transition process for the EPR program from the WCFS Branch to ANCR Agency. The program has been in a state of limbo for 5 years.**
- **That while the Joint Management Committee for ANCR continues to plan for the transition of the EPR program to ANCR, all program planning and development should occur in conjunction with the centralized office for community resource development located in the DFSH.**
- **That the Joint Management Committee for ANCR request Human Resources to review the model of supervision provided to shelter staff and recommend changes specifically to ensure the availability of supervision across all shifts.**
- **That the Joint Management Committee of ANCR request a financial audit of the EPR program to determine actual costs and develop a plan to reduce the cost of the program yet maintain the quality of care that has been established.**

Responding to the Cost of Emergency Shelter Care

At approximately \$377 per child a day (2007/2008), the cost of living in an emergency shelter facility operated by the EPR program is very high. 85% of this is attributed to staffing costs, with the majority of the cost involving the regular, casual and purchased-service staff working directly in shelter facilities. Anecdotal reports suggest that almost 40% of all staff working inside shelter facilities are purchased from private home care or health care organizations. Recruiting and retaining shelter staff has been difficult. There are numerous career choices for young people in positions that are far less stressful and offer greater financial compensation. The shortage of qualified staff has had a significant impact not only for the children and youth in shelter care but also for the regular staff who find themselves working with purchased service staff who have limited knowledge of the child and family services system and few skills to manage the high care needs of many of the children and youth in emergency care. As a result, it is recommended:

- **That the Joint Management Committee for ANCR commence with a independent review of the use of purchased-service staff to support the EPR shelter and hotel staffing compliment with the requirement that the review confirm the accuracy of purchased-service use reports and develop both a short-term strategy for effectively integrating purchased-service staff into the EPR program without compromising a long-term strategy for phasing out the use of purchased-service staff.**
- **That a strategy for the recruitment and retention of qualified residential child care workers be developed by the DFSH. Consideration should be given to providing educational incentives in cooperation with the RRCC, student mentorship opportunities and salary incentives. A retention strategy for residential childcare workers should be developed in cooperation with the Manitoba Association of Residential Treatment Resources (MARTR).**

Enhancing the EPR Program

Throughout this review, issues arose at certain junctures that may well impede the successful operations of the program. The majority of shelter staff cited dissatisfaction with the training they received to prepare them for the high demands associated with caring for a variety of children and youth with different needs and behavioural challenges. A training model needs to be in place that incorporates

principles of best practice and teaches basic work skills needed to implement job responsibilities in caring for traumatized youth with issues such as substance misuse, self-harming behaviours, gang involvement, high medical and mental health needs. An information system is required that will provide qualitative and quantitative information about the needs of children and youth and provide a framework for evaluating effectiveness and fostering continuous improvements in the provision of services to children and youth in short-term, emergency care. Qualified and competent staff, an assessment of need, effective communication and service plans and service coordination are integral factors that will enhance the current emergency placement system in Winnipeg. Specific to enhancing the existing EPR program, the following recommendations are made:

- **That all regularly scheduled shelter staff receive training in the *Child and Youth Care Workers Core Competency Training* program.**
- **That Non-Violent Crisis Intervention (NVC) training be scheduled on a regular basis and a method developed to advise shelter staff when re-certification is required, similar to the method used to ensure First Aid/CPR re-certification.**
- **That the Systematic Tracking of Emergency Placements (STEP) database, managed by the WCFS EPR unit, is reviewed and either replaced or enhanced for the capacity to generate meaningful data for outcome analysis. Measurable outcomes in health, education, social skills, mental health, behaviour, life skills and family objectives are useful in guiding case managers in developing realistic case plans for family reunification or longer-term care that meets the needs of children and youth.**
- **That responsibility for data entry is assigned to one administrative staff person dedicated to input data and maintain the updated tracking system.**
- **That the WCFS Short Term Emergency Placement (STEP) Committee, a formal body used to review emergency placements within the EPR program and make recommendations for children that are in the shelter system over 30 days, expand to include a standardized process with consistent representatives from all Authorities, the PPD and external representatives from the child mental health system, youth justice and the education system.**
- **That an effective communication strategy be developed to ensure that the EPR Placement Desk is consistently informed of foster bed and alternative bed space availability on a daily basis by all child and family service agencies, in order to avoid an emergency placement if an appropriate longer-term placement resource is available.**

- **That the DFSH expand the provincial Outreach Workers program to include a position designated to the EPR program. This position would be responsible for providing outreach services to children and youth who have run from an EPR program shelter facility.**

Strengthening the EPR Home Manual

The EPR Home Manual provides guidelines for shelter staff in meeting the requirements set out in the provincial Child Care Facilities Licensing Standards, outlines the philosophy and expectations of staff, defines standard procedures for dealing with a number of related incidents and requirements and provides guidelines for staff in addressing common issues in their work with children and youth. Overall, it is a practical and effective tool for staff. The OCA would like to see the *Recommended Resolution Process*; Section 2 a), on page 9 and 10 of the Home Manual amended to remove the statement that, “Children will be encouraged to bring an issue to the attention of the person, (child or CCSW) directly involved in attempt to achieve satisfactory resolution”. It is possible that a child may not feel comfortable in directly approaching the child or staff that he or she has an issue with. It is an unfair position to place a child into. There is further concern with the statement, “If more involvement is necessary, the child may request to express concerns to any or all of the following to achieve satisfactory resolution”. Listed are positions ranging from the child’s caseworker to the Director of the Child Protection Branch. The process is too broad and does not provide actual direction to a child who genuinely needs to get support in resolving an issue. Sub section 2 b) states, “the child may request to contact the Office of the Children’s Advocate. A CCSW should be available to assist the child in this process”. There is no reason why a CCSW may have to be present if the child does not need assistance with the telephone. (Appendix III)

The Home Manual contains a section on Children’s Rights on page 8. This section should be reproduced and posted in a visible location in all emergency shelter facilities. It is a comprehensive list of the rights of children and every child and youth should have access to this. (Appendix IV)

Although all shelter facilities included information on the Office of the Children's Advocate posted in visible locations, no information on *Voices: The Youth in Care Network* was found in shelter facilities for older adolescents. In fact, the majority of shelter staff interviewed for this review were not familiar with *Voices*. The Home Manual should contain a section for staff where the role of *Voices: The Youth in Care Network* is explained. All youth aged 12 and over should be provided with information on this resource for children in care.

6. **That the DFSH develop an effective system of tracking and reporting bed space vacancies in foster care and alternative care, accessible through a secure site to all child and family service staff in the province. This system should have the capability to provide analysis of data for trends and future service demands and outcome measures to monitor effectiveness through comparisons to general population trends. This tracking system should be a part of the larger departmental managed care database.**

Tracking Bed Space Occupancy Across the Province

There is no centralized information system, accessible to child and family service workers, that contains data on bed space vacancies in the province. While there are several smaller information systems that collect and maintain data on agency specific foster homes or alternative placement resources, this information is not available system wide. Access to information on skill level and availability of foster home or alternative care affects the entire child and family service system and may be one of the biggest obstacles to moving children quickly from emergency foster homes and facilities to long-term placement resources.

The DFSH is critically in need of an effective, province-wide integrated data management system that has the capacity to accurately track and monitor foster bed and alternative placement bed occupancy rates throughout the province. Although the CFSIS system was meant to provide this service; its accuracy has been questionable due to such issues as inconsistent data entry. An effective and efficient information system should have the capability to report and analyze data including:

- Monitoring trends in demographics to identify such factors as placement needs, geographic distribution, etc. to assist in long-term planning for an efficient out of home placement system in the province,

- Tracking demographic information to obtain indications of future demands for services, such as teen pregnancies, special needs, etc.
- Tracking medical information including medical histories, medical conditions, diagnosis, prescribed medication, as well as physicians attached to and monitoring the child.
- Collecting comparative and longitudinal information, and
- Outcome measures that allow comparisons to general population trends.

13. The Methodology Used in the Review:

- ❑ An interview was held with the Assistant Deputy Minister responsible for the Winnipeg Child and Family Services Branch to discuss the terms of reference and the process for this review.
- ❑ An interview was held with the Acting Assistant Deputy Minister responsible for the Child Protection Branch to discuss the terms of reference and the process for this review.
- ❑ Two interviews were held with the Managing Director of Operations and Service to obtain background information, previous reports and data. Requested information and data on hotel and emergency shelter usage in the province.
- ❑ Three meetings were held with the Manager of Children's Resources at the DFSH to discuss the Provincial Abuse Investigators Unit, the Licensing Branch and the Provincial Placement Desk. Two telephone contacts followed.
- ❑ Telephone contact with the Provincial Resource Coordinator to obtain recent information on the standardized classification system and the foster care recruitment strategy, "Circle of Care".
- ❑ Interviewed and requested information from the Provincial Placement Desk Coordinator.
- ❑ Attended a meeting with the DFSH Child Care Residential Licensing Specialists. Requested data on Incident Reports pertaining to the EPR system.
- ❑ Interviewed the senior program manager with Winnipeg Child and Family Services (WCFS) responsible for the operations of the EPR unit on two separate occasions. Requested information.

- ❑ Attended a meeting of the Standing Committee and requested names of Authority staff who can be contacts in obtaining information for this review.
- ❑ Requested information on Hotel Usage and Shelter Care data from DFSH Policy Analyst. Reviewed results through telephone and e-mail.
- ❑ Attended meetings on two occasions with representatives from the Southern Authority Network of Care. Requested information and data. Followed up by telephone.
- ❑ Attended a meeting with representatives from the Northern Child and Family Services Authority. Requested information and data. Followed up by telephone.
- ❑ Attended a meeting with representatives from the Metis Child and Family Services Authority. Requested information and data. Followed up by telephone.
- ❑ Attended a meeting with representatives from the General Authority. Requested information and data. A follow-up meeting was held to complete discussions.
- ❑ Two interviews were held with the Program Manager for the WCFS EPR unit. Requested information and data. Follow-up contact by telephone and e-mail.
- ❑ Interviews were held with the Supervisors for the WCFS EPR unit. Requested information and data. Arrangements were made to interview Coordinators, and communicate with shelter staff through the EPR communication system.
- ❑ Attended two meetings with WCFS EPR unit Shelter Coordinators. Scheduled individual meetings.
- ❑ Interviewed six Shelter Coordinators. Requested information.
- ❑ Interviewed 16 randomly selected EPR Shelter staff using the same questionnaire that was developed to conduct interviews with shelter staff for the

initial Shelter Review (2004). Interviews were voluntary and anonymity was assured. Five interviews were held in the shelters where the staff worked.

- ❑ Attended two meetings with the WCFS Accounting Manager to request and review statistical and financial information.
- ❑ Along with Marie Christian, VOICES: Manitoba's Youth in Care Network, designed a plan to interview randomly selected children and youth in the EPR shelter system. Marie was contracted to conduct the interviews and produce a final report. 13 children and youth were interviewed using the same questionnaires that were developed to interview children and youth for the initial Shelter Review (2004).
- ❑ Informally had discussions with over 30 staff members working at different child and family service agencies across the province. Discussions occurred during formal and informal meetings and conferences.
- ❑ Reviewed the provincial statutes, policies, standards including the Child Care Facility Licensing Standard Manual and all other provided reports, meeting minutes and documentation related to services associated with the WCFS EPR shelter system.
- ❑ Reviewed all documentation provided by the WCFS EPR unit related to the operations of the emergency placement system, including human resource management.
- ❑ Compiled and analyzed statistical data relevant to children placed in hotels and the shelter system over the years.
- ❑ Completed a literature review on hotel usage and emergency placements for children in care.

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Until we find a way to deal with the shortage of foster families, it's the best
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Appendix I

Appendix 1

Hotel Placement Provincial Standard

Hotels will not be used as placements for children by agencies of the child and family services system, except in the case of the following exceptional circumstances:

1. in the case of flood, fire, other natural disasters or community crisis that require the evacuation from the residence to ensure the safety of children; or
2. in the case of a public health issue that requires quarantine, restricted movement of affected individuals, or removal from an affected area, to prevent the spread of disease or other serious health conditions; or
3. in the case of sibling groups where there are 3 or more children and there is no other option available to place the children together.

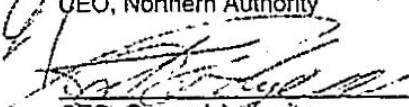
In these circumstances, the Agency(s) must secure child specific approval from their governing Authority prior to the placement of children in hotels. The Authority may delegate approval to an Executive Director of its Agency(s), but this power cannot be delegated to any other individual within an Agency. The Authority or the delegated Agency Executive Director may approve up to 6 nights (in blocks not to exceed 3 nights each) in any 12 month period. Further nights would require daily approval from the Authority. The Authority must be notified in writing of an Agency's decision to utilize hotel placements under these criteria. Written notification of hotel usage under this policy must be forwarded to the Child Protection Branch, who will authorize expenditures only for those placements that comply with this standard for hotel placements.

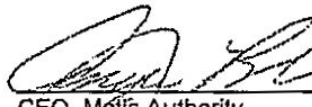
This applies to all children in care.

This standard will be reviewed within 6 months from its effective date of August 1, 2007.

Recommended by:

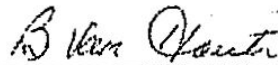

CEO, Northern Authority


CEO, General Authority


CEO, Metis Authority


CEO, Southern Authority

Approved by Acting Executive Director of the Child Protection Branch:



Date

July 25, 2007

Appendix II

A Status Report on the Recommendations made by the Office of the Children's Advocate in the Hotel Review (2000) and the Shelter System Review (2004)

Recommendations from the Hotel Review, May 2000

Five recommendations were made to the Department of Family Services and Housing and the Winnipeg Child and Family Services following the first Hotel Review by the Office of the Children's Advocate. This review was not released to the public; therefore, the recommendations will not be covered in this review. A summary of some of the findings from the first Hotel Review and the recommendations from the second Hotel Review (2000) were included in the Annual Report of the Office of the Children's Advocate for the fiscal year April 2001 – March 2002.

Recommendations from the second Hotel Review, June 2000, titled "Just Another Kid in Care". These recommendations are provided in the Children's Advocate Annual Report 2000-2001

1. Activity money should be provided based on the age, needs and interests of a child

Action: No Change

2. Lunch money should be provided to older adolescents, when appropriate, to allow them to eat meals outside the hotel facilities.

Action: No Change

3. Childcare staff should be assigned to a specific child as opposed to a room.

Action: Rejected

Response: From a general point of view, this recommendation is not feasible due to the cost that will be incurred and from a service perspective. Staffing flexibility allows one staff assigned to one child if the situation requires this.

4. Qualified childcare workers should be assigned to work with high-risk children and youth.

Action: Ongoing

Response:

1. Some child care staff have adequate skills and expertise to work with high-risk children, including those with medical issues.
2. Training is provided for staff who work with children with special medical needs.

5. The Agency (WCFS) should provide administrative supports, including regular on-site supervision of staff, regular staff meetings, and additional training.

Action: Ongoing

Response: A Coordinator has been assigned to work with staff providing care to children in hotel placements.

6. As per standards, social workers should attend the hotels to meet their wards, return phone calls and involve children and youth in case planning.

Action: No Change

7. Children placed should be informed of the Office of the Children's Advocate existence by Agency staff.

Action: No Change in hotel placements

Recommendations from the Review of the Operations of the Winnipeg Child and Family Services Emergency Assessment Placement Department (EAPD) Shelter System, March 2004

Policy Implications

1. The DFSH in conjunction with the four Authorities review the information and demographic data provided in this report, and fully analyze the legislative (regulatory), the policy (service and fiscal) and resource (supportive, supplemental and substitute care) planning implications as it relates to the evolving child and family services system.

Action: Ongoing

- Response:**
- 1. The Shelter Review Implementation Committee (SRIC) was developed to review the recommendations of the Shelter Review and develop an action plan to address them. The Committee ended in June 2005.**
 - 2. A province-wide needs assessment was completed.**
 - 3. A detailed implementation plan was completed.**
 - 4. The implementation plan was given to the Standing Committee for follow up.**
 - 5. Work on several recommendations is in progress.**

Provincial Vision for Out-of-Home Placement Options

2. The provincial continuum of care be re-developed by the DFSH and the Four Authorities to reflect a true continuum and include preventive, supportive services, supplementary services and substitutional care services. Care of children and youth can be provided by the CFS system and or by the families of the children and youth, and as such, should include culturally-appropriate resources that will support and augment the care of a child. Accessibility of services under the continuum of care should not be based solely on a child's care status, and should minimally include:

Supportive and Supplementary Services:

- Preventive services to support children and their families in the community.
- Supplementary services to support children in their families in the community.
- Family Reunification services to support children returning to their families from care.
- Therapeutic Daycare and Emergency and Respite Daycare

Out-of-Home Care Resources:

- Substitutional care services ranging from kinship care, adoptive care, foster care, including therapeutic foster care and family based care settings for siblings.
- Residential care including care settings specializing in variety of high needs service areas including FAS/FAE, drug/alcohol/solvent abuse programs, behavioural challenging child and youth. Bail supervision homes for youth involved with the CFS system leaving correctional facilities on bail but unable to return to their home or previous care setting.
- Shelters (Emergency and Street shelters).
- Facilities (group or individual) for adolescent parents and their children
- Respite care (for parents, kinship, foster, adoptive homes).
- Independent living resources (youth ages 16-21).
- Specialized Care settings (family and group) appropriate for defined subgroups such as English as a second language; physically handicapped, visually impaired and hearing-impaired children and youth.

Action: Ongoing

Response: Child and family service Authorities and agencies are developing both in home and out of home resources that are appropriate to their specific target population groups.

Coordinating Structure

Out-of-Home Placement Resource Co-ordination

3. It is recommended that the DFSH develop, in conjunction with the Four Authorities, a Community Resource Development Office (CRDO) to be housed in the DFSH.

Action: Rejected

Response: The SRIC recommended that the Standing Committee would assume the functions of the CRDO.

4. It is further recommended that the CRDO complete a province-wide community needs assessment of the service providers to find out what resource and service needs are immediately required.

Action: Completed

Response: The SRIC arranged for a province-wide needs assessment of service providers and identified resource and service needs. Both a literature review and a needs assessment was conducted.

Standardized Resource Classification

5. The DFSH through the CDRO develop a standardized classification system for all out-of-home placement resources within the CFS system to evaluate type and quality of care provided amongst similar homes and facilities. The classification system would assist in assessing a child's service needs in relation to the current available resources, while simultaneously identifying gaps that exist.

Action: In Progress

Response: The Alternative Care Sub-Committee is working on a standardized classification system for placement resources.

Provincial Placement Desk

6. The DFSH in conjunction with the Four Authorities redesign the Provincial Placement Desk. A single Desk, managed and co-ordinated through the DFSH should be created. The Desk should incorporate a multi-disciplinary membership, inclusive of the,
- Four Authorities
 - DFSH
 - CFS agency (rotating) membership
 - Child Mental Health
 - Residential care (rotating) membership.
 - Youth Justice
 - Children's Special Services
 - Education
 - Community

Action: No Change

The Desk should allow for additional case-specific members whose expertise can assist in the overall planning for a child to be brought in as needed.

7. Social work staff who are applying for a residential care admission should whenever possible present in person to the desk as well as provide written assessment material. Whenever possible the Desk should travel to rural and northern areas. If this is not economically feasible then all efforts should be made to ensure that agencies are provided the funds to allow their social work staff to travel to make presentation to the Desk or present to the Desk through alternative communication technology (i.e. telephone conference, video conference).

Action: No Change

8. All admissions and discharges from residential care should be under the authority of the Desk. As part of their coordinating roles the DFSH should immediately begin tracking of all residential care breakdowns. Such information should be shared annually with the Four Authorities as well as with the residential care system.

Action: No Change

9. The DFSH post, through a secure site, accessible only to CFS agency staff, all residential care bed openings. This site needs to be kept up to date and include a description of the residential care facility and the program offered. Such information will assist line staff in better planning for their children and youth.

Action: No Change

Provincial Abuse Investigator (PAI)

10. The DFSH create one additional position to investigate allegations of child maltreatment in all forms of residential care licensed by the Province of Manitoba. These positions remain centralized to the DFSH given that it is the department that is the licensing authority.

Action: Completed

Response:

1. An additional investigator was added to the provincial abuse investigators unit in November 2004.
2. Since that time the number of provincial abuse investigators has doubled to four.

11. The PAI should not be bound by the definition of abuse but be allowed to investigate all concerns related to questionable child management practices and provide recommendations for corrective action.

Action: Completed

Response:

1. The Provincial Abuse Investigators now investigate all allegations of inappropriate child management practices and recommend corrective actions.
2. The Provincial Abuse Investigators now review all abuse allegation investigations in foster homes.

12. The PAI should be allowed to make a variety of recommendations, including a person's employee status, as it relates to conclusions reached by the Investigators of the appropriateness of a staff person's individual behaviour and job performance.

Action: Rejected

Response: This recommendation has been rejected after a thorough review of the implications of third party recommendations regarding employment status. Recommendations are made to employers who must deal with bargaining units regarding action on employment status.

13. The PAI be required to investigate all allegations against all staff, either permanent or purchased-services staff, providing care in the shelter system.

Action: Completed

Response: The Provincial Abuse Investigators investigate allegations made against purchased service staff working in licensed residential care facilities.

14. The Agency institute a mechanism to respond to all future PAI reports, outlining corrective actions with stipulated time lines. Further all PAI reports are copied to all required management personnel, including the Human Resource Director in WCFS for information and direction.

Action: No Change

15. The DFSH, as the Licensing Authority, institute a mechanism to track all of the PAI's reports to ensure compliance with recommendations.

Action: No Change

Integrated Services Planning

16. That the DFSH examine the feasibility of creating an Integrated Departmental Services Committee (similar to that of the Inter-Ministerial Provincial Advisory Committee – IMPAC, in Ontario) that would address barriers created through policy that prohibit continuity of planning for children across government service sectors.

Action: In Progress

Response: The Standing Committee created the Interim Child Welfare Intersectoral Committee (CWIC), to develop a work plan for addressing intersectoral working relationships.

Collateral Service Systems

17. The DFSH review the information provided by the OCA with respect to the YECSS system. The DFSH then enters into discussion with the Agency and YECSS to determine if the shelter system is adequately utilizing the YECSS program. Further these discussions continue as the new shelter system is developed to ensure that any new system has ease of access to YECSS resources as required.

Action: No Change

Response: Some meetings were held between the above but discussions are not currently occurring. There is no change to the working relationship between the EPR shelters and YECSS.

18. The DFSH review the information provided in this report as to the shelter's use of Winnipeg Police Service. The DFSH and the Agency then enter into discussion with the WPS to formulate policies and procedures formalizing police response to both the current and future shelter system.

Action: In Progress

Response: The High Risk Youth Committee was established in 2006. This Committee is comprised of representative from several departments of the RCMP, WPS, the DFHS, the WCFS Branch including the EPR department, ANCR, and the Manitoba Association of Residential Treatment Resources (MARTYR).

Cost of Care

19. The DFSH immediately request Internal Audit (IA) to complete a financial management practice review of WCFS, now a branch of the DFSH.

Action: Completed

Response: An Internal Audit was completed in 2005.

From this starting point, the DFSH, in consultation with IA, develop a realistic budgetary process that will take into consideration the actual costs, current and expected needs of the agency's service system.

Action: In Progress

Response: Funding for an emergency care system is part of the province wide budgetary process for child and family services.

20. The DFSH in consultation with IA analyzes current shelter system expenditures and itemizes and documents each cost element.

Action: In Progress

Response: Analysis of shelter system expenditures is part of the transitional planning for the EPR program.

21. Following establishment of the budgetary process, the DFSH in conjunction with WCFS, identify the operational issues of emergency care service delivery and develop a realistic funding formula for the current shelter system.

Action: In Progress

Response: Budgetary planning is part of the transitional planning process for the EPR program to ANCR.

22. Following the resolution of the budgetary process and the establishment of a realistic budget, the DFSH, in conjunction with the Four Authorities, identify the operational issues and create a program model for emergency residential care.

Action: In Progress

Response: Planning is currently underway to transition the EPR program to ANCR.

23. That the DFSH adopt control and responsibility of the current shelter system until the aforementioned recommendations of cost of care have been completed.

Action: Completed

Response: The EPR program is managed by the WCFS, which is a Branch of the DFSH until it is transitioned to become part of the Winnipeg intake system, ANCR. At that time responsibility will shift to the Southern First Nations Authority.

Proposed Amendments to the Current Shelter System

Program Development

24. The Agency obtains the assistance of independent residential care expert(s) to create and document a program model for their current shelter program.

Action: No Change

Response: The Joint Planning Committee for ANCR may utilize independent experts in creating a program model for an emergency placement system in Winnipeg. However, at this time, this has not occurred.

25. The Agency develops a policies and procedures manual reflective of Child Care Facilities Licensing standards, regulations and Child Welfare League of America's best practice standards.

Action: Completed

Response: The WCFS developed the Home Manual in June 2005. This manual is a combination of policies, procedures and step-by-step guidelines and information for shelter staff.

26. The Agency develops the capacity to track internal incident reports

Action: Completed

Response: The Systematic Tracking of Emergency Placements (STEP) database was developed in 2005.

and ensure that all required reports are forwarded to the DFSH.

Action: Ongoing

Response: The capacity of the database is limited and data entry is not maintained because of a lack of dedicated staff and workload demands. As a result, the accuracy of reports generated from this database is questionable.

27. The DFSH and Agency examine the PAI reports and the incident reports to determine if patterns exist that contribute to poor child management practices, and take corrective action.

Action: Ongoing

Response: Although attempts are made to obtain information on corrective actions, the process is inconsistent and without a mechanism in place to do so. Currently it is a “hit and miss” process where shelter coordinators may call to report on the corrective actions taken or the PAI or Licensing Branch may call to ask what corrective actions were taken. The process is handicapped by the absence of a quality information database in both the WCFS EPR program and the DFSH.

Co-ordination and Supervision

28. The Agency should assign a position specifically responsible for coordination and operation of the shelter program. One possible way of achieving this is to remove from the current project manager all responsibility for the implementation of the consolidation plan and reassign to this position the responsibility for coordination and operation. The DFSH continue to support the program through the continued provision of a seconded staff person who should work under the project manager to coordinate the shelter program.

Action: Completed

Response:

1. The Program Manager is responsible for the coordination and operations of the shelter system.
2. A staff, seconded from the DFSH, continues to work with the Program Manager in coordinating the shelter program.
3. An additional supervisory position has been added to the program.

29. The Agency ensure supervisory responsibility of all shelter coordinators be designated to the newly created position responsible for the co-ordination of the shelter program.

Action: Completed

Response: Supervisory responsibility of shelter staff to designated to a management team consisting of the program manager, the seconded DFSH staff and the supervisor.

30. The Agency ensures that all shelter staff has access to supervisory staff across all shifts, as has been implemented within the agency after-hours unit.

Action: In Progress

Response:

1. Some shelter coordinators work an evening shift.
2. The management staff have a rotating On Call schedule after work hours.
3. An On Call Dispatcher is available to shelter staff after work hours. Although this is not a supervisory position, consultations and requests for assistance after hours is provided.

31. The Agency ensures that the shelter coordinators directly supervise all purchased service staff.

Action: No Change

Response: Supervision is indirect and limited to specific issues while the purchased service staff is working in a shelter assigned to the coordinator. Performance issues are reported directly to the private agency that employs the staff.

32. The Agency ensures all shelters have monthly team meetings.

Action: Ongoing

Response: Monthly meetings are not consistent for all shelter coordinators.

33. The Agency undertakes regular site inspections and ensures all shelters meet licensing requirements.

Action: Completed

Response: Shelter coordinators complete regular site inspections and submit the information to the EPR program manager. This information is brought forward to the joint staff – management Health and Safety committee for review and recommendations.

34. The Agency ensures that all shelter staff has on-site access to the agency's internal computer information communication system. This would not include access to the case files but access to email and general agency information for agency staff.

Action: Rejected

Response: The Shelter Review Implementation Committee rejected this recommendation because the cost would be prohibitive. All shelters have facsimile machines.

Training

35. The Agency ensures that all their permanent/casual shelter staff receive CBT for child care workers employed in the shelter system.

Action: Rejected

Response: The SRIC concluded that the implementation of competency based training for shelter staff would neither be practical nor cost effective.

36. Prior to the Agency employing purchased-service agencies to provide childcare in the EAPD system the Agency ensure that all purchased-service staff have successfully completed CBT training. Such training should be made available to these outside agencies, however the costs of the training should be absorbed by the purchased-service agency.

Action: Rejected

Response: The SRIC determined that it would be impractical to require purchased service staff to have competency based training as they may or may not work in the child and family service system. In addition, the expense of this training to private service providers may be prohibitive.

37. The Agency ensures that all shelter coordinators and staff, including purchased service staff, are certified in NCVI.

Action: Completed

Response: All shelter staff and purchased service staff are trained in Non-Violent Crisis Intervention.

Further all staff should be re-certified yearly.

Action: Ongoing

Response: Not all staff are re-certified every year. The EPR program management staff acknowledge that a consistent schedule of NVCI training is needed.

38. The Agency co-ordinate the use of purchased-service staff through one central management position until the use of purchased services can be phased out entirely.

Action: No Change

Response: The supervisory model used in the EPR program has certain limitations, in that casual and purchased service staff in particular, are accountable to a number of different coordinators if they work in more than one shelter.

Human Resource Administration

39. The Agency expands their human resource program to support the shelter system.

Action: Completed

Response: Two positions were added to the WCFS Human Resource Department that support the EPR shelter staff; A Labour Relations Compensation Coordinator and an Employment Equity Coordinator.

All personnel files should be housed in the HR program and be maintained in manner consistent with current departmental standard.

Action: Rejected

Response: The WCFS management reviewed the OCA recommendation to physically store and maintain all EPR shelter personnel files within the Human Resources department and decided that this was not feasible as Shelter Coordinators required regular excess to the personnel files.

40. The Agency, in conjunction with the DFSH, develops administrative HR standards, policies and procedures consistent with departmental standards.

Action: Ongoing

Response: Human Resource standards, policies and procedures for shelter staff are associated with developments and changes to the collective agreement for shelter staff.

41. All shelter coordinators be provided with regular HR training about the current collective agreement and performance evaluations.

Action: Ongoing

Response:

1. All Shelter Coordinators were provided training in working under the collective agreement. This training has to be extended to new staff.
2. The Labour Relations Compensation Coordinator provides regular consultation to EPR management and coordinators.

42. All shelter coordinators and permanent/casual shelter staff receive yearly performance evaluations.

Action: Ongoing

Response:

1. All performance evaluations were completed on shelter coordinators.
2. Performance evaluations are not completed consistently with shelter staff. Improvement is needed in ensuring that all shelter staff receive annual performance appraisals.

Governance

43. The co-ordination and development of any future shelter system serving primarily the City of Winnipeg should rest outside the mandated child and family service system. Governance over the shelter system should come from a non-mandated child welfare agency or authority. The system needs a buffer between those who are placing children and youth, those who are providing care and those responsible for licensing and regulating care. It is a clear conflict for the regulatory bodies and or authorities to license, regulate and provide care. The choice of which system should be brought into overseeing the development of the shelter system in partnership with the DFSH and the Four Authorities is a decision better made as the AJI-CWI process unfolds.

Action: In Progress

Response: Transition planning is in place for the EPR program to move to the ANCR, an agency of the Southern First Nations Authority.

Shelter Standards

44. The DFSH will develop care standards and licensing regulations specifically for emergency shelter care that reflect the CWLA assumptions including:
- No child or youth shall remain in a shelter setting for longer than 30 days. This time line is renewable for one additional 30-day period to allow for continued assessments. No child or youth shall remain longer than 60 days.
 - All shelters shall provide structured programming within a given program outline (ie: recreational, life-skills, cultural programming).
 - Functional assessments shall be completed which can be used to assist in care planning and transition to the new placements.
 - Each shelter will be age appropriate and have a routine and set rules that will promote healthy life and development
 - Provision of competent and regular emergency medical/dental care with attention provided to special medical needs.
 - Employment of qualified and competent staff with at least a two-year child care diploma with experience in behaviour management, crisis intervention and prevention, counseling, and recreation and supervision of children/youth.

Action: No Change

- Response:**
1. The emergency shelter system continues to operate under standards developed for long-term residential care facilities.
 2. The EPR program attempts to meet the 30-day length of stay recommendation, however, this is not regulated.
 3. Programming in shelters is inconsistent and limited.
 4. Functional Assessments on children are not being done.
 2. Rules and routines are appropriate and evident in all

shelters.

3. Medical issues are promptly addressed.
4. Shelters are staffed by individuals with a range of education, training and experience.
5. A high number of staff working in shelters are purchased service staff from private home and health care organizations.

45. The DFSH add one additional position to the licensing program and further ensure annual reviews are completed of all residential care programs in Manitoba.

Action: Completed

Response: A second Provincial Licensing Specialist was added to the Department of Family Services and Housing Residential Facility Licensing Branch in October 2004. Approval to hire a third Licensing Specialist was obtained in May 2008. Several annual reviews are outstanding.

46. The DFSH licensing program review all requests for variances in the shelter program, and complete a site inspection and review of the needs of each child in the shelter prior to issuing the variance. Further the DFSH should give consideration to expanding this recommendation to include all residential care.

Action: No Change

Response: In fact, the process for obtaining variance orders has been simplified to include verbal approvals over the telephone without a site inspection and the delegation of authority to the EPR Program Manager to approve variance requests after working hours. The emergency nature of some placements requires immediate action to ensure children are not left without a placement while site inspections take place.

47. The DFSH require that any variance issued should be posted in the facility.

Action: Completed

Response: Variance orders are posted in shelter facilities.

Staff Competencies

48. Successful completion of Competency Based Training become part of the licensing process of an emergency shelter with respect to staffing qualifications

as is First Aid and NVCI training.

Action: Rejected

Response: The SRIC concluded that competency based training should not be a licensing requirement. Rather, this should be part of professional development plans for staff members.

49. The DFSH build into the funding formula of the EAPD system, current and future, training dollars to ensure agencies can provide CBT training to their staff.

Action: No Change

50. The DFSH review the CBT in order to ascertain if training can be provided through a combination of in class and computer assisted training. Individual computer assisted training can offset the cost of shift coverage and will be less disruptive to the shelter system.

Action: No Change

Response: There has been no commitment to offer competency-based training to emergency shelter staff by the DFSH. However, this issue is by no means inactive as the joint Management – CUPE Staff Training Committee has raised this training in discussions on the training needs of shelter staff.

Group Care Model

Placement of Children

51. It is recommended that no children ages 0 to 7 years of age are placed in any emergency group care facility (with exceptions).

Action: Ongoing

Response: The DFSH created 50 additional emergency foster bed spaces in Winnipeg in 2005, in response to this recommendation. These bed spaces have increased to 165. However, the emergency shelter system continues to place children under the age of 7 in group facilities, particularly members of large sibling groups that cannot be separated.

52. All other group care shelter facilities shall be licensed based upon gender specific age categories,

Primary School age (8-10) up to a maximum bed capacity of four beds.
Pre-adolescents (11 to 13) up to a maximum bed capacity of four beds.
Mid adolescent (14 to 16) up to a maximum bed capacity of six beds.
Late adolescent (16+) up to a maximum bed capacity of six beds.

Action: Ongoing

Response: The EPR shelter system operates gender specific shelters for children over the age of 8. Exceptions to this structure occur when sibling groups of different ages are placed together in a shelter.

53. Youth varying in ages and of opposite gender shall not be placed together. Under no circumstances shall licensing variances be provided which mixes the age groups and gender.

Action: Ongoing

Response: Some emergency facilities outside of Winnipeg are licensed as co-ed and can accommodate either gender. Staff report that precautions are taken to ensure that youth from different genders are not in the facility at the same time. This should be reviewed further.

Staff- Child Ratios

54. All shelters shall operate under an eight to a maximum of 10-hour shift configuration.

Action: In progress

Response:

1. All 24-hour shifts have been eliminated.
2. Most shelter staff continue to work 12-hour shifts, although 8-hour shifts have been implemented in some shelters.
3. Changes in hours of work are complicated by guaranteed hours many staff have secured through bargaining unit negotiations.

55. Child to staff ratio shall be one staff member for every two children/youth throughout all shifts. Particular attention needs to be paid to bringing on additional staff or scheduling of staff during times when incidents would most likely occur.

Action: No Change

Response: There is considerable flexibility in determining staff-child ratios and the needs of the children in the shelter at the time are the biggest determinants of staff-child ratios.

Special Needs Children

56. Shelter settings up to six beds shall be designed to accommodate sibling groups.

Action: Ongoing

Response: The EPR program has two 6-bed shelters that are specifically designed to accommodate sibling groups.

57. Shelters of up to four beds shall be designed to accommodate the physically challenged children and youth. No child under age 7 shall be placed in these shelters unless it is to accommodate a sibling group. These shelters shall be wheelchair accessible and designed to accommodate the special needs of physically challenged children and youth.

Action: Ongoing

Response: One shelter is wheel chair accessible and can be used to care for children with physical disabilities. According to EPR staff, one wheel chair accessible shelter is sufficient. The lease on a second facility is not being renewed.

58. The DFSH enter into discussion with those organizations now providing shelter services and community based programs with respect to expanding street shelter programs (bed space availability) and out-reach program to assist youth.

Action: In Progress

Response: The DFSH created four Outreach Worker positions to work with residential care facilities to locate youth who run from the facilities.

59. Until the CRDO is fully operational, the DFSH and Manitoba Justice enter into discussion to develop emergency care shelters for youth leaving Youth Custody Facilities who are unable to return home or secure alternative care.

Action: Ongoing

Response: Discussions between the DFSH and Manitoba Justice are underway, but no emergency care shelters have been developed for youth leaving correctional facilities.

60. Until the CRDO is fully operational, the DFSH enter into discussion with the Department of Health (Child Mental Health) to develop emergency care services for youth leaving child mental health facilities who are unable to return home or secure alternative care.

Action: No Change

61. Single or two-bed shelters may from time to time be required due to the high or special needs of a child or youth. The system still requires the ability to create this alternative.

Action: Ongoing

Response: There is sufficient flexibility in the shelter care system to develop shelter care specific to special needs of children and youth. The EPR program operates shelters with just one child in them when needed.

Multidisciplinary Team Planning

62. That the DFSH, along with the Four Authorities establish geographically-based multi disciplinary treatment teams to develop comprehensive care and treatment plans for high-needs children and youth. Membership on these teams must also include community members and line social workers from CFS agencies.

Action: No Change

Use of External Specialists

63. The Agency, in conjunction with the DFSH develops the position of Educational Specialist to act as a liaison between the educational system and the emergency care program. The Educational Specialist should have a background in education and policy administration to assist with transitioning children in schools, to support children during this transition, and to assist with the development of educational planning and funding applications where necessary.

Action: No Change

Response: Responsibility for this was given to the Joint Management Group planning for ANCR. There are no reports regarding the status of this recommendation.

64. The Agency, in conjunction with the DFSH, develops the position of Health Specialist to act as liaison between the emergency care program and the public and mental health system. This position would be in addition to their current health care coordinator. The Health Specialist should have a background in public health in order to support to shelter staff in providing health intervention to children with specific medical care needs. The Health Specialist should also be responsible for the provision of ongoing training in health prevention for issues such as communicable diseases.

Action: No Change

Response: Responsibility for this was given to the Joint Management Group planning for ANCR. There are no reports regarding the status of this recommendation.

The Voice of Children and Youth

65. The DFSH ensure that all children and youth in care of a child and family service agency and who are able to understand are made aware of the OCA and that they can request a review of their circumstances through the OCA. This cannot occur on a one-time-only basis but requires a standard directing agencies to inform children and youth of the existence of the OCA.

Action: Ongoing

Response: No formal standards directing agencies to make children in care aware of the OCA was located. However, all shelter staff and most children in shelter care interviewed for this review were aware of the OCA.

66. The DFSH ensure that all child and family service agencies, residential care facilities, treatment centers, foster homes and emergency shelters are provided with rights information, as prepared and authorized by the OCA. Few youth were aware of the existence of Voices Manitoba Youth in Care, the youth-run advocacy group, mentored by the Winnipeg Boys and Girls Club. Youth can and do advocate for one another in an effective manner. Again youth are not able to access this resource if they are unaware of it.

Action: Ongoing

Response: Although information regarding the Office of the Children's Advocate was visible in all EPR shelters that were visited, few

staff or youth were aware of Voices: Manitoba's Youth in Care Network.

67. The DFSH ensure that all youth (ages 14 to 18) in care of a child and family services agency are made aware of the existence of Voices Manitoba's Youth in Care.

Action: No Change

68. The DFSH ensure that all child and family service agencies and regional offices, foster homes, residential care and treatment centers and emergency shelters are provided information about Voices prepared and authorized by Voices Manitoba's Youth in Care.

Action: No Change

The Foster Care System

69. That the DFSH and the Four Authorities implement the above noted recommendations of Judge Linda Giesbrecht.

Action: In Progress

- Response:**
- 1. The responsibility for addressing Judge Linda Giesbrecht's recommendations was given to the Alternative Care Sub-Committee.**
 - 2. The Committee is currently working on the following activities related to the foster care system.**
 - Standardization of emergency rates for foster care.**
 - Standardization of special rates for foster care.**
 - The recruitment and development of new foster homes**
 - The development of a funding strategy to strengthen foster care**
 - Developing a foster parent training program**
 - Review of foster care standards**

70. The DFSH and the Four Authorities work co-operatively with the Manitoba Foster Family Network to develop a province-wide strategy to address the recruitment, support and retention of foster families.

Action: In Progress

Response: A province wide foster home recruitment strategy was announced in October 2006 with an investment of \$6.1 million to improve the foster care system in the province.

71. The DFSH provide the Four Authorities with the financial support to develop one province-wide system to track foster home breakdown. This information will be of assistance to the Authorities to evaluate the needs of children and youth in foster care; evaluate the needs of foster care providers and assist in determining what barriers (case and systemic) contribute to the breakdown of foster care placements from a regional and provincial perspective. This information should be shared annually with the Manitoba Foster Family Network.

Action: No Change

Response:

1. There is no province-wide tracking system in place to accurately and reliably maintain information on foster bed spaces.
2. Foster home breakdowns are not being tracked through a province-wide system.
3. The current system of foster home management does not provide for an organized and consistent communication strategy to share information on available foster bed spaces.

72. That the DFSH support the endeavors of the Manitoba Foster Family Network to complete research determining what supports are needed to retain and support foster care resources. The results of their research should be shared among all Four Authorities.

Action: Ongoing

Response: The DFSH provides support to the MFFN in research, training and advocacy for foster parents in the province.

73. Emergency foster care for children be developed in conjunction with the Four Authorities and existing community agencies who already provide foster care programming to the CFS system. The DFSH will need to review its current foster care system utilizing the standardized classification system of the Community Resource Development Office (CRDO) to ensure consistency in the level of care provided, and that any emergency foster care system complies with Foster Care Regulations and Standards.

Action: Ongoing

Response:

1. Over 160 emergency foster bed spaces were created in

- Winnipeg.**
- 2. All authorities are developing models to recruit, retain and manage emergency foster bed spaces across the province.**

Appendix III

CHILDREN'S RESPONSIBILITIES

At EPR, we believe that with every right, there is the corresponding responsibility to respect the rights of others. The violation of the rights of another may result in consequences for inappropriate behaviours.

Recommended Resolution Process

EPR staff encourages children to Identify and resolve issues that may impede the development of open and supportive relationships between the children or between the staff and children. This fosters the child's progress towards treatment goals and helps maintain a harmonious atmosphere In the group and in the residence.

1. The CCSW will ensure that the child is aware of the EPR resolution process when initially placed in an emergency placement.
2. a) Children will be encouraged to bring an issue to the attention of the person, (child or CCSW) directly involved in attempt to achieve satisfactory resolution. If more involvement is necessary, the child may request to express concerns to- any or all of the following to achieve satisfactory resolution. It is important to note that the process is sequenced in the manner it is, because the belief that the persons with the most information about the situation, the child, and the child's concerns, are often In the best position to resolve the concern:
 - i. the child's staff, any other staff;
 - ii. the coordinator of the home;
 - iii. the child's social worker;
 - iv. the Supervisor of the coordinators;
 - v. the Project Manager/Ass't Program Manager;
 - vi. the Program Manager;
 - vii. the CEO of W.C.F.S.;
 - v. the CEO of the Placing Authority;
 - ix. the Director of the Child. Protection Branch
- b) The child may request to contact the Office of the Children's Advocate. A CCSW should be available to assist the child in this process.
3. The CCSW will advise the child of the availability of Legal counsel through Legal Aid should the issue remain unresolved.

Recommended Resolution Process

4. Where a child or his/her family considers the child's placement in the EPR system as inappropriate, they may contact the child's social worker, that worker's supervisor, the Program Manager, or CEO of the placing Agency and request that the placement be reviewed.
5. Depending on the nature of the child's concern, the child-care support worker may be required to submit specific documentation on the matter. For example, if a child reports that he/she has run away because he wanted to visit his mother, this information would be included In an Incident Report. If a child reports he was mistreated and physically hurt by staff, this would require an Abuse Disclosure Report.
6. A record of all issues and resolutions will be maintained by the EPR system. Copies of all documentation will be forwarded to the EPR Office for filing and tracking purposes.

Appendix IV

CHILDREN'S RIGHTS

The Emergency Placement Resources (EPR) Program recognizes the Importance of providing children with the on-going opportunity to develop judgment and to assume responsibility for the control of their own lives. Child Care Support Workers (CCSW'S) will encourage children to participate in age appropriate decision-making processes, which involve the child's care, education and treatment while in an Emergency placement.

All children placed in EPR are entitled to:

1. The right to be informed of their rights.
2. The right to have all CCSW's advocate for the child's own best interest.
3. The right to physical, emotional, spiritual, social/cultural and intellectual safety and development.
4. The right to adequate food, shelter and clothing.
5. The right to an education.
6. The right to a personal allowance.
7. The right to their own belongings (unless they pose a safety concern for self and/or others).
8. The right to privacy.
9. The right to regular contact with family or guardian (with the approval of the placing agency).
10. The right that their family unit will be supported and. preserved where it is in the child's best interest.
11. The right to receive supervision and discipline in the least intrusive manner possible.
12. The right to be heard and have their feelings and thoughts accepted unconditionally.
13. The right to have their needs recognized and addressed.
14. The right to participate in their own treatment and treatment planning (age appropriate).
15. The right to question, without fear or reprisal, any aspect of treatment.
16. The right to unconditional love, care and acceptance of themselves as a person regardless of their personal strengths and weaknesses.
17. The right to regular contact (at least monthly) with their social worker or designate.
18. The right to a process to express their concerns and have them heard systemically.
19. The right to be informed of the Office of the Children's Advocate, Youth in Care Network, EPR Resolution Process, etc.