

CHILD ADVOCACY: DRAWING THE LINE IN THE SAND

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Introduction

Formalized child advocacy has been in place in the province of Ontario since 1982, with the introduction of the Office of the Child and Family Service Advocacy (Advocacy Office) through Section 102 of the *Child and Family Service Act*.¹ With a history that spans three decades, this is a welcome opportunity to reflect on the critical lessons learned about advocacy in general, and child advocacy in particular. It is important to understand how these lessons propelled us forward in the work that we do today.

The role of the Advocacy Office is threefold. First, and most importantly, it is to elevate the voice of youth. This means more than empowering youth to speak out on their own behalf. It means more than faithfully replaying their words. The standard to aspire to is articulated in an African proverb: “*Don’t speak about us, without us.*” It means speaking together with youth about youth. Second, the role of the Advocacy Office is to intervene when children who live outside of their family’s care report abuse or harsh treatment. Third, it is to ensure that care providers respect the legislated rights and entitlements of children and youth in Ontario.

Lessons Learned

- Advocacy is not a skill, nor is it an intervention strategy or practice tool. Advocacy is a lifestyle. To be an effective advocate, the principles of advocacy necessarily permeate everything one does. It is an integral part of one’s identity and the way in which one conducts one’s life.
- Advocacy is the catalyst for change – not the change agent. An advocacy initiative targets, provokes, and influences change. An advocate may create a climate for change or bring decision makers to a position of having to act. But it is conflictual for that advocate to then participate in or direct the change process. Change in policy or practice must be developed by those responsible for its implementation.
- The process of advocacy is incremental. Each advocacy initiative builds on the one before. Small successes are cumulative. There is a need for continual assessment and re-organization to sustain momentum. Major initiatives undertaken by the Advocacy Office

have often spanned more than five years. For example, unsafe practices in the use of intrusive measures or the management of young offenders, separate and apart from adults, are both advocacy initiatives that have required ongoing vigilance and sustained pressure. It is important to keep advocacy goals focused and in sight.

- Equalizing the power base is a primary function of advocacy. Advocates help young people to access legitimate authority and to learn skilful ways of disagreeing with people. This is more easily achieved when children and youth feel safe and heard.
- In preparing for any advocacy initiative, it is important to estimate the costs involved – both economic and personal costs. When “picking your battles,” these costs need to be weighed thoughtfully. Advocacy is about shifting the status quo or unblocking the inertia, whatever the endeavour, whether it be institutional culture, jurisdictional barriers, policy limitations, gaps in service, or protocols for practice. Advocates face tremendous resistance to proposed change even if that change is necessary or in the best interest of the child or the system. Advocates need to be fully prepared to confront that resistance.
- Champions need to be identified to move an initiative forward. Each community has a wealth of natural advocates for children. Mobilizing these advocates and nurturing those relationships is a critical component of successful advocacy.
- As a Child Advocate, I’ve learned to bring *courage* and dignity to every advocacy initiative. Advocates must anticipate retribution and reprisals for case and systemic advocacy. If the case intervention is not managed, the client (child) will experience retribution for having voiced his or her concerns. Retribution can be direct (such as loss of privileges for the child or loss of access to that child by a parent) or indirect (such as staff collusion with peer-on-peer violence). Retribution against the “whistleblowers,” who may be staff or caregivers, must also be predicted and prevented. Reprisals are frequently directed at the advocate as the “messenger” or “catalyst.” As the Child Advocate, I had never considered that there would be dangers or risks involved in the position. The threat of physical harm, personal property damage, intimidation tactics and bullying, has been common over the past ten years and is now

anticipated. Advocacy requires courage of conviction, the determination to stand your ground, and the ability to put personal fears and interests aside.

- Of paramount importance is to celebrate successes; to be your own historian and consistently tally and record those successes. Retrospective reflection instills hope and strengthens resolution. For example, a recent settlement in favour of young people who reported harsh treatment in a correctional facility is an important milestone. Fear of retribution, fear of denial, the placing of blame, shame and trauma historically inhibited victims of institutional abuse such that their stories were only told as they approached adulthood and gained the courage to report. Children and youth now know that they can speak about their care and be heard. The Child Advocate will be a vehicle for that voice. This reinforces the Child Advocate as a fundamental safeguard for children in care or custody.

Positioning Child Advocacy as a Government Agency: The Dilemma

There are four necessary components of child advocacy: independence, statutory power, accessibility, and exclusivity to children. In Ontario, the Advocacy Office is mandated under Sections 102, 103 and 108 of the *Child and Family Service Act*. It is legislated that children in care or in custody are informed about the Advocacy Office in a language suitable to their development. It is regulated that children are informed at admission and during plans of care about their right to contact the Advocacy Office. Information about the Office and how to access an advocate is to be posted in all residential settings. In 1998, the Advocacy Office shifted from its responsibility to provide advocacy for developmentally disabled adults to the provision of advocacy exclusively for children and youth.

In Ontario, the Child Advocate reports to senior levels of government in the Ministry primarily responsible for services to children and families. The Child Advocate negotiates with that same Ministry to ensure children receive the care they deserve. This creates a dynamic tension between Ministry officials and the Office.

Advocates are constantly balancing their relationship with decision makers against their responsibility to their client. On occasion this involves conflicts of interest. Advocates and bureaucrats have learned a healthy respect for each other while maintaining a social service system that is open and accountable. This emphasizes how important it is for advocates to create and nurture alliances inside and outside the government. It also offers a multi-layered approach

to advocacy strategies. Most successful initiatives have simultaneously created pressure from within and outside the constellation of decision makers. The internal positioning of the Advocacy Office facilitates accessibility to both sources.

Advocacy for Children at Risk

Over the past decade the Advocacy Office has witnessed dramatic changes in the population of children served. Children present with a greater complexity of needs. They often have neuro-developmental disorders, medical complexity, or cognitive impairments. It has been recently acknowledged that deprivation and chaotic family lifestyles contribute to a host of neuro-psychiatric problems. These children exhibit more extreme behaviours.

The clinical capacity in Ontario to assess these children is excellent. However, treatment strategies appear not to have kept pace. Children's Mental Health Centres, which are clinically most able to deal with children with complex needs, function at capacity and maintain long waiting lists for service. These resource intensive children with special needs are therefore managed in group homes which may not be fully equipped in terms of clinical and staffing resources to manage the complexity of needs presented. These agencies, which are dependent upon per diem funding to function at capacity, may not always be able to match the needs of children with the resources required to adequately care for them. Sometimes staff have managed the behaviour of children by employing techniques that worked historically, but are ineffective with the constellation of symptoms children present with today.

The recent amendments to the CFSA are commendable and broaden the safety net for children living in neglectful, chaotic, or abusive family environments. Children are coming into care in dramatically increasing numbers. For the most part, these children present with a range of mental health needs. Presently, there is a lack of adequate resources to manage increased referrals both in terms of numbers of referrals and the clinical capacity. Furthermore, staff in the group homes that care for this province's most vulnerable and difficult-to-serve children are among the lowest paid human service professionals. Society presently appears to devalue the work of child and youth workers and consequently there is diminishing interest in pursuing this profession. Staff turnover contributes to a lack of continuity and further attachment disruption for these children. Staff are young with minimal experience and often aren't offered the necessary training and supervision. There appears to have been a lowering of the bar in terms of standards and expectations of group home providers. In some circumstances, the living conditions of children in care are deplorable.

Since 1996, six children have died in group homes or institutions in Ontario. Two children died during the use of physical restraints, two children died from successful

suicide attempts, one died from assault by a peer, and one youth died of neuroleptic malignant syndrome. The rate of one death per year of children in care is unprecedented in the province of Ontario. All of these deaths were avoidable and unnecessary. There are lessons to be learned from

these deaths. Society collectively needs to draw the line in the sand.

¹ R.S.O. 1990, c. C.11 (CFSA).

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