Someone to Watch Over Us

SPECIAL INVESTIGATION REPORT

MARCH 2021

SASKATCHEWAN advocate FOR CHILDREN & YOUTH

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advocate
FOR CHILDREN & YOUTH

Letter of Transmittal

March 3, 2021

The Honourable Randy Weekes
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
REGINA SK S4S 0B3

Dear Mr. Speaker:

In accordance with sections 12 and 28 of *The Advocate for Children and Youth Act*, it is my duty and privilege to submit to you and members of the Legislative Assembly of Saskatchewan this special investigation report: *Someone to Watch Over Us*.

Respectfully,

Lisa Broda, PhD
Advocate for Children and Youth

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Executive Summary

This report reflects issues found not only within a Ministry of Social Services' (herein called the 'Ministry') contracted group home for cognitively challenged, and extremely vulnerable children, but also reveals insights into the group home system generally. The incident that launched our investigation led to a broader review that revealed significant systemic oversight issues in the Ministry, many of which have been the subject of concern to the Advocate for Children and Youth (Advocate) for some time.

Over several years, the Advocate has fielded numerous group home complaints from children, youth, parents, professionals, group home and Ministry staff, most of which relate to the Ministry's stewardship in group home care. Concurrently, the Advocate has monitored the Ministry's group home review process, has commented on the apparent rapid growth of group homes, and urged legislative improvements to ensure this expanding system has sufficient resources and support, and defines and measures quality of care.

The event that triggered this broader review is the case of Elijah, a seven-year-old child with complex care needs who ran from his group home in the early hours of June 2, 2020 and was discovered naked, lost, and confused in the parking lot of a restaurant in the north end of Saskatoon. The group home where he resided had been struggling with staffing levels, internal discord, and other critical issues that directly affected the care of the Ministry's most vulnerable children. In the weeks following this incident, significant concerns surfaced about staff abuse and neglect, including serious medical neglect of another child in the home. The Ministry conducted investigations into these matters and followed up with added supports. The group home operator (herein called the 'Company'), soon after, gave notice of its intention to terminate its operation of the group home, leaving the Ministry to find another organization to provide service. The incident concerning Elijah is not only egregious due to the nature of what occurred, but more so because it typifies the Advocate's ongoing concerns with group home oversight.

After examining the evidence in this case and other relevant information, the Advocate has made important findings related to oversight. Although the Ministry's investigations and interim actions in this case were satisfactory, it did not identify, plan, and implement long-term solutions to address the causes of the issues it discovered. The Advocate further found the Ministry's current oversight mechanisms do not adequately monitor quality of care in group homes and detect issues early enough, and the Ministry does not adequately plan, resource, or provide ongoing, sustainable supports to group homes for the ultimate benefit of the vulnerable children being served.

Based on the findings of this investigation, the Advocate makes the following three recommendations:

Recommendation #1: That the Ministry of Social Services enhance and re-design its group home oversight and accountability structure to:

- incorporate a leadership role that is responsible for the effective oversight of group homes;
- develop comprehensive evidence-based quality-of-care definitions and standards that promote proactive, not reactive, responses to the care of children;
- articulate what evidence is needed to demonstrate that group homes are meeting quality-of-care standards; and,
- include sufficient human and financial resources to enable timely and proactive reviews of group home care.

Recommendation #2: That the Ministry of Social Services develop a permanent resource for group home operators, which provides a clear point of contact, support, and resources such as skill development.

Recommendation #3: That the Ministry of Social Services enhance its process for approving group home openings to include identifying and verifying the qualifications and training of staff and examining the unique needs of the children who are the intended residents to determine what unique features should be included in the group home.

Pursuant to *The Advocate for Children and Youth Act*, the Advocate is using her discretion to publicize this report, but to not use Elijah's real name.

1.0 Introduction

The Saskatchewan Advocate for Children and Youth is an independent officer of the Legislative Assembly of Saskatchewan. The Advocate has a broad mandate to work on behalf of young people in Saskatchewan under *The Advocate for Children and Youth Act*. The core areas of the Advocate's work consist of advocacy, investigations, public education, and research. The Advocate may give notice of investigation into any matter concerning children and youth, including services provided by a provincial ministry, delegated agency of the government, or publicly-funded health entity. The key objectives of an investigation by the Advocate's office are to identify any contributing factors leading to a death or harmful event, and to achieve policy or service delivery improvements through recommendations to the provincial government. *The United Nations Convention on the Rights of the Child (UNCRC)* is foundational to all core areas of the Advocate's office. The rights and obligations in the *UNCRC* have been distilled into the Saskatchewan Children and Youth First Principles, which the Government of Saskatchewan adopted in 2009.

The *UNCRC*, to which Canada is a signatory, outlines unique rights of children generally, and in specific circumstances. Relative to this investigation, Article 3 emphasizes that the primary consideration when providing services to children and youth must be done in their best interests. Article 20 provides that children who cannot be looked after by their own family have the right to be cared for properly. Article 25 is specific to young people who are placed in care and emphasizes the need for government to monitor their care and all relevant circumstances of their placement. Article 23 highlights the requirement to protect and remove obstacles for children with disabilities to enable their full participation and individual development.

To articulate *UNCRC* standards more specifically, the United Nations General Assembly adopted a Resolution entitled, **Guidelines for the Alternative Care of Children (2010)**[1], to inform policy and best practices in various types of alternative care, including residential based group home care. Standards particularly relevant in this case include:

- that the quality and conditions of a group home are conducive to a child's development;
- staff have requisite training and supervision, to ensure appropriate caregiving to deal with challenging behaviours and respond to children with special needs and chronic disabilities; and,
- those providing such care are subject to accountability measures including frequent and meaningful inspections (both announced and unannounced).

Further, given the overrepresentation of Indigenous children in the child welfare system, it is imperative that special attention be given to the experiences of Indigenous children in residential care, and for governments to work diligently toward prevention with families to mitigate children entering the system. The relevant Calls to Action of the Truth and Reconciliation Commission of Canada requires the federal, provincial, and territorial governments to coordinate annual reports that include the *"[...] total spending on preventive and care services by child-welfare agencies, and the effectiveness of various interventions."*[2] We understand that little progress, if any, has been established to implement this Call to Action.

Equally important is Article 21 of the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*, which provides that "Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities."[3] This report calls for the Ministry of Social Services to incorporate a quality-of-care model and a proactive approach to the care of the children, which is sorely needed to ensure the rights, best interests and well-being of not only Indigenous children it serves, but for all children who must spend a portion of, or all of their childhood, in residential care. Anything less is not acceptable.

[1] https://resourcecentre.savethechildren.net/node/5416/pdf/5416.pdf

[2] Truth and Reconciliation Commission of Canada (TRC). (2015) *Honouring the Truth, Reconciling for Future.* Truth and Reconciliation Commission of Canada: Calls to Action. Winnipeg, MB: Author.

[3] United Nations General Assembly. (2007) *United Nations Declaration on the Rights of Indigenous Peoples.* New York, NY: Author.

1.1 CIRCUMSTANCES OF INCIDENT

Just before 5:00 a.m. on June 2, 2020, staff members of a north end Saskatoon Tim Horton's arrived to open the restaurant and found a naked, frightened, and non-verbal little boy in the parking lot. Although distressed, he was otherwise unharmed. Staff contacted the Saskatoon Police Service and provided Elijah with some clothing and food. As Elijah was non-verbal, the police were unable to identify him or determine where he lived and issued a public statement asking for assistance in identifying him. Mobile Crisis Services attended the scene and brought Elijah to the Ministry of Social Services office shortly after 8:00 a.m.

It was during its morning shift change at the group home at about 7:30 a.m. when staff realized Elijah was not in his room, and that the Saskatoon Police Service's public alert about a boy found about one kilometer away in the Tim Horton's parking lot was Elijah. Staff contacted the Ministry and then picked up Elijah and resettled him back in the home that morning. At the time of the incident, there were four children living in the group home, including Elijah, all with varied complex needs. We learned that the lone group home staff member working during the night shift had last checked on Elijah sometime between 3:00 and 4:00 a.m. and had not detected his absence.

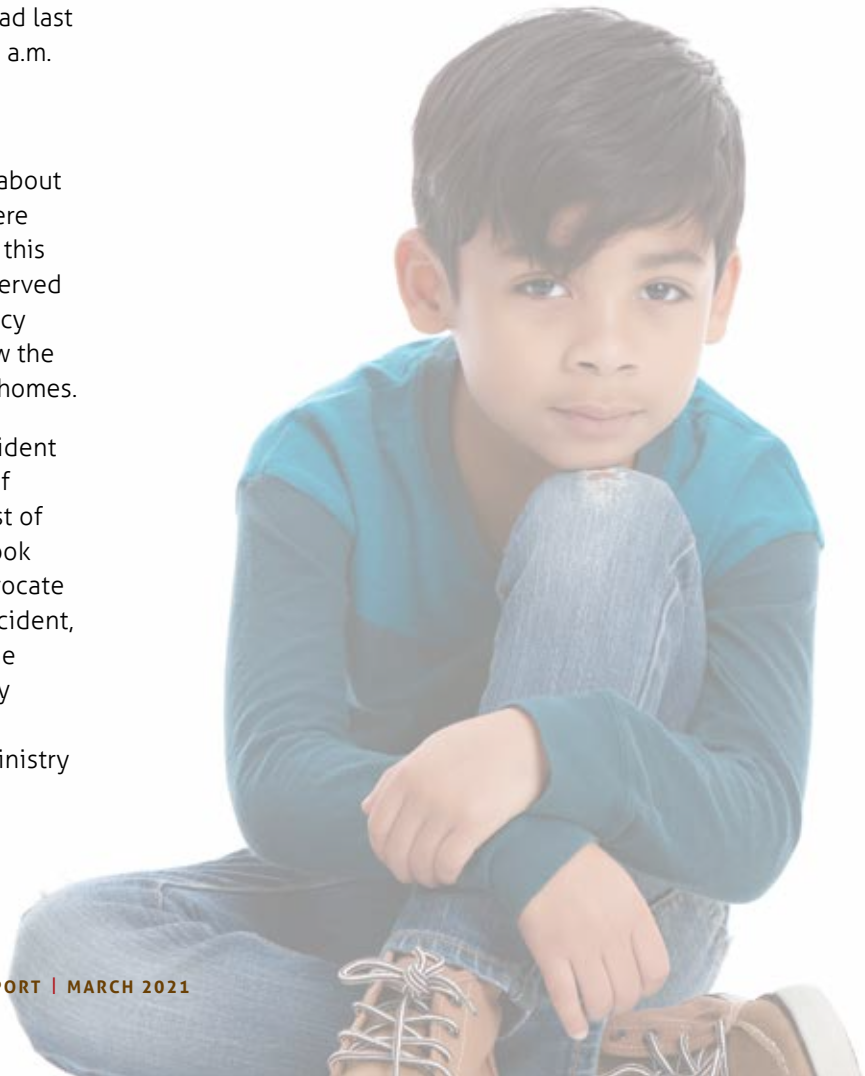
After learning about this incident, the Advocate immediately sought answers from Ministry officials about the circumstances of this situation. As the details were revealed, the Advocate registered the similarities of this case with ongoing group home oversight issues observed over the years through our investigative and advocacy work, which have raised critical questions about how the Ministry monitors quality of care provided in group homes.

The Ministry conducted investigations into this incident and subsequent complaints involving allegations of medical neglect and abuse in the group home, most of which were substantiated. Although the Ministry took interim actions, after further consideration the Advocate decided to investigate the circumstances of this incident, the care being provided by the group home, and the oversight given by the Ministry. Under the authority of *The Advocate for Children and Youth Act*, formal notification of investigation was provided to the Ministry on June 23, 2020.

1.2 SCOPE AND METHOD

This public report is the result of a review of all available Ministry documentation related to Elijah's care, its investigations and reviews of the group home of which Elijah resided, a review of Ministry legislation, policies and procedures related to group homes, and interviews with Ministry and group home operator staff. We have also considered other background research and technical reports as it relates to best practices in governance and oversight in residential care involving children and youth.

While this is not intended to encompass a full system-wide review into Ministry oversight into group home care, the aim of this investigation was to examine whether the findings related to the circumstances in this case are indicative of gaps in oversight and accountability. It was also to examine how the Ministry proactively assesses and ensures the highest possible quality-of-care outcomes for young people residing in group homes.



2.0 Chronology of Events

Initial Placement in Care

Elijah, born in 2012, is an active, social boy who came into Ministry care in early **January 2018**, along with his two younger siblings. Ministry staff quickly arranged for Elijah to be assessed based on concerns with his health and challenging behaviours. In late January that same year, he was diagnosed at the Alvin Buckwold Child Development Program with moderate symptoms of Autism Spectrum Disorder and moderate intellectual disability. Elijah is non-verbal and communicates his needs through gestures and sounds.

Elijah was initially placed into two short-term group homes, until the Ministry could determine options for long-term care, which included seeking extended family caregivers. In **March 2018** he began residing with a caregiver known to Elijah from his group home residency. This placement was meant to be temporary until the Ministry could find a suitable long-term resource. The Ministry funded extra staff to come into the home to support Elijah's care. Although he bonded well with his caregiver, she could not provide long-term care due to other responsibilities.

> The Ministry provides various out-of-home care resources for children whose safety cannot be assured at home, ranging from placement with extended family, specialized foster care, staffed residential services such as community-based group homes, and private treatment programs.

Unable to locate extended family who could meet Elijah's challenging needs, the Ministry identified a specialized group home in Martensville, and in the **spring of 2019** transition planning began. At this same time, the Martensville group home operator was planning on closing this home in favour of providing group home services in Saskatoon. Up to this point, Elijah was a temporary ward of the Ministry until it became clear that reunification with family was unlikely. He became a long-term ward in **July 2019**, meaning he was committed to the care of the Minister until age 18.

Establishment of Group Home for Vulnerable Children

When there is difficulty finding a long-term care option for a child, or children with special needs such as Elijah, the Ministry looks to developing other resources such as group homes. The Ministry's Community Service Development staff are responsible for developing or expanding community-based resources, which may include community-based supports, programs, or residential care. Once a decision is made to establish a specialized group home, a Request for Proposals (RFP) is created and posted on the government's website outlining what is required.

> The Children's Services and Residential Services policy manuals provide guidance to Ministry and group home staff about the standards and practices required in providing services to children and youth.

The RFP for the home in which Elijah ultimately resided was posted publicly on December 6, 2018. It stipulated the Ministry was seeking a group home provider to deliver care to a small group of young children with developmental delays, including autism spectrum disorder and cognitive impairments. Among other responsibilities, the RFP specified that the successful provider must comply with policies, standards, and procedures in the Residential Services Manual (RSM) and Children's Services Manual.

Before the posting closed, the Company that operated the Martensville group home provided a submission to operate the group home. The Company is a national for-profit organization that provides various types of health-related services across Canada. As part of its Specialized Community Services division, it operates group homes for both children and adults. In addition to the Martensville group home, which opened in 2015, the Company had been operating two 15-bed short-term placement group homes in Saskatoon since 2018.

The Company's RFP Submission

In its January 7, 2019 75-page submission, the Company outlined its ability to meet the expectations of the RFP due to previous experience in working with children in care in Saskatchewan and understanding Ministry policy and care standards. It further cited its extensive experience in working with children with complex needs, that included:

- a person-centred residential care model;
- staffing resources including RN or LPN-level nursing, physiotherapy, occupational therapy;
- the use of specialized clinical support through either Board Certified Behaviour Analysts or Behavioural Psychologists;
- staff orientation and ongoing training and skill development in areas such as 'Caring for Individuals', 'Person-centred' care, care planning, empathetic care, and quality-care delivery; and,
- accreditation credentials that focus on, ***"delivering a high quality of residential services to children with intellectual, physical or mental health disabilities, including those with complex behaviour needs."***

According to Ministry staff, staff training levels are not verified by the Ministry prior to a group home opening.

The Company was the successful organization chosen from six RFP submissions. According to Ministry staff, a scoring matrix was used by a panel of staff to determine that the Company was the preferred applicant based on its RFP submission, in addition to being known as a provider of competent resident-based child-care services for the Ministry.

The Company located a home in the Lawson Heights area of Saskatoon to operate the new group home. In accordance with *The Residential Services Act*, Ministry staff completed or managed various inspections, all which passed scrutiny. These included physical inspections to ensure compliance with *The Residential-service Facilities Regulations*; with various relevant fire, safety and building codes, with requirements of the Saskatchewan Health Authority, and verification of proper insurance coverage.

Ministry staff indicated the vision for this specialized developmental group home was for the children to reside in the home until such time when they could transition (likely at age 18) into supportive living in the community with Community Living Service Delivery (CLSD) supports. This could include a range of possibilities, including CLSD-funded group homes, and other supports to enable them to reside in and successfully integrate into the community.

CLSD is a Branch within the Ministry that, among other things, provides supports and services to adult clients with intellectual disabilities.

Group Home Contract Issued

Community Service Development staff oversee the licensing and contract process for group homes. The contract awarded to the Company was to operate a four-bed home for children receiving services under *The Child and Family Services Act*. Objectives included providing a safe living environment in a family-like setting where children in the home would have emotional, behavioural and social needs met and demonstrate personal and social growth. The contract specified the requirement to comply with CLSD's Comprehensive Personal Planning and Support Policy, but not those in the RSM, which had been cited as a compliance requirement in the RFP. This was later recognized by the Ministry as an error.

CLSD's Comprehensive Personal Planning and Support Policy guides CLSD staff and outside service providers in program policies including comprehensive behaviour support and person-centred planning.

Once the contract was signed and the group home opened, Community Service Development continued to be a key point of contact for the Company. The Company commented to our office that they have always appreciated the support from this staff, however, lamented that initial monthly meetings eventually decreased in frequency due to workload demands of Ministry staff.

Elijah's Transition to the New Group Home

Elijah moved into the Company's new Lawson Heights group home in May 2019, and although there had been transition planning, all staff were new. One child from the Company's Martensville group home had also transitioned to the new home and two more children moved in during May and June. All children, ranging from 7-11 years old, had significant complex care needs.

Since coming into care, the Ministry had initiated various assessments and supports, including through the Alvin Buckwold Child Developmental Program, Speech Language Therapy, Occupational Therapy, Autism Services Saskatoon, and the Ministry's Multi-Disciplinary Outreach team. Consequently, by the time Elijah began residing in the Lawson Heights group home, it had comprehensive assessments and recommendations to ensure the care he received aligned with his unique developmental needs. These assessments outlined such issues as his tendency to be destructive, his learning and communication challenges, and his urges to run away. In the fall of 2019 Elijah also transitioned to a specialized education program at a Saskatoon elementary school.

Each of the four children residing in the home had a Ministry Children's Services Worker assigned to them. These caseworkers work within the Child and Family Service Delivery Branch and oversee the care of children, conduct ongoing assessments, and ensure they receive care commensurate with the requirements set out in Ministry policy.

> **The Company** noted it is neither ideal for the children nor staff to have different caseworkers for each child.

Not long after Elijah's placement in the home, there were several behavioural incidents documented by the Company. According to Ministry records, between May 2019 and June 2, 2020, the Lawson Heights group home staff had written approximately 63 incident reports specifically involving Elijah. Completion of these reports is required by Ministry policy. The Ministry's response or intervention depends on the nature of the incident, and level of impact. Several of these incident reports were deemed to be low impact, and involved Elijah being aggressive to staff or roommates, or involved destruction to property, and 11 involved Elijah attempting to or successfully running from the group home or from staff during outings.

> RSM policy requires group homes to document and submit **Incident Reports** for incidents such as: running, self-harm or suicidal ideation, allegations against staff, disclosures of abuse, management of severe behaviour through use of physical intervention.

These incident reports were reviewed by Ministry staff such as Elijah's caseworker or the Manager, Resident Services, to determine if the issue was fully resolved by the group home, or if further Ministry involvement was required. Several of these incident reports did not require follow up by the Ministry because the group home had addressed the issues to the Ministry's satisfaction.

Internal communications during the spring of 2020 show that front line and managerial staff from Child and Family Service Delivery began to question the ability of the Company to properly care for the children in the Lawson Heights group home. An official from the Company told our office that during that same time the group home was having difficulty with staffing, noting that, *"[...] there was a lot of turmoil. Staff were scared. It was COVID. Staff were busy. Staff were -- were leaving. Staff were not -- complying -- to the care plans."* Also, in the spring of 2020 the Company lost its Behaviour Analyst, a key staff member who worked with and directed the care of the children in

the group home. In late April 2020, concerned with Elijah's attempts to run and for his safety, the Company inquired with Ministry staff about installing additional security features, such as special door locks. The Company awaited further Ministry direction after being told there may be concerns with fire safety and licensing requirements.

On **May 20, 2020**, Elijah's caseworker wrote an email to her immediate Supervisor and relevant Manager of Community Service Development to bring to their attention the *"[...] continuous incident reports from this group home regarding [...] Elijah [...]"* The caseworker provided a summary of incidents from December 2019 to May 2020 related to Elijah's attempts to run and his aggressive or destructive behaviours, and what steps the group home had taken to address these concerns. In her concluding remarks she questioned the level of supervision provided in the group home and the training staff had to work with children with autism. She asked for assistance, including identifying supports the Ministry could offer to reduce the number of incident reports relating to his running and general safety.

Ministry staff from Quality Improvement who were invited into this email communication noted that because the funding for this home was for a ratio of two staff for four children, supervision was a challenge given the complex needs and behaviours of the children. Quality Improvement staff added that due to the COVID-19 pandemic, *"[...] all of the group homes have had additional stress of caring for children 24-7 with disruption to schooling, recreational activities and family contact that may increase child behaviours, particularly due to the importance of routine for autistic children."* A supervisor involved in the follow up chain of emails stated, *"I am not seeing that [the Company] is a very skilled CBO,"* and commented on a lack of communication, organization and routine in the home, and insufficient skill in working with autistic children.

At this point, various managers became involved in these communications and within days consulted with the Company and approved several supports such as extra one-on-one care for Elijah (over and above the contracted allowance), assistance from Autism Services, and a referral to the Ministry's Multi-Disciplinary Outreach Services to work with Elijah and the group home. Additionally, the Company inquired about its request for added physical security systems, emphasizing the daily risk of children escaping from the home, and the Ministry agreed to explore.

Multi-Disciplinary Outreach Services is a service stream of the CLSD Branch, which provides individuals with intellectual disabilities access to a team of professionals to complete assessments, mitigate risks and provide proactive strategies to caregivers.

Ministry Investigates June 2nd Incident

After fleeing in the early hours of June 2, 2020, Elijah was picked up by group home staff that same morning from the Ministry office. He re-settled into the group home, and on **June 3rd**, a Child Protection caseworker was assigned to investigate the incident. Nine group home or Ministry staff were either interviewed or contacted by email, and relevant records were reviewed. The investigation report was completed and approved by supervisors on **June 11, 2020**. The report concluded that the group home care worker who worked the overnight shift had failed to complete the required hourly room checks during the night. Elijah was known to run and had made several attempts prior to this event. The investigation report found that overall, the group home *"[...] [was] not staffed properly, designed for children who are violent and have high needs, or equipped to care for children who have autism."*

Child Protection workers under the Child and Family Service Delivery branch conduct **investigations** when there is evidence of child abuse or neglect.

Based on the investigation, the report identified critical areas of deficiency that would require significant correction. These included, in part:

- insufficient staff complement to properly supervise the children;
- inadequate staff qualifications and training to meet the children's complex care needs;
- internal organizational issues leading to lack of communication about children's care and safety;
- insufficient physical security systems built into the home; and,
- medical needs not consistently being met.

This report was shared with the Company's management who did not dispute its findings. As a result of the Ministry's immediate reaction to this incident, several measures were quickly instituted, including:

- hiring one-on-one staff for each child;
- increasing the staffing complement;
- improving physical security measures (alarm systems); and,
- instituting weekly meetings between the Company management and Ministry leadership to address deficiencies and provide support.

Also, during this time, the Company conducted an internal Quality of Care review with respect to the staff member who was responsible for overnight supervision of Elijah and took commensurate human resources steps.

Quality of Care Reviews are conducted by the contracted group homes and reported back and reviewed by the Ministry. These reviews address what are typically considered human resource and organizational issues that are best addressed internally by the group home.

Subsequent Group Home Investigation

On or before **July 8, 2020**, the Ministry received several new concerns about the care of children in the Lawson Heights group home, including medical and physical neglect allegations involving five group home staff and affecting all four children in the group home. The same Child Protection caseworker assigned to conduct the June investigation was also charged with investigating these new allegations. This investigation began on **July 10th** and involved direct interviews with approximately 20 staff from the Company and Ministry, a review of relevant email and file information, as well as additional email communications with those involved. The report findings were finalized and signed off as approved by Ministry superiors on **July 30, 2020**. All but one allegation was substantiated, including:

- inappropriate discipline;
- neglect ranging from lack of sufficient COVID-19 protocols to egregious medical neglect resulting in one child requiring hospitalization;
- lack of staff training (identified in the June 2020 investigation as being an ongoing concern);

- internal dysfunction within the group home staff; and,
- that a senior staff member from the Company had not been forthcoming or honest with certain information during the investigation.

The Advocate has reviewed and determined the findings to be consistent with the evidence gathered, however noted the lack of recommendations typically included in such an investigation report.

The Company and the Ministry's Responses to July 2020 Investigation

An official from the Company acknowledged to our office that it accepted the concerns found in this investigation, particularly with training deficiencies, however added that it took some time for group home staff to fully appreciate the complex care needs of these four children. This official noted that when the home first opened, the Company had, *"[...] a board-certified behavioural analyst who had her own practice and was very involved with on boarding and transitioning the children into the home and setting up the care plans."* When she resigned from her position in the spring of 2020, it created challenges that the Company was contemplating how best to address. Additionally, the Company noted there was some confusion about what the training requirements were until later. Further, once the COVID-19 pandemic forced schools and recreational activities to pause in the spring of 2020, the four children were constantly at home, which presented new challenges for the staff in the home.

While acknowledging the compliance deficiencies found in the July 2020 investigation, the Company reported it did not believe the Ministry fully appreciated all aspects of the dynamics in the home. The Company's regional office conducted a follow-up investigation and gained greater understanding about the level of discord that had developed in the home.

The Company's leadership also noted that it was not until after this incident that they had started weekly meetings with all the caseworkers assigned to the children, and that one child's caseworker had never attended the home previously. Nonetheless, the children's caseworkers sometimes sent other supervisors or co-workers to attend these meetings in their absence, which was reported as not always beneficial since these alternative staff had limited knowledge of the child. Upon reflection the Company indicated they wished they had requested, or the Ministry had offered, this level of collaboration sooner, especially when incidents in the home were increasing.

As a result of the issues in early July, the Ministry permanently removed two of the four children from the home. Elijah remained in the home and Ministry officials began holding regular meetings with the Company's leadership. Further, extra staffing supports from outside agencies were also put into place for added child-care and supervision.

On **July 30, 2020**, the Company provided notice to the Ministry that it would discontinue operating the Lawson Heights group home. According to the Company, this decision related to several factors, including chronic difficulty recruiting staff, concerns with continuity of care with having staff from multiple agencies in a home, and that, *"[...] it was best for the children if we just gave up the contract."* Meanwhile, the Company continued to operate its other two short-term emergency receiving group homes in Saskatoon.

As a result of the Company discontinuing its services to the group home, the Ministry found a new organization that had previously provided supplemental staffing supports in the Lawson Heights group home to assume its operations on **September 15, 2020**. In its contract with the Ministry, funding for staffing was increased and the child capacity was reduced from four to three.

As a result of the June and July investigations, and corresponding findings, the Ministry conducted two Program Standards Reviews – one for the Lawson Heights group home, and another for the Company's two other short-term care group homes in Saskatoon. Program Standards Reviews are detailed reviews that scrutinize a group home's files and include observational visits and interviews with a sample number of staff and resident children to assess its compliance with relevant policies.

The Ministry's Quality Improvement Unit conducts **Program Standards Reviews** periodically to assess group home compliance with policy and make corrective recommendations.

The Program Standards Review for the Lawson Heights group home was conducted in June and July, and a draft report was completed by the assigned staff in August 2020. The report was not finalized until December 2020, after the Ministry had opportunities to meet with representatives from the Company. The report noted various shortcomings, some of which included:

- inadequate communication between Ministry caseworkers and the group home;
- group home staff not having timely access to the Company's management to address issues, resulting in staff being left to make critical decisions;
- staff not always fully aware of policy requirements including all aspects of incident reporting, such as *"[...] requirements for responding to and reporting allegations of abuse against group home staff."* (Ministry caseworkers reported a lack of detail within some incident reports, however The Company was not advised about these concerns);
- training standards as set out in the RSM were not met, such as in Crisis Intervention Training, cultural awareness, suicide intervention, food safe handling, or universal precautions. Some staff had no previous experience working with children with intellectual or physical disabilities;
- use of physical restraints contrary to the Company's policy prohibiting use of physical restraints;
- failure to consistently comply with policies such as CLSD person-centered planning, or critical RSM policies for child development that included setting goals, strategies to achieve them, and monitoring progress;
- lack of proper COVID-19 precautions (one child in the home was immunocompromised and yet there were no precautions in place for protecting them or the other children from COVID-19);
- insufficient sensory and therapeutic tools to meet the cognitive and developmental needs of the children in the home; and,
- poor staff culture including staff displaying a, *"[...] lack of respect towards leadership and colleagues which appeared to manifest itself in ongoing quality of care concerns."*

> *"Virtually all staff reported feeling 'burnt out' and felt they lacked skills in caring for complex needs children."*

The Ministry's Program Standards Review of the Company's two short-term group homes was completed in the fall of 2020 but not yet available for the Advocate's review. However, according to some interviewees, these other group home operations were in greater compliance, and with less concern about the organization's functioning.

In addition to the investigations, Program Standards Reviews, and additional supports, the Ministry initiated operational support teams to enhance communication and support with the Company and another group home operator that had been facing similar challenges. As well, the Ministry initiated a pilot project in the Centre Service Area (out of Saskatoon) in October 2020, appointing a Supervisor from Child & Family Service Delivery to act as a group home liaison, to give group homes a clear point of contact when issues or questions arose.

> The Company reported that having one main point of contact at the Ministry has been a welcomed change, since there has not always been clear and coordinated lines of communication or understanding of who to reach out to, and when. They believe the Ministry recognized and filled a gap when it initiated this resource and hope it will become permanent.

Given the investigation by the Ministry and its subsequent Program Standards Reviews, the Advocate saw no advantage to further investigating these events or issues in the Lawson Heights group home. However, the Advocate remained interested in how the Ministry reflected on its own responsibility and the oversight it provides to contracted group homes generally.

Our office has received ongoing concerns relating to the quality of care in group homes generally, which have been monitored and addressed through our advocacy operations, in cooperation with the Ministry. In health care, the World Health Organization[4] identifies common causes of poor quality of care to include the following:

- inadequate or unhygienic infrastructure;
- lack of competent, motivated staff;
- lack of availability or poor quality of service;
- poor compliance to policy standards or evidence-based clinical interventions and practices; and,
- poor documentation and use of information.

These characteristics are common themes in literature relating to quality of care in child welfare services and will be further discussed in this report. Consequently, the Advocate has deep and persisting concerns about whether the Ministry's current oversight mechanisms constitute a comprehensive framework supported by adequate resources that ensures the highest quality of care and outcomes for young people who reside in group home care.

In 2017 the Advocate was invited and submitted feedback on *The Residential Services Act* and its regulations. The focus of our submission was on, *"[...] strengthening accountability in the Act to improve outcomes for and uphold the rights of children and youth who receive services through Child and Family Programs in residential settings."* Highlights from this submission most relevant to this investigation include our suggestions for:

- a licensing mechanism that enunciates clear physical and quality-of-care standards;
- quality-of-care standards that are embedded into legislation to provide a consistent understanding of expectations across all licensed providers, and form the basis for standard measurements to assess, enforce, and improve quality of care for children and youth;
- fulsome cyclical reviews or other types of inspections that measure compliance against established physical and quality-of-care standards; and,
- the ability to conduct unannounced inspections, to increase the mechanisms available to the Ministry in holding these services to a high standard of care.

To our understanding, these proposals have not been adopted.

[4] https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/quality-of-care

As detailed above, the Ministry identified the need for a specialized group home, followed its standards to issue a public RFP, scrutinized submissions, and selected the Company as the best applicant. The Ministry took appropriate steps to ensure compliance with Regulations and other physical inspection requirements before the home was approved to open. Ministry staff viewed the Company as a competent partner in resident-based child-care, and made a good faith assumption that staff had the minimum standard training and any additional skills required to meet the unique needs and challenges to care for Elijah and the other three children in the home.

> The Company stated that in addition to reporting requirements such as financial and incident reports, they found it unusual that the Ministry does not request progress reports that make the group home accountable in meeting measurable outcomes to demonstrate the Company is providing quality care.

Once the Company's Lawson Heights group home opened, ongoing monitoring involved a variety of Ministry staff attending the home, assisting the Company when issues arose, receiving and reviewing incident reports and other types of utilization or financial statements, annual physical inspections and eventually, conducting investigations and Program Standards Reviews.

We also acknowledge the Ministry's efforts to examine the June 2nd incident and subsequent July concerns, and the intervention toward improving its practices in the interim. However, the Advocate questions whether initial planning efforts in this case and in general are adequate to ensure group home infrastructure is set up to meet the needs of its intended residents, and ongoing processes are sufficient to proactively monitor quality of care and identify issues before they fester and place a child's safety into jeopardy, as happened on June 2nd to Elijah. As a result of its June and July investigations, the Ministry added monitoring and supports but conveyed that these are interim measures rather than a systemic shift in how it provides oversight to its group homes overall.

3.0 Ministry Legislation, Policy and Responsibilities

To garner a greater understanding of how group home governance is operationalized by the Ministry, we studied the most relevant legislation, policies, and staff responsibilities.

3.1 LEGISLATION

Child and Family Services Act is the overarching legislation used by the Ministry to protect children and provide support services to families. This legislation enables the Minister to determine if a child requires protection and authorizes out-of-home care resources such as group home care. When children are long-term wards, the Minister is considered to have the responsibilities of a parent.

The Residential Services Act and its regulations govern the licensing of resident-based services for children and youth who are in the care of the Minister. Licenses are issued annually and are geared toward compliance with physical standards. The *Act* does not enable the Ministry to license resident-based homes on First Nations, in which case the Ministry may enter Protocol Agreements.

> *"Before children are placed into new group homes, I think they should do some kind of assessment or investigation into the organization first; to know that staff are trained, have the knowledge base, and the understanding needed."*
>
> Quote - Ministry Staff

3.2 POLICY

Child Protection Services Manual outlines standards, procedures, and practice guidelines for Ministry and First Nations Child and Family Service Agency staff who deliver child protection services.

Children's Services Manual contains policies, standards, procedures, and practice guidelines specific to children who are in out-of-home care, whether that be temporary (with the goal to reunite children with family) or long term (when reunification is not the primary objective) where the Minister assumes parental responsibility for the child.

> *If I had a magic wand, we would be doing our reviews on a regular basis, potentially doing more in terms of the quality of care -- almost like a quality-of-care investigation -- more thoroughly."*
>
> Quote - Ministry Staff

Key sections include guidance for reporting and managing allegations of abuse and neglect against group home resources, and roles and responsibilities within these procedures which include investigations by Ministry staff and Quality of Care reviews by group homes. Additionally, it provides direction for Serious Occurrence Reporting and Quality Assurance Reviews as a way to review and improve services to children, youth, and their families.

> *"The role of Resident Services is unclear, and if it is meant for oversight of group homes, it should not also be involved in the front-line activities of managing and overseeing incident reports and allegations of abuse and neglect. Oversight and front-line duties should remain separate".*
>
> Quote - Ministry Staff

Residential Services Manual includes *"provincially recognized standards of care to ensure residential care and case management practice effectively responds to each child/youth's individual developmental needs, supports healthy personal, cultural, and social well-being, and encourages family reunification wherever possible."* This manual describes:

- the fundamentals of physical, emotional, and spiritual care within group homes settings;
- case management principles and practice;
- child and family rights and responsibilities;
- living accommodations; and,
- expectations for human resources (including staffing, training), safety measures, and responding to and reporting various incidents.

As with the Children's Services Manual, the Residential Services Manual provides group home operators and Ministry staff with direction about reporting and managing various types of incidents and allegations, and who is responsible during the required processes.

> *"Due to the number of group homes, it is not feasible to do Program Standards Reviews regularly, and this key oversight role needs more resources."*
>
> Quote - Ministry Staff

Another key section of the RSM includes the requirement to *"establish processes for monitoring performance, evaluating services and outcomes, reviewing policies, standards, and procedures, and utilizing the results to make improvements to the programs and services of the group home program."*

3.3 MINISTRY RESPONSIBILITIES IN GROUP HOME CARE

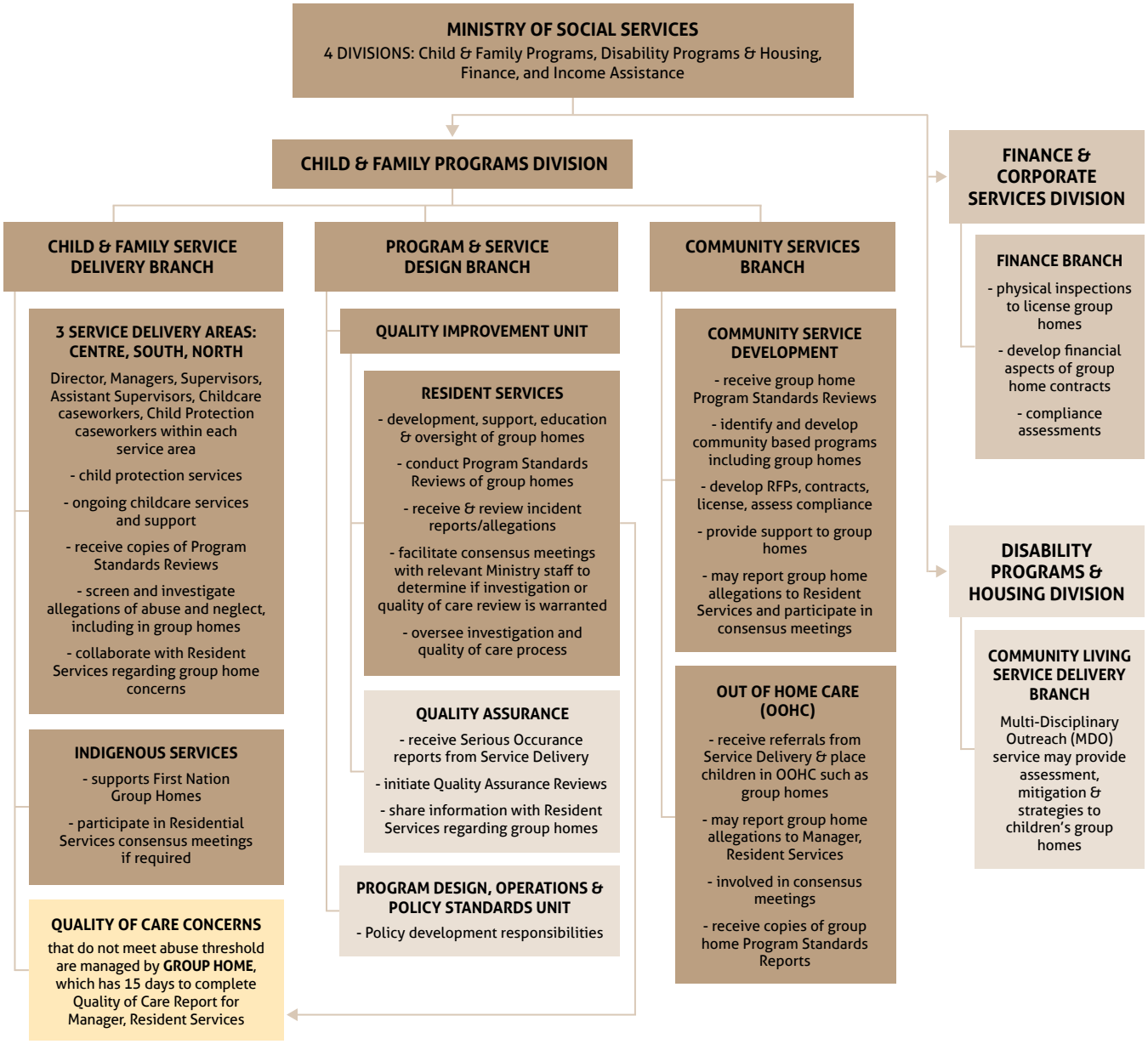
Broadly, the Ministry of Social Services provides various safety net programs and services in areas such as income support, affordable housing, supports for persons with disabilities and child and family services. The four operating Divisions of the Ministry are: Child & Family Programs, Disability Programs & Housing, Finance & Corporate Services, and Income Assistance.

Although Child & Family Programs has the most responsibility for group home functions, Finance & Corporate Services and Disability Programs & Housing Divisions offer limited supports and oversight.

> *"The Ministry does not always fund group homes to meet or exceed its requirements, and some group homes identify that funding is inadequate for behaviour supports and training, and they do not have the ability to access training on their own."*
>
> Quote - Ministry Staff

The chart on the following page is an example of the number of roles and points of contact within the Ministry that may be involved in group home support and oversight (see Appendix A for more detail about these roles).

Ministry of Social Services Group Home Oversight Responsibilities



What this illustration is intended to show is the number of working areas and contacts within the Ministry that may limit or interfere with the capacity for a streamlined and efficient mechanism for oversight and support. While it is recognized that some of these areas are certainly required to be involved, it is unclear where ultimate responsibility lies for the support and comprehensive oversight of services provided to children under this domain of group homes. We learned in our review that these varied departments often overlap, lack resources, cause confusion about who is doing what role and who is responsible for what, and in the end, are not efficient. There is no question, this has resulted in children falling through the cracks.

Note: The darker the brown, the more involvement in Group Home governance or oversight

4.0 Growth In Group Homes

In 2015 the Advocate learned, and has since been monitoring, that a decline in foster care resources and a significant increase in apprehensions resulted in some children and youth being placed in hotels in two Saskatchewan cities, under the supervision of the Ministry or CBO staff. The Ministry increased its efforts to recruit foster care providers and although recruitment strategies have been somewhat successful, approved foster home spaces have remained relatively unchanged. To address the need for appropriate emergency placements, the Ministry began developing more short-term spaces operated by group home providers.

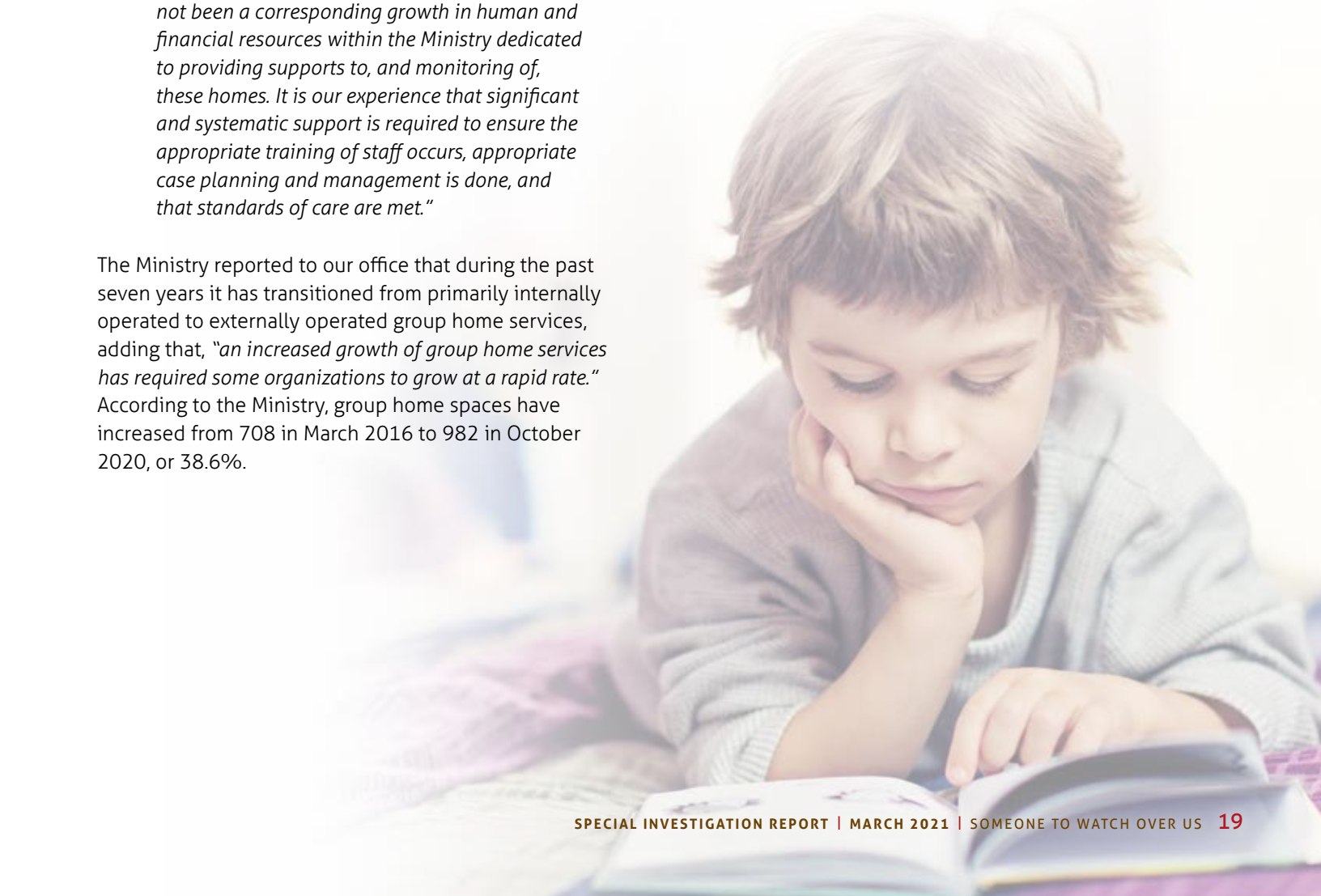
In our 2016 Annual Report we commented on these developments:

> *"While we acknowledge the efforts of the Ministry to find creative solutions to reduce the use of hotel rooms, we do caution that there has not been a corresponding growth in human and financial resources within the Ministry dedicated to providing supports to, and monitoring of, these homes. It is our experience that significant and systematic support is required to ensure the appropriate training of staff occurs, appropriate case planning and management is done, and that standards of care are met."*

The Ministry reported to our office that during the past seven years it has transitioned from primarily internally operated to externally operated group home services, adding that, *"an increased growth of group home services has required some organizations to grow at a rapid rate."* According to the Ministry, group home spaces have increased from 708 in March 2016 to 982 in October 2020, or 38.6%.

The case of Elijah and our systemic concerns about how the Ministry manages its group homes has raised questions for the Advocate as to whether this growth has impacted the Ministry's ability to provide quality supports and oversight.

During our interviews, Ministry staff also indicated that resources have not increased substantially and in proportion to the growth in group homes over the last several years. Staff reported the need to support group homes including dedicated resource workers and a comprehensive training package that is similar to the provisions for foster homes. Staff emphasized the need for training on trauma-informed practices to deal with children who have a multiplicity of issues and complex behaviours such as autism or Fetal Alcohol Spectrum Disorder. Staff warned that the lack of resources was impeding its ability to complete the reviews needed to keep the Ministry aware of issues before they become critical.



5.0 Findings and Recommendations

The case of Elijah triggered a larger review of the process by which services are provided to children in group homes. While this was not a full comprehensive systemic review of all group homes, this investigation provided some critical insights into the gaps and lack of oversight that culminate into the findings and recommendations below. As stated above, the Advocate remains troubled the Ministry has not engaged in a process to reflect on how gaps in service, support or otherwise, illustrate system issues that it will tackle in the long run.

In terms of the Ministry's response to the incident, the Advocate acknowledges there was a thorough investigation into the claims of abuse and neglect. With most allegations substantiated, the Ministry worked to ensure it instituted several appropriate measures to improve the immediate safety and care of the children in the home and increase its efforts to communicate with, and support, the Company. The results of these investigations were appropriately shared with the Company's management which took exception to some conclusions in the second investigation. Nonetheless, the Advocate acknowledges that the Company accepted responsibility for the effects these deficiencies had on the children.

Overall, the Advocate is satisfied with the interim responses to these troubling circumstances and finds that the Ministry has demonstrated, throughout these events, its ability to leverage existing mechanisms and manage in times of crisis. However, this is reactionary. We understand from the Ministry that its operational support, increased meetings between caseworkers and the group home, and its new liaison resource, are only meant as interim, not permanent, measures.

Since these unfortunate events unfolded, the Ministry has acknowledged responsibility for some issues found in this case. However, the Advocate has not received a clear, long-term, sustainable, and permanent plan of action based on an articulation of the gaps the Ministry has identified in these circumstances.

> **FINDING #1** - The Ministry's current oversight mechanisms were not sufficient to prevent or identify the issues in the Lawson Heights group home before these became a crisis, and do not adequately provide oversight or proactively monitor quality of care in group homes generally.

The investigations completed in June and July found the children in the Lawson Heights group home were neglected, restrained, and suffered poor quality of care due to insufficient staffing, skill levels and training, poor communication, and troubling staff discord. This resulted in a failure to provide optimal care for these children. In considering why the Ministry did not detect these problems before there was a crisis, the Advocate considered whether the Ministry's oversight structure was sufficiently robust to proactively, not reactively, monitor the quality of care being provided to children placed in group homes.

When the Ministry selects an organization to operate a new group home, various inspections and processes are completed before a license is issued and a contract signed. The organization agrees to comply with policies, submit regular reporting of financial and utilization information, and undergo an annual compliance assessment. Various staff maintain contact and assist in supporting group homes, track and assess each child's progress, do periodic reviews, and respond to concerns as they arise.

The disparate roles and responsibilities in this current structure enabled very vulnerable children to fall through the cracks in this case, as no one role or area is designed to proactively monitor group home systems to identify and rectify quality-of-care issues before a crisis. Rather, the Ministry reacts to what is already a breakdown in the system and makes recommendations that it does not efficiently monitor. In the Lawson Heights group home, the four different caseworkers for each of the four children attended the home irregularly. Elijah's caseworker became concerned about the skill level of staff after numerous incident reports had accumulated, and not because of visits to the home. And although these caseworkers play a critical role in monitoring children's progress, given their various workload demands this is not a reasonable or comprehensive approach to monitoring all aspects of quality care in a group home.

Group homes must comply with standards in applicable policy manuals, but the most critical ones do not appear to assist the Ministry in defining, assessing and monitoring quality of care with such frequency and depth as to detect impending problem areas. For instance, policy requirements that group homes develop and submit Child Update Reports or maintain an internal continuous improvement process are either not examined or do not provide a comprehensive guide to evaluating quality of care. And as we have seen in this case, assessing and managing incident reports and allegations of abuse or neglect may highlight ongoing or chronic issues, which is simply reactive and only serves to highlight the issues and make the changes after the fact.

It would be expected that the best action taken by the Ministry to assess the quality of services in group homes is through its Program Standards Reviews. Traditionally these have been close examinations of adherence to policy but have not always delved deeply into assessing whether or how compliance to policies illustrates quality of care. According to Ministry staff, more recent efforts have focused on observing and capturing in written narratives about quality of service, such as through observations about how a child might be demonstrating attachment to their caregivers. Staff expressed interest in expanding these reviews to probe more deeply into quality-of-care examinations, rather than simply measuring policy compliance quantitatively. However, current resources are insufficient to achieve this goal as evidence by its inability to conduct these reviews early and often.

In 2016, a system-wide review of Ontario's child and youth residential services was conducted by an independent panel resulting in a report entitled, *Because Young People Matter* [5], which emphasized the **need for a *"unifying mechanism to ensure the oversight, accountability and quality of care required across the province."*** The report highlighted that significant focus must be placed on the oversight of quality of care:

> *"The everyday experience of young people in out-of-home care is impacted first and foremost by the quality of care provided in residential services. Such quality of care is a function of a wide range of factors that include the quality of human resources, the relationships among young people and between young people and care givers, the physical infrastructure of residential programs, the appropriateness of program routines, rules, and activities, and also the quality of food, the attention to identity and developmental growth, the levels of physical and emotional safety, and the on-going connections to family, kin, friends and community."*

The Advocate agrees that children in group homes will be highly impacted by the above stated factors which are critical in assessing quality of care by service providers. Additionally, and of great concern is that the business of group home systems, with its revolving staff and its overall type of operations, does not tend to afford an environment that fosters the deep attachments and love needed for a child to feel emotionally safe and secure in order to contribute to their full growth potential, as is their right.

According to established research in health care, quality of care can be generally described as the degree to which services increase the likelihood of desired outcomes while placing particular importance on quality of life.[6][7][8] This definition can also be applied to quality of care in child welfare. Achieving high quality of care requires current professional knowledge and ought to put the needs of children at the centre throughout the child's time in that service. Characteristics of quality of care may be evaluated by assessing the factors noted in the above quote and must incorporate two important components: **the quality of the provision of care, and the quality of care as experienced by the child.** Quality of care can be both systemic and case specific and, in this case, we see the children in this home experienced a breakdown in both. We believe the Ministry has intent to provide quality care, however, lacks an appropriate framework of quality measures and a streamlined, sustainable oversight mechanism to work to this end.

[5] http://www.children.gov.on.ca/htdocs/English/documents/childrensaid/residential-services-review-panel-report-feb2016.pdf

[6] Medicare: A Strategy for Quality Assurance: Volume 1. Institute of Medicine (US) Committee to Design a Strategy for Quality Review and Assurance in Medicare; Lohr KN, editor. Washington (DC): National Academies Press (US); 1990.

[7] https://www.who.int/health-topics/quality-of-care

[8] http://www.children.gov.on.ca/htdocs/English/documents/childrensaid/MCCSS-Residential-Resource-Guide.pdf

At this time, it is unclear whether the Ministry has considered or incorporated such quality-of-care factors into its policies or has established a framework that directs the proactive examination of quality of care by group home service providers - one that includes clear definitions and measurements. Instead, we see an overreliance on reactive oversight and a focus on adherence with physical standards, completeness of files, policies, and minimum standards.

As outlined in *UNCRC* Article 25 and in its Guidelines for Alternative Care for Children, accountability measures must not only be in place, but must have the efficacy to monitor care, protection, and health, and assess whether quality and conditions are conducive to the child's development.

The use of a comprehensive quality-of-care framework, one that clearly defines roles and responsibilities, quality standards and identifies what evidence and variables of quality are to be measured, is necessary to demonstrate whether quality standards are being met. Had such guidance existed, it would have placed the Ministry in a better position to identify issues in the Lawson Heights group home before these became chronic, leading these most vulnerable of children to be neglected.

Thus, it is critical that any oversight approach to group homes is one that requires a streamlined, sustainable, and operational approach that is resourced properly to ensure the high standards of care to which children are entitled and to the safety and protection of which is their right.

> **FINDING #2** - The Ministry does not adequately plan, resource, or provide ongoing supports to group homes, and did not do so with respect to the Lawson Heights group home.

This case reveals a lack of thorough planning and effective support that would have otherwise contributed to the success of the Lawson Heights group home in caring for these vulnerable children.

When a new group home is developed and passes the various critical stages of scrutiny before its doors open, Ministry staff who consider placing children must have full confidence in the group home's ability to effectively care for these children. Planning in this case, however, did not include key assessments and verifications. For instance, knowing children with autism and developmental delays would reside in this home should have prompted Ministry staff to examine what physical security systems would be appropriate to install prior to the home opening. Instead, proper wired-in alarm systems and specialized door locks were not considered nor installed until after escapes became chronic. Additionally, instead of advanced verification, the Ministry relied on good faith that training, and skill levels of the Lawson Heights group home staff were in place when the children moved in. Planning by Ministry officials must go beyond current inspections, and should anticipate, examine, and properly equip group homes in consideration of the unique needs of the children they are intended for.

As revealed in the Ministry's investigations, staff skills were not at a level commensurate with the complex needs of the children residing in this group home. Even if staff had met minimum standards for training, this would not have raised skills to a level sufficient to meet the exceptional needs of these children. The Ministry does not take all reasonable steps to identify the unique training needs required for each group home, assess whether staff meet those requirements, and provide necessary support, either through funding or direct training opportunities, all which are critical in ensuring proper care and best outcomes. The Advocate finds it untenable to leave to chance that group home staff have the requisite skills to fully care for and ensure children in these group homes thrive.

Additionally, and as evidenced by the Ministry's post investigation action, the lack of a clear and consistent point of contact at the Ministry was a barrier to effective communication with the Company and likely prevented the Ministry from identifying needs and issues in a timely manner. The Company did not always know who to approach about certain issues, and Ministry staff did not always clearly communicate its concerns with the Company. The Company has welcomed the recent introduction of a Ministry liaison because it provides certainty about where to bring inquiries and offers consistent messaging, all which they hope will continue.

A more coordinated and efficient form of communication between the Ministry and group home operators would generate a consistent source of knowledge about the day-to-day operations and needs in a group home, and more readily identify and problem-solve issues as they arise. It is the Advocate's view that such an approach would have more likely enabled the Ministry to have identified issues in the Lawson Heights group home earlier.

The provision-related Articles of the *UNCRC* (particularly 20, 23, and 25) and its Guidelines for Alternative Care for Children emphasize that children are entitled to adequate standards of living, and when placed into residential-based care, must receive care from staff who are sufficiently trained to meet any challenging or special needs, and reside in an environment that is nurturing and provides the resources necessary for them to thrive.

Enhanced planning and resourcing geared to the unique needs of each group home, targeted training supports, and streamlined and responsive communication, is imperative to better equip group homes to meet the challenging and complex needs of children and ensure the group home environment is conducive to a child's development.

5.1 RECOMMENDATIONS

Recommendation #1: That the Ministry of Social Services enhance and re-design its group home oversight and accountability structure to:

- incorporate a leadership role that is responsible for the effective oversight of group homes;
- develop comprehensive evidence-based quality-of-care definitions and standards that promote proactive, not reactive, responses to the care of children;
- articulate what evidence is needed to demonstrate that group homes are meeting quality-of-care standards; and,
- include sufficient human and financial resources to enable timely and proactive reviews of group home care.

Recommendation #2: That the Ministry of Social Services develop a permanent resource for group home operators, which provides a clear point of contact, support, and resources such as skill development.

Recommendation #3: That the Ministry of Social Services enhance its process for approving group home openings to include identifying and verifying the qualifications and training of staff and examining the unique needs of the children who are the intended residents to determine what unique features should be included in the group home.

The Advocate will monitor the progress made by the Ministry in achieving these recommendations, through various approaches that includes requesting updates at regular six-month intervals, and through other collaborative contacts as necessary.

6.0 Conclusion

Canada is a signatory to the *United Nations Convention on the Rights of the Child*. The Government of Saskatchewan has endorsed and committed to these articles in its Children and Youth First Principles. The corresponding expectation is that when the Government of Saskatchewan places a child who is in need of protection into residential care, it is obliged to: provide strong oversight, ensure staff training is sufficient to meet the needs of children, thoroughly assess the qualifications of potential group home operators to provide the care required, create clear plans for children in care that include ways to measure the quality of care, and enable government staff to inspect these group homes in meaningful ways.

The Ministry provides group home services, support, and oversight largely across three Branches within the Child and Family Programs Division, in collaboration with and support from two other Divisions. Because of the size and complexity of these disparate areas, the Ministry must ensure responsibilities are clear and that silos do not prevent important cross-communication and collaboration. Perhaps most importantly, as identified in the *"Because Young People Matter*[9]*"* review of residential services in Ontario, ***"a single unified, integrated governance structure must reside within the Ministry to provide systemic oversight and accountability for all residential services through mechanisms that have at their core, the foundation and elevation of quality of care."*** This requires a comprehensive governance and oversight framework; one that enables a particularly disadvantaged and vulnerable child, like Elijah, to not only reside, but to flourish in a group home until transitioning out of mandated care.

The Advocate finds that Elijah's case and the concerns found at the Lawson Heights group home are symptomatic of systemic shortcomings in Ministry oversight. What is revealed in this case has been the subject of growing complaints to the Advocate's office for years, and of our ongoing pleas to the Ministry to improve oversight and supports. The Advocate further concludes that in its current state, the Ministry's oversight scheme does not fully meet its parental obligations to vulnerable children who are placed in group home care and who may be further disadvantaged by their developmental and cognitive impairments. Without taking more control over the desired outcomes, more children in group home care will languish and not realize their fullest potential.

The Advocate strongly urges the Ministry to take up the challenge to review and renew its structure, to properly resource the group home system, and to provide support, comprehensive oversight, and accountability, so that children and youth who are placed in group homes will have the quality of care expected from a Ministry who stands in place of a parent.

[9] http://www.children.gov.on.ca/htdocs/English/documents/childrensaid/residential-services-review-panel-report-feb2016.pdf

Appendix A

Below are additional details about the roles and descriptions found in the chart on page 16. Given the scope of this investigation, these are not meant to be an exhaustive accounting of all functions with respect to group home responsibilities, but rather an attempt to highlight key areas of oversight and support.

CHILD AND FAMILY PROGRAMS DIVISION

Community Services Branch:

Community Service Development – largely responsible for identifying needs and developing community-based resources, including group homes. Staff develop RFPs, meet with Ministry leadership to vet RFP proposals and make selections based on a scoring matrix, and create budgets, oversee initial and annual licensing processes, and develop contracts. Staff meet with and support group home operators, based on need and other factors. Staff receive and review the organizations' program and financial reporting, and on an annual basis, work with the Finance Branch to complete a Compliance Assessment and Planning Report to evaluate group home licensing and funding conformity and ensure key aspects of contracts are being fulfilled.

Out of Home Care – receive referrals from Child and Family Service Delivery Branch to place children with appropriate residential-based out of home care resources. They may meet with Resident Services about concerns arising from group homes and share information with other Ministry staff as appropriate.

Child and Family Service Delivery Branch - is focused on child protection services. Childcare caseworkers are responsible for the child's wellbeing while in care, for completing various assessments and other documentation to assess the child's medical, educational, social, cultural, recreational, and therapeutic needs, and evaluating the child's care and development, among other goals. Caseworkers visit children in group homes, observe how they are progressing and how the group home is operating. Caseworkers receive copies of incident reports relating to their children. Assistant Supervisors, Supervisors, Managers and Directors provide direction and approvals to caseworkers, and assist in the ongoing care of children when issues arise, as necessary. Staff participate in Resident Services consensus meetings to assess the need for investigations when allegations arise in group homes. Child Protection workers screen and investigate allegations of abuse and neglect. Indigenous Services Consultants provide support in First Nations group homes.

Program and Service Design Branch – Quality Improvement unit:

Resident Services examines services provided in group homes. The Manager facilitates consensus meetings to review and determine, in conjunction with other key Ministry staff, whether investigations or Quality of Care Reviews are needed to address issues that become apparent. The Manager reviews the results of these processes to determine next steps and collates and analyzes this data to extract themes and identify concerning issues. Staff conduct periodic Program Standards Reviews of group home practices to assess policy compliance, examine quality of care provided, and make and monitor recommendations.

Quality Assurance examines services provided by Ministry staff by conducting reviews of serious occurrences, (illness, injury, condition, or event that affects the health and safety of children and youth who are in care) with the goal of identifying shortcomings, making recommendations, and improving service delivery. Although not involved in group home oversight, Quality Assurance may share information with Resident Services when cases may reveal group home concerns.

FINANCE AND CORPORATE SERVICES DIVISION

The **Finance Branch** assists with developing financial aspects of contracts and completing regular reviews of financial and utilization reporting from group homes to ensure Ministry spending is following standards. Staff assist with physical inspections of group homes and prepare an information package for review by the Community Service Branch before a license is approved. Much of this work is done in cooperation with Community Service Branch staff.

DISABILITY PROGRAMS AND HOUSING DIVISION

The **Community Living Service Delivery Branch** may receive referrals from Child & Family Service Delivery to assess and mitigate risks and provide proactive strategies to group home staff to work better with children with intellectual impairments. Staff also assist older children with cognitive impairments to transition to adulthood, and to its community-based supports.

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