



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Not Fully Invested

A Follow-up Report on the Representative's Past Recommendations to Help Vulnerable Children in B.C.

October 9, 2014

Exhibit: National Inquiry into Missing and Murdered Indigenous Women and Girls		
Location/Phase: <u>Part 213 Winnipeg</u>		
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REPRESENTATIVE FOR
CHILDREN AND YOUTH

October 9, 2014

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

Dear Ms. Speaker:

I have the honour of submitting the report *Not Fully Invested: A Follow-up Report on the Representative's Past Recommendations to Help Vulnerable Children in B.C.* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 6(b) of the *Representative for Children and Youth Act*.

Yours sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth
Province of British Columbia

pc: Mr. Craig James
Clerk of the Legislative Assembly

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



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Executive Summary

In the six-year period covered by this review, the Representative for Children and Youth, an independent Office of the B.C. Legislature, has made a total of 148 recommendations – carefully considered prescriptions for how the lives of vulnerable children in British Columbia can be improved.

The Representative has made these recommendations to the bodies that carry the responsibility to protect and provide services to children in this province. As such, the vast majority have been made to the B.C. government and its designates.

Recommendations have been made after completing detailed investigations into individual incidents of death and injury to B.C. children – the kinds of cases from which it is essential to learn. Recommendations have also come as a result of aggregate reviews of such incidents and through careful examination of issues and trends that affect the safety, health and well-being of vulnerable youth in this province. Recommendations have been shaped and advanced strategically by the Representative's Office as we address sectors of the child and youth population that continue to be inadequately served.

This report – the first to track progress made toward fulfilling the Representative's cumulative recommendations – shows that 72 per cent of all recommendations have been substantially or fully implemented.

At a superficial glance, that might seem like encouraging progress. But it is not. We are talking about the lives of children and youth – impressionable, needy and vulnerable youngsters who each deserve the full help, protection and commitment of their government. And in that context, a progress rate of less than 75 per cent is just not good enough.

The Representative does not make recommendations lightly. The 148 recommendations she has made were the result of a total of 22 reports from 2008 to 2013. Each of the Representative's reports require months and sometimes years of research, file reviews, data analysis, interviews with staff and professionals working in the child- and youth-serving field, as well as interviews with family members and young people themselves.

It is critical to know the status of recommendations stemming from these reports, and whether outcomes and long-term prospects are getting better for B.C.'s most vulnerable children and youth. This is not only important for the Representative's Office but for all British Columbians so they are kept informed about how well their government is serving and protecting its most needy citizens.

The need for a critical eye to be placed on B.C.'s child welfare system came into focus with the 1995 *Gove Inquiry into Child Protection in British Columbia* following the death of five-year-old Matthew Vaudreuil. The focus intensified a decade later with the Hon. Ted Hughes' *B.C. Children and Youth Review* in 2006, following the death of toddler Sherry Charlie.



The Office of the Representative for Children and Youth was created in 2007 following the Hughes Review, which re-confirmed the need for oversight that was identified in the Gove Inquiry. The genesis of the Representative's Office lies in these critical investigations into the tragic deaths of children – circumstances similar to those we continue to encounter and investigate and report out on.

Hughes recommended that the Representative should assume an oversight role to *"monitor and report on government's services to children and families, and on the Ministry's responses to child deaths and critical injuries."*

Hughes wrote: *"There is also a need for an external body to push for change to the system from time to time. The Representative will have the authority, the expertise and the resources to study the child welfare system from an informed but external perspective and recommend change where needed."*

The *Representative for Children and Youth Act (RCY Act)*, gives the Office the authority to publicly report on designated services for children and youth and offer recommendations for change.

The vast majority of those recommendations have been made to the Ministry of Children and Family Development (MCFD) and its designates, including delegated Aboriginal Agencies (DAA), with others going to a number of other provincial ministries, the government of B.C. as a whole, and public bodies such as policing services, Aboriginal organizations and other independent offices of the Legislature. Recommendations have been made with careful consideration of the experiences of children and youth and their families and also of the experiences and knowledge of the staff who work in the field.

A close look at the status of the Representative's recommendations since 2008 shows that public bodies, including MCFD, have generally been willing to follow through on recommendations that addressed needed changes to policy, standards or procedures, or compliance in these areas – vital changes required to improve service systems and their delivery.

However, it is important to look at the recommendations that government has not implemented and to ask why not. What has been the impact of government decisions to ignore important recommendations?

The answer to this question is troubling to the Representative. Of the nine recommendations made to the B.C. government as a whole – the ones that require the greatest cross-ministry involvement and organization – seven have been largely disregarded. These include several significant recommendations that are central to improving the lives of B.C.'s vulnerable children and youth.

These are the recommendations that require overarching accountability, leadership and commitment from the provincial government and the fact they have been ignored is both deeply disappointing and the most striking finding of this report. It has been too easy for government to use the notion that child welfare "is difficult work" as an excuse for not tackling it with the determination and resources required. Difficult work is done willingly by those on the front lines of the system. Organizational leadership and



the adequate deployment of resources – things that have too often been lacking on government's part – demand the same level of commitment.

Unaddressed recommendations include a call for a provincial strategy and action to reduce child poverty. It is unacceptable that B.C. has consistently had one of Canada's highest child poverty rates and yet there has been no concrete, over-arching action plan to address this glaring problem in our province. Living in poverty deeply affects long-term outcomes for children, both physical and mental. Leadership is desperately needed in B.C. to tackle this problem with the urgency it requires.

Similarly, the B.C. government has failed to act on a recommendation for a comprehensive plan to tackle the complex issue of youth mental health. Most British Columbians know someone who is affected by a mental health problem. In a number of reports, the Representative has identified the inability of B.C.'s mental health services to respond appropriately and effectively to the needs of children and youth and yet the problem persists. In *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*, the Representative's top recommendation was for government to provide the necessary leadership and accountability on this file by creating a Minister of State for Youth Mental Health. Government has ignored that recommendation and failed to address this area as a whole in any meaningful way.

Children living in situations of domestic violence are dramatically affected by what they see and hear, yet the government's response to recommendations on domestic violence has been weak, lacking clear outcomes, time frames and measurements of success. In addition, poverty and unemployment are clear risk factors for domestic violence, but the government's three-year domestic violence plan, which is long on generalities and short on resources, ignores these risks.

It has long been known that Aboriginal children and youth are grossly over-represented in the B.C. child welfare system. Despite comprising just eight per cent of the total B.C. child population, more than 50 per cent of the children in government care are Aboriginal.

The Representative has issued a number of reports that have identified concerns about the well-being of Aboriginal children and youth, but subsequent recommendations have resulted in slow response and little commitment to a dedicated focus on this issue – from either the federal or provincial government.

A major focus of the Representative's recommendations since 2008 has been on quality assurance and outcomes reporting. The Representative believes that it is essential for MCFD and other government bodies to track performance in serving children and youth and to be able to say, with certainty, that performance is improving.



Disappointingly, this report finds that it is still not possible to say with certainty whether things are getting better for B.C.'s vulnerable children and youth. The demand for RCY advocacy services and reports of injuries and deaths remain consistently high. MCFD's ability to measure performance and publicly report on whether it is achieving results has remained inconsistent and inadequate. The lack of quality assurance and outcomes reporting is yet another sign of a gap in overall government leadership in this area.

The Representative's work as an oversight body for child welfare in B.C. is grounded in the concept of government serving as the prudent parent of all children in its care. The test is: What would a prudent parent do for his or her child? Government has a duty, at a minimum, to meet that standard for the children and youth in its care.

A big part of that duty is to step up and fill the gaps identified by the Representative, an expert independent body that carefully considers the B.C. child-serving system and determines what is missing and what is required. Those careful considerations result in report recommendations. While the B.C. government is not compelled by legislation to follow our recommendations, to do so shows commitment and makes good sense – for the good of children, youth and families in our province.

Considering what is at stake, government can and should do better.



Introduction

The Representative issues public reports for two main reasons: to improve services for children, youth and their families; and to learn from children's experiences in order to better support all vulnerable children. The Representative's reports often contain recommendations to assist government, public bodies and service providers in improving services and outcomes for children and youth in B.C.

Section 6(b) of the *RCY Act* makes the Representative responsible for monitoring, reviewing, auditing and conducting research on the provision of designated services, making recommendations to improve the effectiveness and responsiveness of these services, and commenting publicly on any of these functions.

This report is the first comprehensive review of progress on these recommendations and includes the Representative's assessment of how government and other public bodies have responded to the recommendations contained in reports released between Jan. 1, 2008 and Dec. 31, 2013.

It is the Representative's role to monitor and report on the child- and youth-serving system and to make recommendations for improvement. It is the government's responsibility to respond to those recommendations. This report enables the public to hold government accountable for its performance in operating the system and provides an important reminder to the public and the government about critical deficiencies that are yet to be addressed. Have MCFD and other ministries changed their policies and practices as a result of recommendations? Can government speak with confidence about improvements it has made and whether children, youth and their families are better served as a result? These are the questions this report seeks to answer.

During the six-year period ending Dec. 31, 2013, the Representative issued 22 reports containing 148 recommendations. These recommendations have strategically addressed the services provided to our most vulnerable children and youth and have been directed to several different government ministries and other public bodies. They have targeted a number of key areas identified through the Representative's work, including services to Aboriginal children and youth, domestic violence, mental health and planning for children in care.



The Representative is concerned that several key recommendations to government have not been implemented, or even accepted. This report reviews those recommendations and identifies why some remain unaddressed.

While implementation of recommendations is a measure of government responsiveness to oversight, the most important measure for assessing services for children and youth is whether or not services and outcomes are getting better. This report summarizes the types of service quality and child outcomes data available, recognizing that there remain serious weaknesses in MCFD's ability to assess whether services for children and youth are improving.

This report enables the Representative and the public to determine to what extent government has listened to and acted upon advice provided by the Representative's Office.



The Representative's Independent Oversight

There is an inherent power imbalance between children and youth and the systems in place to serve them. There are many interests at play in the management and delivery of services, and in some cases the best interests of children and youth do not receive adequate attention. The independent oversight of the Representative is intended to focus the attention of service systems, elected representatives and the public on what is most important – how well vulnerable children, youth and their families are supported.

In his 2006 independent review of B.C.'s child protection services, Hughes stressed the need for external oversight to restore public confidence in child welfare services and recommended external oversight of those services through the creation of the Office of the Representative for Children and Youth. Government implemented this recommendation in 2007 with the passing of the *RCY Act* which established the Representative's mandate.

The Representative is independent from the governing party of the day, appointed by and accountable to the B.C. Legislature and reports to the Speaker. The Representative appears regularly before the Select Standing Committee on Children and Youth (SSCCY) to present and engage in dialogue on the Representative's activities and findings. SSCCY meetings provide a public forum in which the Representative can promote greater awareness of the performance of the child-serving system and highlight areas of particular concern.

The Representative's oversight mandate extends to reviewable and designated services identified in the *RCY Act*, including but not limited to:

- family support
- child protection
- foster care
- adoption
- guardianship
- children and youth with special needs
- early childhood development and child care services
- mental health and addiction services for children
- youth justice
- services for youth and young adults during their transition to adulthood
- CLBC services for young adults between their 19th and 24th birthdays.



Oversight Activities

Children, youth and families receiving services often face multiple challenges and are among the most vulnerable members of our society. They often do not have a voice or means to share their service experiences or comment on how well services are supporting them. The Representative undertakes a variety of oversight activities that help to refocus service-delivery systems on the best interests of vulnerable children and youth and how to respond appropriately to them.

Advocacy

In some cases, children, youth and their families require support in order to receive services as they should and ensure that they are treated fairly. From April 1, 2007 to March 31, 2014, the Representative's Office opened 11,761 advocacy case files. Oversight in the form of advocacy for individual children and youth helps ensure that they, and those who care for them, have the information and support required to interact as successfully as possible with services. RCY advocates work to ensure that services meet expectations outlined in government policies and standards. In this way, advocates provide on-the-ground oversight on a daily basis.

When advocacy is provided for many children and youth over a period of time, analysis of their challenges with services can bring to light systemic issues that need to be addressed. This window into system-wide challenges assists the Representative in determining the service-delivery monitoring activities to undertake to ensure that government services are meeting the needs of those they serve.

Monitoring the Service System

Service systems and those responsible for them should be accountable for the quality of services and the outcomes they achieve. The Representative provides independent oversight to track and assess changes in the overall service system that affect service quality and outcomes for children and youth. The Representative also carries out reviews, audits and research activities on specific services and performs on-going monitoring of government approaches to delivering and improving services for children and youth, in areas such as:

- governance and leadership
- organizational and service-delivery structures
- policy, program development and service delivery
- quality assurance and accountability
- other identified areas of concern as required, such as the impact of the Integrated Case Management (ICM) system on child protection services.

The Representative's monitoring activities result in public reports identifying challenges within the child-serving system and making recommendations for improvement. The Representative strategically targets these



monitoring activities to pressing issues with services based on input from the public, systemic issues identified through advocacy and investigation activities and expert advisers.

Reviews and Investigations of Critical Injuries and Deaths

The Representative has a mandate to review and investigate critical injuries and deaths of children who have received services or programs under the *Child, Family and Community Service Act (CFCS Act)* and *Youth Criminal Justice Act* as well as mental health and addictions services for children.

The Representative receives reports of injuries and deaths from MCFD and DAAs, and reviews all incidents of particular concern. Between June 1, 2007 and Jan. 31, 2014, RCY received 1,555 critical injury reports and 628 death reports. Some reviewed incidents go on to full investigations that include interviews of witnesses. When children and youth receiving public services suffer injury or death, independent review and investigation provides unbiased reporting on what happened, why, and what can be done to prevent similar tragedies in the future, both for individual cases and in aggregate.

The Representative publishes reports and recommendations based on individual investigations of critical injury and death as well as aggregate reports on a number of cases with similar characteristics. Similar to the advocacy function, results of an aggregate review or individual investigation can highlight a concern that requires further analysis of the wider service system's responsiveness and effectiveness.

Reports and Recommendations

The Hughes Review recommended that "*the Representative provide advice and recommendations ... through annual reports and special reports.*" While annual reports provide summaries of the Representative's activities, special reports are presented to the Legislature, the leaders of ministries and other public bodies and the public with findings of oversight activities.

In developing reports and recommendations, the Representative takes into account input from children, youth and families as well as from professionals working with them on the front lines. These reports assess how well services are addressing the needs for children, youth and their families, draw attention to the experiences of those receiving and delivering services, and make recommendations with the intent to foster real improvements in the child- and youth-serving system.

Following the release of a report, the Representative presents the report's findings and recommendations to the SSCCY. The Representative also tracks the implementation of recommendations and reports on their status in annual reports to the Speaker. The Representative informs the SSCCY of concerns regarding lack of implementation and reports on the overall implementation status of recommendations in annual reports.

In some cases, the same concern appears in multiple reports over time, pointing to weak links in the service system as well as to demographic groups such as Aboriginal children and youth who are chronically underserved. The Representative has strategically referred to or repeated previous recommendations in current reports when government has failed to act on those issues.

The Representative's oversight activities, including reports and recommendations, hold government accountable, promote public accountability and both spark and influence fundamental change and improvement in the system of services for children and youth.

Lessons from Other Jurisdictions

While focused on oversight activities here in B.C., the Representative takes into account lessons from oversight activities elsewhere. For example, an emerging body of literature from other countries speaks to the risk of oversight processes having unintended consequences. Implementation of recommendations focused on standardizing practice can result in an overburdening of front-line staff with "check-box" procedures that get in the way of genuine connections and the use of professional judgement with children, youth and families.¹ The Representative recognizes that it is critical to be aware of what is happening on the ground and to connect recommendations with the realities experienced by front-line staff and the children, youth and families they serve.

A number of studies have also found that focusing on recommendations that are relatively easy to implement can mean that the underlying systemic issues that are important to more fundamental change can get sidelined.² The Representative has found that government is more likely to act on recommendations regarding policy, procedure and standards than on those that require collaborative change across government.

Oversight Environment

As MCFD receives the majority of the Representative's recommendations, it is important to understand the relationship between MCFD and the Representative's Office during the time frame of this report. Leadership sets the tone for any organization, and has been highly influential in how MCFD has responded to the Representative's oversight activities.

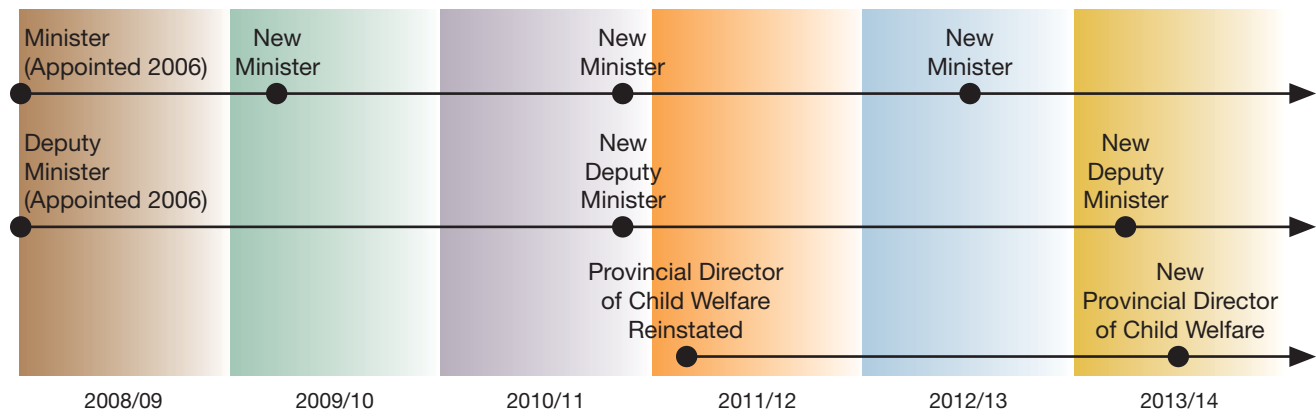
Between 2008 and 2011, MCFD had three different ministers. One deputy minister led the organization throughout this period. A new premier took office in 2011, and another minister and two deputy ministers have been appointed between the beginning of the new premiership and the end of 2013. In total, MCFD has had four different ministers and three different deputy ministers since the Representative's Office was established.

¹ Munro, E. (2011). *The Munro Review of Child Protection: Final Report*. London: Department of Education.

² Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2013). *New learning from serious case reviews: a two year report for 2009-2011*. Department of Education.



Figure 1: Changes in MCFD Leadership 2008/09 to 2013/14



The period between 2008 and 2011 was marked by the ministry's general disregard for the Representative's oversight. MCFD was also slow to respond to the recommendations of the 2006 Hughes Review on B.C.'s child welfare system. In 2010, the Representative's final report on the implementation of the Hughes Review recommendations found that *"the ministry's lack of overall success in meeting the aim of the review remains a major concern."*

During this period, discussions with MCFD regarding report findings and approaches to acting on recommendations were limited. MCFD's focus during this time appeared to be on transforming its service-delivery system, with minimal consideration of the role and potential benefits of external oversight.

The time period under this deputy minister was marked by a move by MCFD to decentralize to more autonomous regional structures and a blending of previously distinct service lines. Both of these actions eroded the accountability of MCFD at the provincial level. It was also a period without a provincial director of child welfare – a key leadership role that had previously been accountable for the provision of services under the *CFCS Act* and for ensuring consistent, quality practice throughout the province.

The years from 2006 to early 2011 were, for the most part, a lost opportunity to address issues raised by external oversight, first by the Hughes Review and later by the Representative.

In addition to the general disinterest in oversight described above, in 2010 MCFD and the Office of the Premier failed to comply with their statutory duty under the *RCY Act* to provide the Representative with Cabinet submissions associated with the Child in the Home of a Relative (CIHR) program and its replacement, the Extended Family Program. In this case, MCFD and the Office of the Premier failed to comply with their duty to provide all information necessary for oversight to be exercised by the Representative's Office. The Supreme Court of B.C. ordered the Province to comply, and information has since been appropriately shared.



In 2011, a new minister and deputy minister were appointed. The deputy minister soon announced a direction of incremental change and a departure from the "transformation" approach of the previous leadership that had consumed significant resources, caused instability, and eliminated the internal oversight mechanisms that were in place to ensure quality service delivery. Service lines were clarified and a process of rebuilding MCFD began.

The deputy minister also announced that MCFD would review all of the Representative's reports and recommendations from 2007 through 2010 and discuss with the Representative the findings, themes and status of the recommendations. Moving forward, the position of a provincial director of child welfare was re-instated and played a central role in responding to recommendations from the Representative.

The ministry produced an *Operational and Strategic Directional Plan* for the years 2012/13 to 2014/15, which has since been updated annually. In 2012, MCFD began issuing policies and practice directives to address a wide variety of service issues. While the Representative continues to have many concerns about the quality of MCFD's services, leadership since 2011 has set a much clearer course for the ministry and has been much more responsive to recommendations from the Representative.

The contrast in MCFD's attitude toward external oversight in the two periods described above underlines the importance of the context in which the Representative carries out mandated oversight activities. Government and its ministries must respect and see the value of oversight if meaningful change is to be achieved.

Government and oversight bodies must each maintain their independent mandate but, as the Hughes Review indicated, they must also work in a "*spirit of cooperation and collaboration*." Had MCFD been responsive to oversight and consistent in addressing issues raised beginning in 2006, it could have achieved significant progress and children and youth could now be experiencing the benefits of improved services as a result.

MCFD Budget

No one ministry alone dictates government priorities. Government as a whole must commit focus and dedicate the resources needed to make services for children and youth better in relevant ministries.

MCFD's annual budget was reduced by more than \$37 million between 2008/09 and 2013/14 – this amounts to a nearly \$100-million reduction in its budget³ when accounting for inflation. It is difficult to improve services on a shrinking budget.

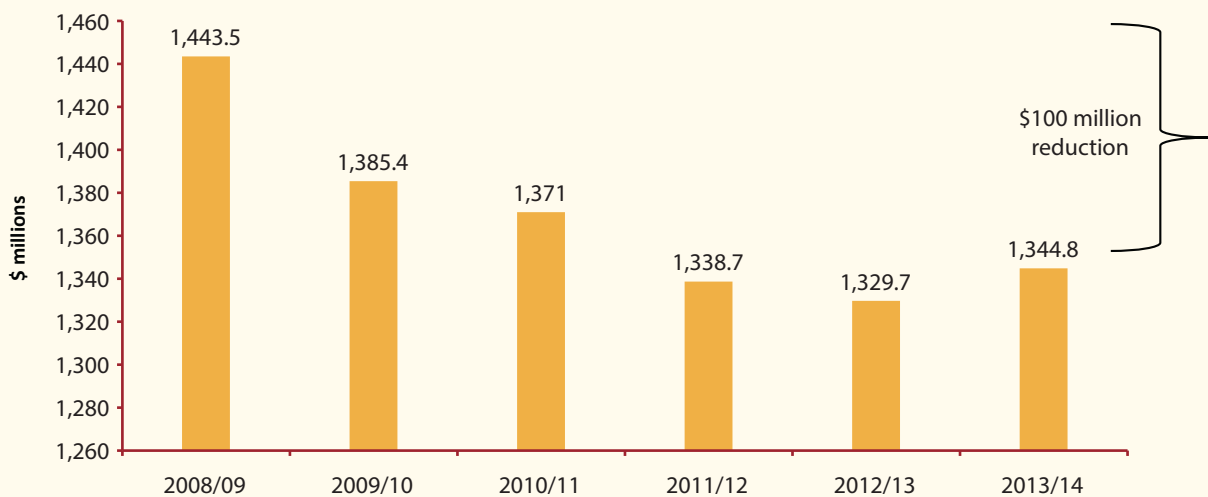
While a willingness to accept oversight and act on recommendations is crucial to service-delivery improvement for B.C.'s most vulnerable children, government's lack of financial commitment since 2008 has also no doubt played a major role in its failure to meet key recommendations by the Representative.

³ Calculations based on the restated estimates for MCFD's budget from MCFD Service Plans (BC Budgets 2009 to 2014) and adjusted for inflation (2013/2014 fiscal year dollars) using the Consumer Price Index for B.C. by Fiscal Year (Statistics Canada).



The Representative observes that this failure to implement key recommendations presented between 2008 and 2013 occurred during a time of budget restrictions and staffing freezes. The Representative believes there has been a deterioration in MCFD's five core areas of service during this period due to these staffing and budget shortfalls.

Figure 2: MCFD Budget Adjusted for Inflation (2008/09 to 2013/14)



Note:

1. Figures are based on MCFD Service Plans, Restated Estimates (BC Budget 2009-2013)
2. Adjusted budget are based on BC Stats, Consumer Price Index (CPI) for BC (2008/09 to 2013/14)
3. Figures are adjusted based on 2013/14 base dollars

Reports and Recommendations

Representative's Reports

The 22 reports reviewed in this document are comprised of investigations into individual cases of critical injury or death or audits and reviews of service systems. These reports have centred on aspects of MCFD's six service lines and focussed on specific topics that include child safety, domestic violence, mental health, service coordination and planning for children in care.

The Representative weighs a variety of factors to determine whether a report is warranted, and what kind of report is appropriate in the specific circumstances.

An investigation into an individual case of injury or death may proceed if the case illustrates an issue the Representative believes should be scrutinized to help prevent similar injuries or deaths in the future. Aggregate reports on injuries and deaths enable the Representative to review and make recommendations on issues that appear across multiple cases.

Reports on reviews and audits into an aspect of the child- and youth-serving system result when an issue has been identified. Such concerns can come from a variety of sources, including members of the public, through analysis of issues that present in the Representative's advocacy services and through recurring systemic issues identified in reviews and investigations of injuries and deaths.

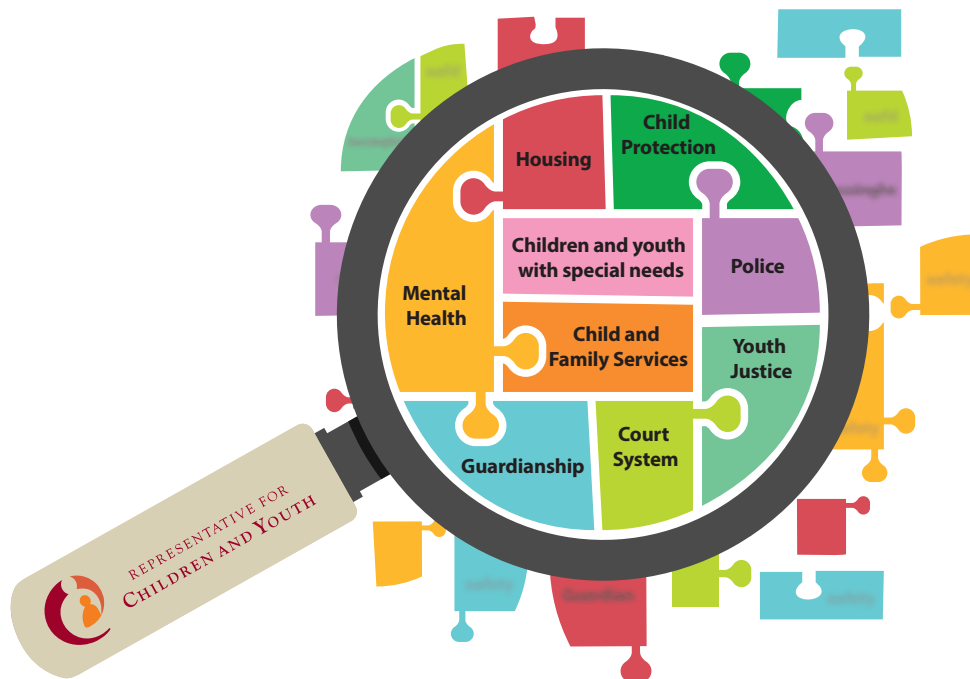
The Representative also releases research reports that focus on vulnerable children and youths' long-term interaction with services such as youth justice, education, health and income assistance. The intent of these reports is to bring attention to how the experiences and outcomes of vulnerable children and youth differ from those children and youth in B.C.'s general population. Research reports highlight areas where government should be focusing its attention to improve the health and well-being of vulnerable populations overall.

About three-quarters of the Representative's reports between 2008 and 2013 focused specifically on children and youth in government care or children, youth and their families who had been involved with MCFD and DAA child protection services, including related family support services. This focus on children and youth involved with MCFD and DAAs stems from the Representative's mandate and the fact that all of the critical injury and death reports involve children (or their parents) who have received services from MCFD or DAAs. While many reports addressed issues related to Aboriginal children and youth – this population has been strategically targeted for oversight by the Representative's Office because it has been poorly served – two reports specifically focussed on this group.



Reports from the Representative have looked at nine over-arching service areas. They have focused primarily on child protection, guardianship, child and youth mental health services and services to children and youth with special needs. Other service areas addressed include youth justice services, the court system and housing. A number of reports covered multiple service areas.

Figure 3: Service Areas Addressed by RCY Reports



Recommendations – What did we find?

In the period covered by this review, the Representative's reports included 148 recommendations to address concerns about services to children and youth (a full list of reports and status of recommendations appears in Appendix 1). About half of the reports contained recommendations related to the following issues:

- a lack of appropriate policy, standards and procedures required to guide services and practice
- the need to change practice by shifting the culture or focus of an organization or service
- gaps in services.



About one-third of the reports contain recommendations addressing:

- poor collaboration and coordination among services
- governance concerns
- inadequate quality assurance
- service quality not meeting expectations, including lack of compliance with existing policies, protocols and standards.

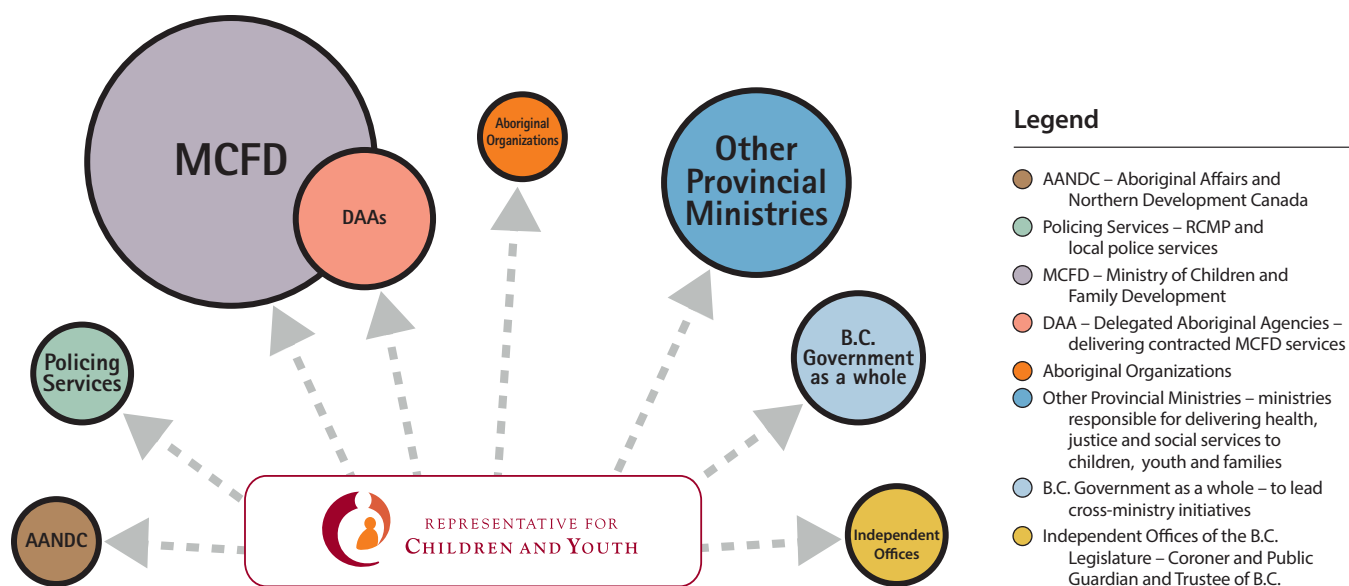
Over time, two concerns were consistently raised in the Representative's reports – the need for new or improved policy, procedures and/or standards to guide practice, and the lack of compliance with existing policy standards.

The Representative's reports have also recommended a range of actions that public bodies can take to improve services and outcomes for children and youth. More than one-third of recommendations called for actions to better collect and report data on services or to improve quality assurance activities. The ability to collect, analyze and report on service and client data is essential for managing, improving and being accountable for services to children and youth.

One-third of recommendations called for actions to improve guidance to staff and service systems through the creation or refinement of policy, procedures or standards. About one in seven recommendations called for employee training to increase capacity within the child- and youth-serving system.

Responsibility for child and youth well-being goes beyond that of a single organization or ministry. Reports by the Representative have made recommendations to 15 different organizations. While about 75 per cent of the Representative's recommendations have been made to individual organizations, 25 per cent called for coordinated action from two or more organizations. This speaks to the fact that public bodies often share responsibility and need to work collaboratively if positive change is to occur.

Figure 4: Organizations that Received Representative's Recommendations



By far the majority of recommendations – more than 80 per cent – were made to MCFD, either as the sole recipient or in conjunction with one or more other organizations. This is in part due to the Representative's mandate and in part because MCFD has responsibility for the majority of community-based child and family services identified in the *RCY Act*.

Importantly, nine recommendations were made to the government of B.C. as a whole, rather than to an individual ministry or public body. These sought system-wide improvements in services to children and youth that required leadership and commitment at the highest level.

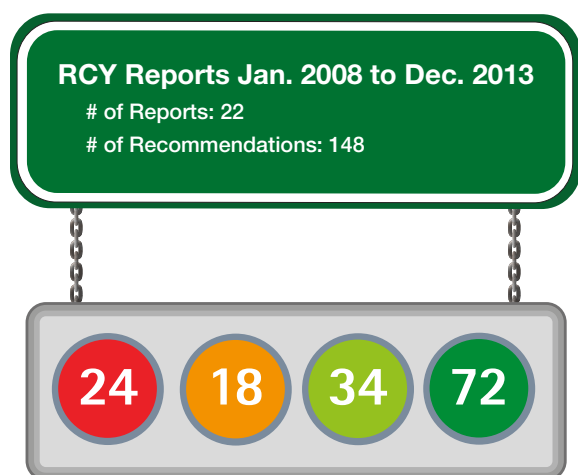
Responsiveness to Recommendations

Implementation of Recommendations

As of the end of March 2014, public bodies (provincial government ministries and other public organizations such as the BC Coroners Service, police, the Public Guardian and Trustee of BC and Aboriginal Affairs and Northern Development Canada) had made substantial progress on or fully implemented about two-thirds of the 148 recommendations covered in this report. On the other hand, no progress at all was made on 24 of these recommendations (see Figure 5).

Specifically, government has not been responsive to recommendations that have called for significant system change that cuts across ministry mandates and requires inter-ministerial coordination and commitment. Of the nine recommendations made to the B.C. government as a whole, seven have been largely ignored (see Figure 6). These include the call for a plan to reduce child poverty in B.C., much needed improvements to services for Aboriginal children and families, the need for government accountability and the lack of a comprehensive system of services for youth with mental health challenges.

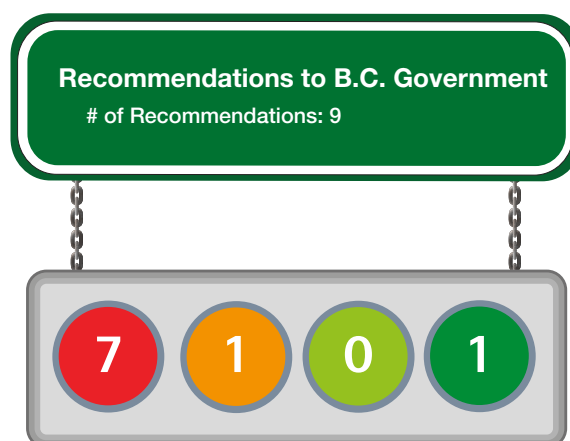
Figure 5: Status of RCY Recommendations



Note:

- No progress on recommendation
- Some progress on recommendation
- Substantial progress on recommendation
- Recommendation fully implemented

Figure 6: Status of Recommendations to B.C. Government





The only recommendation made to government as a whole that has been fully implemented is the expansion of RCY's advocacy services to include children and youth with neurodevelopmental disorders and their families from birth to age 24. While some progress has been made on recommendations regarding domestic violence, progress is not good enough. The Representative is extremely concerned about this lack of action from the highest levels of public leadership in B.C.

Government Response Example

GOOD

Report Title: *Kids, Crime and Care – Health and Well-being of Children in Care: Youth Justice Experiences and Outcomes*

Recommendation #5: That every school in British Columbia assign a single staff person to oversee education planning, monitoring and attainments of the children in care that attend their school. This function should be in place and functioning by September 2009.

FEB 2009

Report Released

MAR 2009

Ministry of Education (MOE) states intent to partner with MCFD to implement recommendation.

JUNE 2009

MOE advises Superintendents of Schools of recommendation and ministry's support to implement it.

SEPT 2009

MOE and MCFD distribute information to school districts about children in continuing care.

FEB 2010

All districts have a person in each school to monitor success of children in care and promote appropriate interventions.

AUG 2012

Recommendation is fully implemented.

MCFD and other government ministries and public bodies have generally been responsive to recommendations that addressed inadequate policy, standards or procedures or compliance in these areas, but the record has been poor on recommendations addressing concerns related to gaps in services for children and youth. Only seven of 15 recommendations that identified such gaps have been substantially or fully implemented, while just three of seven recommendations on the governance of services for children and youth have been substantially or fully implemented.

Implementation of recommendations addressing collaboration and cooperation among service providers has also been relatively weak, with just over half of such recommendations seeing substantial progress or full implementation.

Of the 89 recommendations made solely to MCFD, the ministry made good progress on or fully implemented more than three-quarters (69) of them. More than two-thirds of the recommendations made jointly to MCFD and one or more other public bodies were

substantially or fully implemented. Just over half of the recommendations made to public bodies other than MCFD were substantially or fully implemented.



Key Recommendations that Remain Unaddressed

The Representative is concerned about the risks posed to children and youth by the lack of progress on a number of important recommendations involving domestic violence, poverty, mental health and vulnerable Aboriginal children and youth. These recommendations, in particular, have been strategically advanced because they represent significant shortcomings in service to vulnerable children and youth.

Recommendations that require the coordination of more than one ministry or other public body cannot simply be ignored. These recommendations are a key to changing systems of services that impact the present and future well-being of children and youth.

Committed and concerted action in these areas is necessary if we are to prevent children and youth from falling behind their peers, falling into or being stuck in poverty, being left at risk in homes with domestic violence, or suffering from mental health challenges without proper support. Failing to address the gross over-representation of Aboriginal children in care of the government in a meaningful way will also ensure that this vulnerable population continues to suffer significantly poorer outcomes than other B.C. children.

Government Response Example

INADEQUATE

Report Title: *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence*

Recommendation #3: That the Ministry of Attorney General undertake a review and enact necessary changes to improve the administration of justice in criminal matters involving domestic violence, including establishment of domestic violence courts, to better protect the safety of children and their mothers.

SEPT 2009

Report Released

APR 2010

Representative requests update on implementation of report recommendations.

MAY 2010

Ministry of Public Safety and Solicitor General indicates that specialized domestic violence courts will not be created.

MAR 2012

Representative releases *Honouring Kaitlynne, Max and Cordon: Make Their Voices Heard Now*, another report on a domestic violence tragedy, and renews call for specialized domestic violence courts.

FEB 2014

British Columbia's Provincial Domestic Violence Plan commits to "working with the judiciary and other justice system partners to explore the development of a framework for domestic violence courts."

Children in Situations of Domestic Violence

The Representative investigated the deaths of children in situations of domestic violence: *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence* (2009) and *Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now* (2012).

Both of these reports called for co-ordinated, effective and responsive systems that meet the safety needs of children involved in situations of domestic violence (see Figure 7).

Government did create a Provincial Office on Domestic Violence, although the Office is under-resourced and cannot compel the inter-ministerial cooperation necessary to advance this important work.

The government's three-year domestic violence plan launched in February 2014 does not address the role of key risk factors for domestic violence such as poverty and unemployment. It also lacks clear outcomes, concrete time frames, and measurements of success, and there has been no real progress on the creation of specialized domestic violence courts that were first recommended by the Representative in 2008.

Two years after the release of *Honouring Kaitlynn, Max and Cordon*, there had been "some progress" on half of the report's recommendations. However, a solid foundation is not yet in place for implementing them. Given the risk associated to children witnessing domestic violence, "some progress" is not good enough.

Research shows that, compared with Alberta and Ontario, B.C.'s response to the needs of children in situations of domestic violence is underfunded and limited in scope. For example, the Ontario Coroner has a Domestic Violence Death Review Committee (DVDRC) that has been conducting annual reviews on domestic violence deaths for 10 years.

Figure 7: Key Recommendations from *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence* (2009), and *Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now* (2012)

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<p>That the government of British Columbia take the following actions to demonstrate a renewed and serious commitment to protect children who are exposed to or are living in circumstances of domestic violence:</p> <ul style="list-style-type: none"> Adequate additional funding Appointment of a permanent lead or agency of government with sufficient authority across government to be accountable for delivering on a comprehensive approach Continuous evaluation and regular public reporting of outcomes. 				



Children and Youth Experiencing Mental Health Challenges

Prior to the April 2013 release of *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*, the Representative had identified in a number of reports concerns about the capacity of the Province's mental health services to meet the needs of children and youth:

- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm (2012)*
- *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children (2013)* and,
- *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care (2013)*.

These reports speak to a population of children in care that is experiencing varying degrees of mental health challenges, and also of a child protection system that is struggling to meet their needs.

The Representative raised concerns about the ability of these systems to understand the needs of children and youth with mental health concerns and provide the needed support. The reports' recommendations to the ministry focused on bolstering services and practice for children and youth in care struggling with mental health or complex behavioural concerns.

Government Response Example

NO ACTION

Report Title: *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*

Recommendations: A Minister of State for Youth Mental Health as a single point of accountability to address the needs of transition-age youth with mental health problems.

A three-year operational plan to improve service delivery to youth from acute care needs through to self-care supports, including immediate improvements to emergency, acute and community-based intensive intermediate care as well as youth-friendly service delivery models.

A robust system of quality assurance, including performance measures and outcomes, and regular plain-language reporting to the public, decision-makers and service providers.

An assessment of hospital acute care beds for transition-age youth in B.C. including a plan to address unmet service needs.

APR 2013

Report Released

MAR 2014

No response received from government. No progress on implementation of recommendations*

*This report considers progress on recommendations as of March 31, 2014. Initial correspondence regarding the report in this example was received in April 2014 from the Ministry of Health and MCFD. The correspondence indicated that the ministries would work together, with Ministry of Health taking the lead, to create an action plan responding to the findings of the *Still Waiting* report. Further correspondence received in July 2014 provided information on planned activities and stated that a *Still Waiting Action Plan* would be provided to the RCY by Dec.15, 2014. This information did not change the Representative's assessment of progress on *Still Waiting* recommendations.



In 2012, the Representative undertook a review of youth mental health services in B.C. Based on input from more than 850 people with first-hand experience, *Still Waiting* describes a mental health system that is fragmented, frustrating to navigate and remains plagued by serious gaps in the continuum of services. Findings from the report emphasize the lack of leadership and overall accountability as a major contributor to the failings in the system.

The provincial government has made no progress on four recommendations from the *Still Waiting* report in the year following its release (see Figure 8).

Figure 8: Recommendations from *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (2013)

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<ul style="list-style-type: none">• A Minister of State for Youth Mental Health as a single point of accountability to address the needs of transition-age youth with mental health problems				
<ul style="list-style-type: none">• A three-year operational plan to improve service delivery to youth from acute care needs through to self-care supports, including immediate improvements to emergency, acute and community-based intensive intermediate care as well as youth-friendly service delivery models				
<ul style="list-style-type: none">• A robust system of quality assurance, including performance measures and outcomes, and regular plain-language reporting to the public, decision-makers and service providers				
<ul style="list-style-type: none">• An assessment of hospital acute care beds for transition-age youth in B.C. including a plan to address unmet service needs.				

Some children and youth have complex needs involving multiple co-existing problems that can involve physical and/or mental health challenges, developmental disabilities, significant life trauma, and environmental stressors such as poverty. The 2013 report *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* documented how the system failed to provide support or protection to just such a child with complex needs. In this report, the Representative recommended:

"that MCFD urgently create a comprehensive plan to develop a continuum of residential services for children and youth in B.C. with complex needs that cannot be met in traditional foster home or group home settings, and fully fund and support that plan to ensure that these vulnerable children have access to residential care to support their optimal development."

MCFD has made very little progress on creating these much-needed services.



Given that a conservative estimate of the chances of a Canadian having a mental illness in his or her lifetime is one in five,⁴ and that about half of all lifetime cases of mental disorders start by age 14 and three-quarters by age 24,⁵ the provincial government's lack of response to the Representative's recommendation is both surprising and discouraging.

Child Poverty

The issue of child poverty has been a recurring theme across several reports by the Representative since 2008.⁶ Children who live in poverty are at a higher risk of developing health problems, and have a higher likelihood of experiencing more behavioural and developmental issues, achieving lower levels of education, and living in life-long poverty.⁷ B.C. is one of only two provinces without a poverty reduction plan.

B.C. has become known as the province with the highest child poverty rate in Canada. In 2011, the provincial child poverty rate was 11.3 per cent (based on the Low Income Cut-off, Income after Tax LICO-IAT), well above the national rate estimated at 8.5 per cent. About 93,000 children live in poverty in B.C.⁸

Poverty Measurement

The low income cut-off (LICO) is the income threshold below which a family will spend a larger share of its income on food, shelter and clothing than an average family would in similar circumstances. The measure used in this report is the LICO-IAT (Low Income Cut-off, Income After Tax), which is based on after-tax income – the most precise measure of the total income resources available to a family.

This issue has been of concern to others besides the Representative. A recent report by the Conference Board of Canada also highlighted the risks to children who grow up in poverty, noting that *"failure to address poverty may place a heavy burden on a country's economy."*⁹ In addition, a 2011 cross-Canada status report on child and youth health by the Canadian Paediatric Society rated B.C. *"poor"* in addressing child poverty reduction. A *"poor"* rating means a province has neither legislation nor a strategy to reduce child poverty.¹⁰

⁴ Kirby, M. J., & Keon, W. J. (2004). *Report 1. Mental Health, Mental Illness, and Addiction: Overview of Policies and Programs in Canada*. Standing Senate Committee on Social Affairs, Science and Technology. Government of Canada.

⁵ Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.

⁶ *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants (January 2011), Housing, Help and Hope: A Better Path for Struggling Families (July 2009), Kids, Crime and Care: Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes (February 2009), Amanda, Savannah, Rowen and Serena: From Loss to Learning (April 2008)*.

⁷ Canadian Paediatric Society. (2012). *Are We Doing Enough?: A status report on Canadian public policy and child and youth health*.

⁸ Statistics Canada. (2013). *2011 Census of Canada. Persons in low income families*. CANSIM, table 202-0802. Retrieved from <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&tid=2020802&paSer=&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid=>

⁹ Conference Board of Canada (2014, August 11). *Child Poverty*. Retrieved from <http://www.conferenceboard.ca/hcp/details/society/child-poverty.aspx>.


¹⁰ Canadian Paediatric Society. (2012). *Are We Doing Enough?: A status report on Canadian public policy and child and youth health*.



In January 2011, the Representative released *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants – Aggregate Review of 21 Infant Deaths*. This report looked into the lives of 21 infants who died before age two between June 1, 2007 and May 1, 2009. All of the infants' families had been involved with MCFD. Families in this review, particularly the Aboriginal families, were often stuck in chronic, deep poverty that was found to be the single largest risk factor in their environment.

The Representative's first recommendation in this report addressed the issue of poverty head on (see Figure 9).

Figure 9: Recommendation from *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants – Aggregate Review of 21 Infant Deaths* (2011)

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<ul style="list-style-type: none">That B.C. develop a non-partisan child poverty plan, with leadership from the Premier's Office, through a special initiative that identifies strategies to address all aspects of child poverty in the province, including specific strategies to address poverty affecting Aboriginal children and families.				

However, rather than developing a province-wide child poverty plan, the B.C. government chose to address poverty by focusing on a job-creation plan designed to strengthen the economy and by developing community poverty reduction strategies in selected communities.

In 2012, government announced a community poverty pilot project, in partnership with the Union of British Columbia Municipalities, to be implemented in seven B.C. communities. The project was designed to connect families directly to existing services in their communities, address the key challenges that low-income families face and develop community action plans. No new funding was provided for the initiative.

According to the project's May 2014 progress report, the pilots assisted just 72 families – a poor response for a province with a population approaching 4.7 million and 93,000 children living in poverty. It is discouraging that the progress report identified already well-known barriers for families living in poverty as “*key findings*,” including basic food security, housing, health and education/skills training. Report findings also identified a need for an “*inter-ministerial, cross-sector*” approach to supporting low-income families.

It is clear that the B.C. government still has not made a meaningful impact on the issues facing families struggling with poverty. There are no plans to expand the community poverty pilot projects to other communities and the province has yet to create a comprehensive province-wide plan to reduce poverty.



Vulnerable Aboriginal Children and Youth

Aboriginal children and youth are significantly over-represented in the B.C. child welfare system and under-represented in many supportive services. More than 8,000 B.C. children are in government care, and more than half of these children are Aboriginal, despite the fact only about eight per cent of the province's entire child population is Aboriginal. The high rate of Aboriginal children in care is of specific concern to the Representative, especially given the evidence showing poorer outcomes related to education, health and safety for Aboriginal children and youth compared to other children and youth in B.C.

Over the years, a significant number of initiatives between government and communities and leadership (i.e. memoranda, accords, agreements and plans) have committed to improving the lives of Aboriginal children, youth and families in an effort to close the social and economic gaps between Aboriginal people and other British Columbians. These initiatives brought a focus to the issue of Aboriginal child welfare and highlighted the need to take action and engage Aboriginal communities in the search for solutions.

Has anything changed in the lives of Aboriginal children, youth and families as a result of these initiatives? Has measurable progress been made in achieving these goals? What outcomes have resulted?

Hughes commented specifically about the circumstances of Aboriginal people, Aboriginal child welfare service delivery and the over-representation of Aboriginal children in care in his 2006 *BC Children and Youth Review*. The Representative has issued 13 reports since 2008 that have explored some issue of well-being for Aboriginal children and youth, with two reports focusing solely on the delivery of services to Aboriginal children and youth.

The Representative continues to advocate for the B.C. government, the government of Canada and Aboriginal leadership to develop stronger policies for Aboriginal children, youth and families and to ensure a real effort to improve outcomes. But response has been slow and there is still much more work to be done in measuring outcomes for this vulnerable population that continues to be ignored (see Figure 10).

To date, the B.C. government has not worked effectively with the federal government and First Nations leadership to develop a poverty reduction plan, just as it has not developed a province-wide plan to address poverty for all children and youth in B.C.



Figure 10: Key Recommendations to close the outcomes gap for Aboriginal children and youth

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<ul style="list-style-type: none">That the government of B.C. engage the federal government and First Nations leadership and communities to develop a plan to reduce Aboriginal child and family poverty in B.C. (<i>Housing, Help and Hope: A Better Path for Struggling Families</i>, 2009)				
<ul style="list-style-type: none">That B.C. develop a non-partisan child poverty plan, with leadership from the Premier's Office, through a special initiative that identifies strategies to address all aspects of child poverty in the province, including specific strategies to address poverty affecting Aboriginal children and families (<i>Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants</i>, 2011)				
<ul style="list-style-type: none">That MCFD take the lead in developing a clear plan for B.C. to close the outcomes gap for Aboriginal children and youth across government ministries including Education and Health as well as other service-delivery organizations, with clear targeted outcomes and performance measures that would be applicable on- and off-reserve, and encompass all Aboriginal children and youth regardless of where they reside (<i>When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.</i>, 2013)				

Given the lack of response by government to address issues facing Aboriginal peoples, child welfare service delivery to Aboriginal children, youth and families continues to be a significant focus of the Representative's work. In her 2013 report, *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.*, the Representative described a lost decade when more than \$66 million was spent by MCFD on Aboriginal governance endeavours that produced very little real benefit for Aboriginal children, youth and families.



The Representative concluded that MCFD failed in its mandate to set out effective, responsive and culturally appropriate child welfare services to Aboriginal children, youth and families. There have been no measurable outcomes and demonstrated improvements for Aboriginal children and youth and evidence-based strategies and practices have not been adopted.

In June 2014, Hughes reiterated his concerns and recommended national action on the “*gross disproportion*” of Aboriginal children in government care across Canada, calling the situation “*a national embarrassment*.”¹¹ He said a national action plan should tackle the effects of colonization including poverty, inadequate housing and unsafe drinking water – conditions, he said, that underlie the over-representation of Aboriginals in the child welfare system, as well as in rates of suicide and incarceration. Hughes said other benefits would include improved educational achievement, employment and economic opportunity. Such leadership and coordinated, sustained action needed to close the outcomes gap for Aboriginal children and youth are long overdue.

Each of the reports referred to in this section called for significant changes to how government addresses issues of domestic violence, mental health services, poverty and Aboriginal inequity. Most of the unfulfilled recommendations in these reports require the involvement of more than one ministry, allocation of adequate resources and leadership from the highest levels of government.

These changes are not easy, but they are necessary if we are to prevent children and youth from falling behind their peers, falling into or being stuck in poverty, being left at risk in homes with domestic violence, or suffering from mental health challenges without proper support.

The cost of not mending our services to provide adequate support to vulnerable children is huge. The human cost of suffering and despair is immeasurable. The economic costs of preventable long-term use of public services, unfulfilled human resources and drain on productivity are very clear. There are many more reasons to act than not.

¹¹ Hughes, T. (2014, June). *Speech by Ted Hughes, June 5, 2014 to the staff of the Office of the Representative for Children and Youth, Victoria, B.C.*



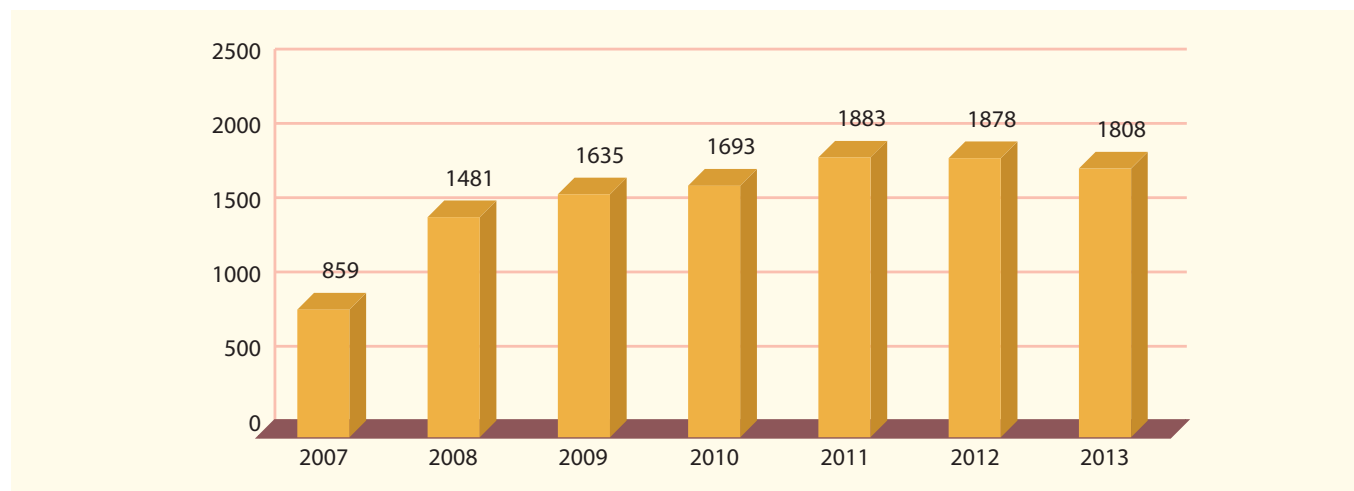
The Need for Service Quality and Outcomes Measurement

The intent of the Representative's recommendations is to improve the quality of services that contribute to the well-being of children and youth, and to identify gaps in those services. Well-being is all about a child's social, educational, physical and developmental progress. Public services are among the many factors that can affect this well-being. Government must be accountable to the public for what and how services are provided, and whether those services are achieving their intended results.

After 22 Representative's reports containing 148 recommendations, are government services achieving better outcomes for B.C.'s children and youth?

It is the Representative's view that this key question remains unanswerable, due mainly to a lack of data on service quality and outcomes. While more – not fewer – concerns are being brought forward to the Representative's Office via requests for advocacy services, and reports of injuries and deaths have not changed, it is impossible to say whether this is a result of greater awareness of the Representative's services and mandate, or from ongoing and increasing challenges in MCFD service delivery experienced by children and youth.

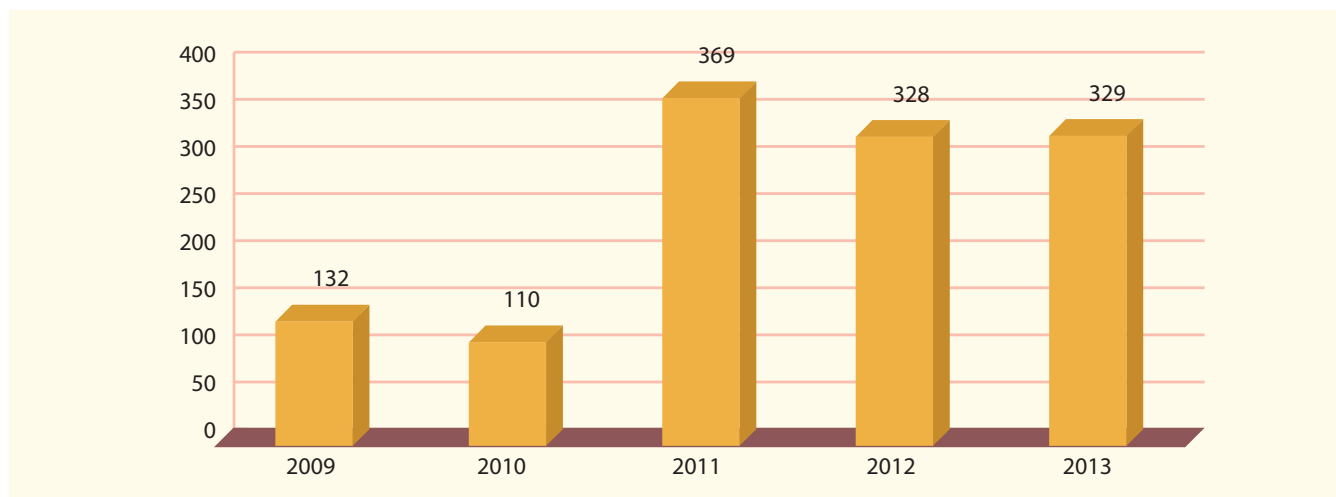
Figure 11: Total RCY Advocacy Cases Opened by Calendar Year 2007 to 2013



Notes:

1. Figures are reported for January to December.
2. RCY Advocacy program began in April 2007. Figures for 2007 only include data from April to December 2007.

Figure 12: Number of Critical Injuries Received by RCY Calendar Year 2009 to 2013



Notes:

1. Figures are reported for January to December
- * Prior to 2011, MCFD was not reporting all critical injuries to the Representative that should have been reported as outlined in the *RCY Act*. MCFD changed its reporting after the Representative cited her concerns in a December 2010 special report. Effective March 1, 2011, the number of critical injuries reported to RCY increased substantially.

It is critical for government to publicly report on service quality and how effectively services are meeting the needs of children and youth. But this information is, for the most part, not available in B.C. In the areas of quality assurance, performance measurement, and public reporting – activities that can demonstrate how well services are delivered and whether expected results are achieved – MCFD has much more work to do.

Quality Assurance

Quality assurance is about complying with standards and policies that govern service expectations and it requires a process to measure and track this compliance. The ministry must know whether or not services meet agreed-upon standards of delivery and publicly demonstrate commitment to maintaining quality service delivery for children, youth and families.

Director's case reviews and case practice audits are two key quality assurance activities that measure MCFD's compliance to practice standards.



Director's Case Reviews

MCFD can conduct director's case reviews after the death or critical injury of a child or youth who has received services within the 12 months prior to the incident. The most important reason for these reviews is to prevent similar deaths and injuries from occurring. Reviews focus on the ministry's decisions, actions, and provision of services and determine whether practice was consistent with legislation, policy and standards and if practice contributed in any way to the death or injury in question.

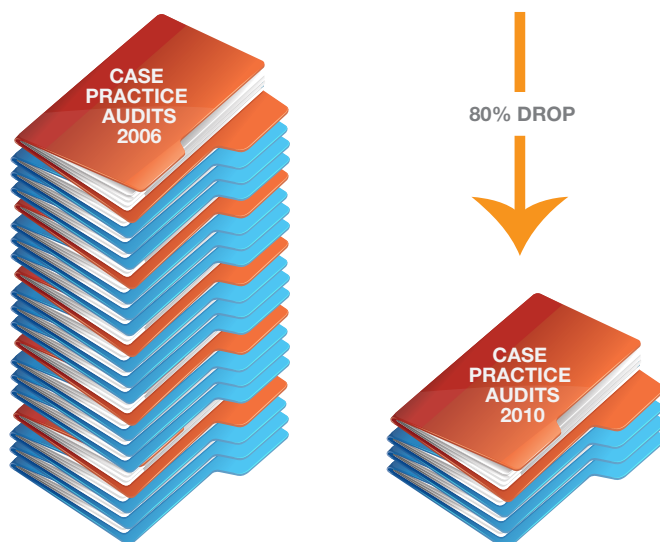
The Hughes Review recommended that MCFD produce an aggregate analysis of recommendations that stem from case reviews as a way to educate staff, policy-makers and the public about key risk factors and opportunities for child death and injury prevention. Such a report has not been done since 2007, although the ministry continues to conduct individual case reviews on an annual basis.

Without these aggregate analysis reports, it is impossible to know whether there are any significant risk factors or patterns that require provincial strategies for child death and injury prevention. For a half-dozen years, there has been no public accountability from MCFD in this crucial area.



Case Practice Audits

MCFD case practice audits are meant to measure whether practice standards are being followed and identify areas in practice that should be strengthened. Historically, the ministry's internal audits have shown low compliance in areas that include planning for children in care, internal reporting on child deaths, injuries and serious incidents, and completing child protection investigations in a timely manner.



The Representative's *Much More than Paperwork* report (2013) found that the number of MCFD case practice audits declined significantly between 2006 and 2010 – from about 500 audited files to fewer than 100. It is clear that by 2010 MCFD had discontinued case practice audits, leaving a void in the systemic monitoring of the quality of child protection practice.



In 2012, the ministry re-instated the case audit program as a pilot project for the first year using new audit tools and methodology. In 2013/14, family service practice audits were completed in four geographic service delivery areas (SDA).

The provincial pilot and two completed SDA audit results for family services have been shared with the Representative. These results show low compliance across several critical measures. The implementation of the new audit program occurred at the same time as social workers were transitioning to using new child protection response policies as well as using the ICM system – a system that has been fraught with technical issues since April 2012 and could potentially impact audit results.

Given these other issues impacting social workers at the time of the audit pilot, the Representative is concerned that the audit results are inconclusive and do not accurately determine whether the ministry is meeting its own standards and whether good practice outcomes are being achieved. Rather, the audit results identify that substantial work is required by the ministry to improve its understanding of how practice decisions are being made and whether they actually comply with policies and standards.

Measuring Performance and Public Reporting

The Hughes Review stated: *"When programs and policies are introduced, the ministry and the public need to understand the expected results for children; and after implementation, they need to be able to tell whether those results are being achieved."*¹²

Measuring organizational performance and publicly reporting out on progress communicates to the public the ministry's priorities, how well the ministry is carrying out its responsibilities and the ministry's accountability to the public for its performance.

The ability of the ministry to measure and report publicly on outcomes for the children and youth in its care is a necessary pre-condition for determining if the actions taken are having the desired result.

From 2008 to 2010, MCFD's work was guided by its policy document, *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth* (MCFD, 2008). Performance measurement reporting on this document was communicated through the *Integrated Framework for Children and Youth*, which outlined government's expectations for children and youth in B.C. No public reporting on identified indicators ever occurred so it was not possible to assess whether or not completed activities contributed to achieving desired outcomes.

In its 2010/11 service plan, the ministry committed to developing an array of performance measures that reflect practice change and to increase public reporting on those measures. From 2010 to 2012, the ministry released three reports that expanded to 30 measures across an array of areas such as early years,

¹² Hughes, T. (2006). *BC Children and Youth Review: An Independent Review of BC's Child Protection System*.



child protection, education and fatalities. These reports indicated a positive direction by MCFD, although work still needed to be done to understand client outcomes and how the information was being used to improve services.

In 2012, MCFD moved towards a performance management framework to focus on improving outcomes for children, youth and families with more meaningful analysis of programs and services to develop measurable actions on improvement. This led to the release of two Operational Performance and Strategic Management (OPSM) reports that provided information on several aspects of MCFD service delivery, including a few measures of service quality and a number of outcome measures.

In the September 2013 OPSM report, MCFD's own assessment of its operational data was that it was *"clearly inadequate in the short term to support effective progress in a number of strategic key actions."* Another challenge with these reports is that they do not provide enough comparative data to identify whether the ministry is achieving the intended progress.

The Representative agrees with the ministry's own assessment and concludes the reports lack context to understand progress towards improving service-delivery and client outcomes. More meaningful analysis is required to understand how the measures are to be interpreted, what the results mean and how the ministry intends to use the information to inform decision-making. Targets are required so that the organization and the public understand the ministry's performance expectations and the gaps that exist between actual and targeted performance.

There continues to be a gap in available data, including a lack of data from service providers who deliver contracted services to children, youth and families. In addition, there is inadequate data collected for services other than child protection services, such as child and youth mental health services and services for children and youth with special needs. These gaps include basic client information, wait times, the number of children and youth served, prevalence rates and the outcomes for children and youth receiving service. Having this information would provide more accountability to the public to judge whether government-funded services are adequate and whether outcomes for children and youth are improving. The Representative is disappointed that there hasn't been an improvement to these gaps during the seven-year oversight period of her Office to date.

The Representative's own reports go some way to filling the gap in understanding the experiences and outcomes of vulnerable children and youth. However, the Representative's Office does not have the capacity to conduct on-going data collection and on-going assessment of service quality for the many diverse services responsible for supporting children, youth and their families.

Individual ministries need to be accountable for publicly stating service quality and client outcomes expectations and reporting out on whether they are achieving their desired goals. Certainly, much more needs to be done so that the public knows whether services and outcomes are getting better for children and youth.

Conclusion

The Representative is committed to making worthwhile and valuable recommendations to help improve the child- and youth-serving system in B.C., recognizing that it is critical to be in tune with what is happening on the ground and to connect recommendations with the realities experienced by front-line staff and the children, youth and families they serve.

However, the Representative does not have the authority to carry out these recommendations. That is up to government, which means that government leadership is extremely important to improving services for B.C.'s vulnerable children and youth.

This report concludes that government as a whole must exhibit better leadership and commitment when it comes to addressing the needs of children and families in this province.

Commitment means providing adequate resources to deliver those services. More money is not the answer to every question, but it is difficult to understand how a provincial government can reduce its budget in constant dollars to children and families at a time when B.C. leads the nation in child poverty rates and at a time when Aboriginal children continue to experience poorer outcomes and receive poorer services than their contemporaries.

Since 2007/08, MCFD's annual budget has been reduced by more than \$37 million, which equates to a nearly \$100-million reduction in real dollars when inflation is taken into account. This has happened during a period when vulnerable B.C. families have also been dealing with the effects of a severe economic downturn.

The Representative is also troubled about front-line staffing resources. Accounts of staff shortages within some MCFD offices have come to the attention of the Representative through a number of ways, including advocacy cases. The Representative is concerned about the potential impacts these shortages may have on children and youth and the Office plans to conduct a review of MCFD staffing levels in the coming months.

Adequate resources and staffing are necessary for MCFD and other child-serving ministries. But just as important is a willingness by B.C. government leaders to listen to and act on recommendations by the Representative's Office. And that doesn't mean acting only on the easier recommendations while claiming that a 72 per cent implementation rate is good enough. It is not.

Government leadership must drive B.C. to fulfill the tougher recommendations from this Office, the ones that require cross-ministry participation, change and commitment – to implement a strategy to address child poverty, for example; or to provide a consistent and equitable system of services to address child and youth mental health problems. Government leadership must act to address the key areas of deficiency in the system that the Representative has strategically emphasized over the years – services to Aboriginal children and youth, domestic violence prevention and child and youth mental health services.



Government leadership must also drive competent and consistent evaluation of the job it is doing for children and youth in this province. In 2006, the Hughes Review recommended that MCFD establish a strong quality assurance function, track and report on a comprehensive list of outcomes for children, youth and their families and develop shared data sets with other ministries. Pockets of progress have been made in this regard, such as reporting of education outcomes of children in care. But on the whole, MCFD and other ministries have fallen far short of the mark set by Hughes. Large gaps exist in understanding who is receiving what types of services and what service experiences and outcomes are for clients. On the surface, it seems simple – in order to improve, you have to know what kind of a job you are doing now.





The Representative's mandate provides for valuable oversight that can influence public services for children and youth. However, it is up to government to deliver these services, ensure that they are of high quality and that they are making desired contributions to the well-being of children and youth. The scope of the Representative's reports and recommendations make it clear that this responsibility is shared across government ministries and at the highest level of government leadership.

MCFD, the lead ministry for many aspects of services to children, youth and families, has taken some steps in the right direction, particularly since 2011, to respond to oversight recommendations, develop quality assurance mechanisms and report on performance. Leadership at MCFD must build on the foundation that is now being laid, and government must ensure that progress at MCFD continues. There remains a long way to go.



Appendix 1

Recommendation Status Categories

Status	Description
 No Progress	No substantial action has been taken to implement the recommendation. The intent to do something or the development of a high level plan is not considered substantial action. OR Action that has been reported to RCY does not meet the intent of the recommendation.
 Some Progress	Implementation has begun. Action to date has not produced the foundation that will be required for full implementation.
 Substantial Progress	Implementation is well underway. A solid foundation has been built and full implementation is expected if action continues as planned.
 Implemented	The recommendation has been fully implemented.



Appendix 2

Status of all RCY Recommendations: 2008 to 2013

Reports by Year (January 1, 2008 to December 31, 2013)	Number of Recommendations	Implemented	Substantial Progress	Some Progress	No Progress
2013					
<i>When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C. – Nov. 2013</i>	5				
<i>Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces – Sept. 2013</i>	4				
<i>Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C. – April 2013</i>	4				
<i>Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care – March 2013</i>	10				
<i>Who Protected Him? How B.C.'s Child Welfare System Failed One of its Most Vulnerable Children – Feb. 2013</i>	4				
2012					
<i>Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm – Nov. 2012</i>	1				
<i>Special Report: The Impact of Criminal Justice Funding Decision on Children of B.C. – March 2012</i>	3				
<i>Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now – March 2012</i>	8				



Reports by Year

(January 1, 2008 to
December 31, 2013)

Number of
Recommendations

Implemented

Substantial
Progress

Some
Progress

No
Progress



2011

*So Many Plans, So Little Stability: A Child's Need
for Security – Sept. 2011*

3



*Isolated and Invisible: When Children with Special
Needs are Seen but Not Seen – June 2011*

4



*Issue Report: Phallometric Testing and B.C.'s Youth
Justice System – April 2011*

4



*Fragile Lives, Fragmented Systems: Strengthening
Supports for Vulnerable Infants – Aggregate Review
of 21 Infant Deaths – Jan. 2011*

7



2010

*Special Report: Reporting of Critical Injuries and
Deaths to the Representation for Children and
Youth – Dec. 2010*

1



*Issue Report: Sexual Abuse Intervention Program –
Sept. 2010*

6



*No Shortcuts to Safety: Doing Better for Children
Living with Extended Family – June 2010*

10



*Hearing the Voices of Children and Youth:
A Child-Centred Approach to Complaint
Resolution – Jan. 2010*

7





Reports by Year

(January 1, 2008 to
December 31, 2013)

Number of
Recommendations

Implemented

Substantial
Progress

Some
Progress

No
Progress



2009

*Honouring Christian Lee - No Private Matter:
Protecting Children Living with Domestic
Violence – Sept. 2009*

7



*Housing, Help and Hope: A Better Path for
Struggling Families – July 2009*

5



*Kids, Crime and Care: Youth Justice Experiences
and Outcomes – Feb. 2009*

7



2008

*Issue Report: Medical Assessments in B.C.'s Youth
Justice System – Sept. 2008*

4



*Amanda, Savannah, Rowen and Serena: From
Loss to Learning – April 2008*

32



*Monitoring Brief – System of Services for Children
and Youth with Special Needs – Feb. 2008**

12*



Recommendation Status as of March 31, 2014

*Outstanding issues will be addressed through appropriate responses to the recommendations provided in the *Isolated and Invisible: When Children with Special Needs are Seen but Not Seen* report.

Glossary

Aboriginal – a broad term which, according to the *Constitution Act* of 1982, includes the Indian, Inuit and Métis people of Canada. However, the term "Aboriginal" is generally more broadly interpreted as including people who are registered status Indians, non-registered Indians, Inuit and Métis. Non-registered Indians are generally people who self-identify as having Aboriginal heritage, but who are not eligible to be registered under the *Indian Act*.

Child, Family and Community Service Act (CFCS Act) – legislation enacted in 1996 that governs child protection in British Columbia.

Child or youth in government care – any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act*.

Child protection services – services delivered under the *Child, Family and Community Service Act* in response to reports of child abuse or neglect. Child protection services can include investigation, providing or arranging for support services to families, supervising the care of children in their homes, and protecting children through removal from their families and placement with relatives, foster families or specialized residential resources.

CLBC services – services to adults with developmental disabilities that are funded by the Crown agency Community Living B.C.

Delegated Aboriginal Agency (DAA) – through delegation agreements, the Provincial Director of Child Protection (the Director) gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *CFCS Act*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Domestic violence courts – courts that are dedicated to domestic violence cases and have the underlying principles of increased safety for victims, early intervention for low-risk offenders, vigorous prosecution for serious and/or repeat offenders, commitment to rehabilitation and treatment, and coordinated systems response.

Family support services – services provided to families by MCFD, delegated Aboriginal Agencies or contracted service providers to support and assist families to care for their children. Services may include services for children and youth, counselling, in-home support, respite care, parenting programs and services to support children who witness domestic violence.



First Nation(s) – a term that became more common during the 1970s to replace the term "Indian." While there is no legal definition for term "First Nation(s)," it is meant to describe those persons who are registered as "Indians" under the federal *Indian Act*.

Foster care – a family or persons approved by and funded by the Director, to care for children who are in the care, custody and guardianship of the Director. Family care services are provided from private homes lived in and maintained by the foster parents. Foster care includes Restricted, Regular, Level 1, Level 2, and Level 3 Family Care Homes. Persons who provide family care services are referred to as family care parents, foster parents or as a foster family.

Guardianship services – services provided by MCFD or delegated Aboriginal Agencies to children and youth who are in long-term or continuing care as a result of a child custody order granted under the *Child, Family and Community Service Act*, or an order under the *Family Relations Act* when a child has no parent or guardian. Guardianship services have parental duties and responsibilities towards children and youth and are responsible for their care, custody and guardianship.

Hughes Review (The BC Children and Youth Review) – the 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was a review that recommended the appointment of an independent Representative for Children and Youth.

Public bodies – provincial government ministries and other organizations that serve the public such as the Coroners Service of BC, RCMP, Public Guardian and Trustee of BC and Aboriginal Affairs and Northern Development Canada.

Select Standing Committee on Children and Youth (SSCCY) – an all-party committee of the B.C. Legislature responsible for fostering awareness and understanding among legislators and the public about the B.C. child welfare system. The Representative reports at least annually to the SSCCY, and the committee receives and reviews the Representative's service plan and annual report, receives and considers all reports of the Representative and may refer a critical injury or death of a child to the Representative for investigation.

Youth justice services – services for youth who have been accused or found guilty of a criminal offence and were aged 12 to 17 at the time of the offence. A youth may be subject to community-based services (such as probation), youth custody, or a combination of both.



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