CUSTOMARY CARE:

A SUMMARY OF MEETING DISCUSSIONS ON JANUARY 26, 2011

HOSTED BY THE

TRIPARTITE TECHNICAL TABLE

ON CHILD WELFARE

Submitted to the Tripartite Technical Table on Child Welfare

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Customary Care: Summary of Discussion Hosted by the Tripartite Technical Table on Child Welfare

I.INTRODUCTION

This report is a summary of discussions at a meeting hosted by the Tripartite Technical Table on Child Welfare on January 26, 2011 in Toronto Ontario regarding customary care. The Tripartite Technical Table on Child Welfare is comprised of representatives from the Ontario First Nations; the Social Services Coordination Unit of the Chiefs of Ontario; the Association of Native Child and Family Services Agencies of Ontario; the Ministry of Children and Youth Services; the Ministry of Aboriginal Affairs; and Indian and Northern Affairs Canada.

Meeting participants in the discussion included representatives of eight Children's Aid Societies (CASs), three of which were Aboriginal[1] CASs; Aboriginal child and family service agencies; the Ontario Association of Children's Aid Societies and Association of Native Child and Family Services Agencies of Ontario; representatives of First Nations associations and treaty organizations; the Social Services Coordination Unit of the Chiefs of Ontario; the Ontario First Nations Young Peoples Council; and the Social Services Portfolio Holder for the Political Confederacy of the Chiefs of Ontario.

The meeting focused on identifying challenges and opportunities associated with promoting the use of customary care and lessons learned by First Nations and CASs regarding how to promote CAS and First Nations' use of customary care, drawing on both positive and negative experiences. It was also intended to provide recommendations on the types of information, tools, training and other supports that would promote CAS and First Nations' understanding and use of customary care and contribute to relationship building. Legislative and/or regulatory provisions or desired changes that were seen as barriers or possible facilitators to the use of customary care were also to be noted.

A number of the comments throughout the discussion illustrate the need for more widespread, factual information to assist in the implementation of customary care. The results of this discussion will contribute to the development of a Tripartite Technical Table action plan for increasing the use of customary care.

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[1] The terms "Aboriginal" and "Native" used here denote the three constitutionally-recognized Aboriginal peoples of Canada: Indians, Métis and Inuit. Status Indians in Canada have adopted the term "First Nation" and voiced their preference to use this term or their nations' names, such as Anishinaabe, Haudenosaunee, Mushkegowuk or Lenaape, instead of the generic "Aboriginal" or "Native".

II.OVERVIEW

After a welcome by the facilitator and an opening prayer by Elder Basil Greene, the agenda was briefly reviewed. Grand Chief Phillips of the Association of Iroquois and Allied Indians, Social Services Portfolio Holder for the Political Confederacy of the Chiefs of Ontario then provided opening comments. He noted that customary care is a fundamental component of the First Nation approach to child welfare and contained within Part X of the *Child and Family Services Act* (CFSA).

Grand Chief Phillips emphasized the importance of keeping families intact and that the discussion should focus on sharing good ideas that work. Customary care is about each First Nation determining its own approach to customary care arrangements; thus, the good ideas that emerge from this discussion should not be misinterpreted as a "how-to guide" or model.

Grand Chief Phillips stated that the challenge with customary care is in how it is implemented. He stated that templates are not appropriate given that customary care as set out in the legislation is according to "the custom of the child's band"[2]. At the same time, First Nations want the rules everyone follows to be clearly understood and to be acceptable and equitable. The tripartite process is essential to influencing decision-making with regard to the issues raised.

III.BACKGROUND/CONTEXT

MCYS provided a brief context regarding the 2010 review of the *Child and Family Services Act (CFSA),* which in keeping with Section 226 of the Act, examined CAS compliance with the "Indian and native" provisions of the Act. The section 226 review process included written submissions, six regional discussions with Aboriginal and non-Aboriginal groups and a case file review of over 300 cases from both Aboriginal CASs and non-Aboriginal ("mainstream") CASs.

The review found varying levels of compliance with the "Indian and native" provisions of the Act, both between and within CASs. Utilization and understanding of customary care was limited, and there was a tendency by some CASs to use kinship care. Use of alternative dispute resolution was also found to be limited. The review noted the importance of building relationships between CASs and First Nations and developing culturally responsive and flexible approaches and tools; staff training in cultural sensitivity and relationship-building between First Nations and CASs. Aboriginal input to

[2]Section 208, Part X, *Child and Family Services Act.*

the review also called for a shorter and more consistent process for designation of Aboriginal CASs.

IV.CUSTOMARY CARE CHALLENGES AND OPPORTUNITIES

A roundtable discussion occurred in which First Nations and CAS participants shared comments regarding customary care, each based on their own experiences and perspectives (see Appendix I for a complete roll-up). Their comments, summarized below, reflect some of the challenges and opportunities that customary care offers, and also the need to provide more information to clear up any misinformation that may exist regarding its implementation.

1. CAS Relationships and Processes

FIRST NATIONS VIEWS

First Nations participants emphasized throughout the discussion that they have not given up jurisdiction for First Nations children. They made several comments related to CAS relationships and processes as they impact customary care implementation, highlighting issues outlined below such as:

- Variances in relationships between CASs and First Nations communities or organizations
- The importance of trust and willingness around the table
- The need to address systemic barriers such as the length of the process
- The need for persistence in communications and notification procedures.

Relationships Vary

Several First Nations participants commented that their working relationships with CASs are positive; these CASs are willing to listen to First Nations and work with them. Other First Nations participants indicated that their communities or organizations are struggling to achieve a relationship of mutual respect and dialogue with the CASs.

Trust and Willingness

First Nations participants stressed the importance of trust and willingness around the table. Some commented that First Nations parents are intimidated by others telling them what they are doing wrong rather than what they are doing right as parents.

Some cited the home assessment as the first point of contact, which in their experience is often a shaming rather than an empowering experience for the First Nation family. One participant commented that a house can still be acceptable even without strictly meeting the formal physical requirements (e.g., related to bathrooms/bathing facilities) and suggested that trust be established at the first point of contact, for example by having the workers and family members introduce themselves and share a bit of personal background information such as their spirit name and clan.

Addressing Systemic Barriers

First Nations participants raised systemic barriers such as the length of time it can take to resolve cases. Some stated that in their experience, a child's bonding begins at the point of apprehension and placement in foster care, and it becomes hard to separate the child from the foster family. It may take several meetings before a placement is finalized; one participant shared an extreme example of the length of time involved, amounting to a total of 39 meetings.

Addressing Notification and Communications Procedures

With regard to the notification process, First Nations participants commented that CASs need to communicate more frequently and effectively to First Nations and not leave it at one telephone call or letter. They called for communications to inform all the agencies that First Nations have expertise in terms of customary care and to encourage non-Aboriginal CASs to work with First Nations to implement customary care and to empower Part X of the CFSA.

CAS VIEWS

Relationships and Processes

In their roundtable comments, CAS participants acknowledged the First Nations' views regarding relationships and processes as expressed above. CASs echoed the need for openness and trust. They agreed that initial CAS communications to First Nations should be supplemented with follow-up calls and letters to First Nations to ensure receipt of notification.

Additional Perspectives of Aboriginal CASs

In addition to the above-noted comments of CASs, participants from Aboriginal CASs also talked about the impacts of organizational growth and staff turnover. They also noted that they sometimes encounter fear, resistance and anger in their work with First Nations. Aboriginal CASs are seeking to play an active role in child welfare with First

Nations communities and families, to ensure that families are included as part of the plan and to strengthen partnerships. They advocated the use of their prevention programs in parenting and anger management. They emphasized that when doing risk assessment, the risks of putting children into care should also be considered. They called for funding to support the Band Representative program to ensure appropriate professional representation in court and more regular training.

2. Defining and Implementing Customary Care

In addition to CAS relationships and processes, First Nations participants spoke about how customary care is defined and implemented. Topics included:

- Recognition that customary care is defined by each First Nation
- First Nation implement customary care according to their own customs and practices
- Customary care encompasses prevention, protection, healing and reunification
- Protocol agreements to support implementation.

FIRST NATIONS VIEWS

Defining Customary Care

First Nations participants placed customary care within the realm of their inherent right to care for First Nations children. They emphasized that there is no one form of customary care - it is defined by each First Nation. They described customary care as the spiritual and cultural transmission of knowledge for the next generation. Customary care empowers a way of life. For example in one First Nation community it involves extended family, with grandparents, aunts and uncles doing everything to help accommodate a child. Safety and security is at the core of traditional child care – customary care - and the ultimate purpose of child welfare.

Implementing Customary Care: First Nations Customs and Practices

First Nations participants stated that communities can outline the process they go through to implement customary care. For example, some communities identify the names on the mother’s side first and then on the father’s side to determine where the child should go, considering the child’s needs for their whole lifetime. Some traditional naming ceremonies identify individuals who would take on the responsibility of looking after a child in the event that it becomes necessary.

Customary care acknowledges that there is a responsibility for sharing with the next generation that unspoken knowledge and understanding of one's First Nation identity; and that this responsibility lies first with the family, then the extended family, then the community and finally the Nation.

Customary Care: Prevention, Protection, Healing and Reunification

First Nations see customary care as encompassing a broad range of prevention services, protection if required, and healing - working with children, providing caregiver support to parents and extended family, teaching skills and offering healing for substance abuse.

The goal is reunification of the family. If this is not possible then the process would involve custom adoption.

Protocol Agreements to Support Customary Care

First Nations participants stated that there is significant variance between how each CAS works with First Nations; they called for more consistency across the board. Some First Nations participants indicated that their working relationship with CAS has been facilitated through formal protocols and agreements.

CAS VIEWS

Lack of Understanding

Some CAS participants commented that their understanding of customary care tends to be limited and that this has been a source of conflict at times.

Some commented that the lack of First Nations communities within their area can become an excuse to avoid implementing customary care.

In some cases there is a perceived bias that customary care arrangements are "less than mainstream processes". Cultural biases might also be impacting customary care implementation. In one case a worker cited the mother and grandmother's use of their language and cultural practices as reasons why they would be seen as unsuitable as a placement.

One CAS participant stated that embracing the practice of customary care requires a shift in worldview.

Implementing Customary Care: Risks-Taking, Steps, Common Interpretation

Some CASs shared insights in implementing customary care. In the experience of one CAS, taking a "risk" can be justified. For example, when caregivers might not otherwise meet approval criteria, this CAS contracts with a First Nation child and family service agency to complete the home study. There are issues regarding the identification process – eligibility for Part X and around family members from off the territory. The steps that have to happen must be spelled out and in some mainstream there are some necessary rules, including those that relate to the application of Standards and mandate. Staff knowledge and awareness are key, as is ongoing training since there are limited numbers of customary care agreements.

One CAS recommended that content be jointly developed regarding a common interpretation of the CFSA and customary care agreements.

One CAS indicated that they see the opportunity to "stop the clock" using out of court agreements. They have found however that First Nation parents would rather work with prevention than with CAS workers and structures. They have had many potential but few actual agreements. They suggested that early intervention and support of families be funded at the front end, to reinforce traditional customary care before CAS and institutions are obligated to get involved.

They stated that Part X court training supported the practice of one CAS which has an agreement with a First Nation. This CAS implements mandatory Part X court training for all staff every three years to ensure they have that level of understanding. This training is presented by the First Nation.

Perceived Barriers and Potential Opportunities

CAS participants identified some perceived barriers to implementing customary care. One such challenge for CASs involves a lack of understanding regarding the monitoring of customary care arrangements. CASs are required to monitor these arrangements if a child is in CAS care; however for those out of care arrangements (e.g., kinship care), CASs must ensure a plan is in place for monitoring the arrangement.

In order to comply with legislative and regulatory requirements, a template to guide CASs would be helpful to them. Because First Nations see customary care as being unique to their own distinct cultural ways and customs, they do not see a template being appropriate.

Regarding the notion that there is no money for customary care, CASs clarified that in fact there is funding available and that some CASs have been accessing it.

Some CASs identified accountability as an ongoing pressure and a possible barrier that might reduce the likelihood of undertaking customary care. They noted that this is further impeded by inconsistent or unclear corporate messages within agencies regarding approval to implement customary care.

Some procedural issues need to be addressed. For example, minimum standards for approving customary care homes mean that some do not get approved. There are also issues related to who should sign the agreement: for example, if the two parents are from two different First Nations, which First Nation is the agreement with? If a parent leaves and cannot be located, does the First Nation have signing authority for school consent forms or in case of emergency? For some CASs, these and other procedural issues need to be covered off. For other CASs, this speaks to a broader policy issue regarding why customary care is being implemented by some CASs and not by others.

Despite the perceived barriers, one CAS with several years of experience in customary care indicated that they view this approach as a win-win. Since establishing their protocol with the First Nation, there have been no apprehensions. It was noted that this has resulted in substantial cost saving to the ministry for the number of children in care. Because of this they are taking the unusual step of entering negotiations with another First Nation community not in their area but bordering it. From their perspective, the key is the relationship. Having a protocol for customary care requires taking risks and must be built on trust.

Additional Perspectives of Aboriginal CASs

Aboriginal CASs concurred that customary care arrangements require a lot of time, energy and trust. There has not been an opportunity for front line workers to come together to talk about customary care. It was suggested that groups of workers from less experienced and more experienced CASs and agencies could do an exchange.

Examples of successful customary care arrangements were shared. In some cases a safe home declaration was used, allowing the agency to place a child there until a home study could be completed. Aboriginal CAS participants commented that this can be implemented when you know the families and have a trust relationship with them. Some longstanding practitioners of customary care noted the importance of being consistent and using evidence based approaches to achieve successful arrangements where children are placed in First Nations families in their own communities or territories. They described their process in terms of a decolonizing approach, employing traditional concepts and empowering steps with case management and accountability.

One Aboriginal CAS said that because of timelines of children coming into care, they try to get First Nations to make agreements with foster homes to avoid the court process.

They suggested the process should also allow them to go to the First Nation and say, “here is your child, can you find him a home?” They further identified a need for staff education and more communications with First Nations.

One significant aspect of customary care is the removal of timelines. Participants noted that it takes most families a lot longer than six months to heal. One successful case took six years, and the children had ongoing access to the mother as she went through her healing process. There is a belief that our people will straighten up in their own time as long as we work with them. The waiting can be difficult for the worker as well as the children.

Customary care has timelines that reflect the goal: to get the child back to the parents. There is a perception that resources are not available for customary care and child welfare; thus people opt for kinship care because it offers financial support for caregivers. In fact, as noted in the MCYS guidelines, customary care is permanently funded. We need to build relationships and trust, and challenge those rules and perceptions that are not in the interests of the child.

Aboriginal CASs noted that significant community commitment and participation are required to assist in customary care placement but there are no dedicated resources.

Additional procedural obstacles in implementing customary care were cited. For example customary care arrangements are not recognized as a legal document by passport offices, and there are difficulties with consents for medical treatment and other legal documentation regarding who is the legal guardian – the caregiver, the agency or the First Nation. Some First Nations back away from customary care arrangements out of concern over liability issues.

Some participants noted that there is some confusion regarding whether the ministry will recognize and support customary care arrangements for 16 and 17 year olds. They noted to need to clarify that in fact there is funding to support such agreements; since 2006, children age 16 and 17 who are part of a formal customary care agreement are eligible.

3. Family and Caregiver Supports

FIRST NATIONS VIEWS

First Nations participants identified a number of supports and strategies to facilitate implementation of customary care. First Nations participants recalled their grandparents taking in and caring for children and providing support to other families who needed

help. They described the changes First Nations have undergone over the last few generations. With the impact of residential schools there has been a shift in values and family structure. In the view of some participants, a dependency mentality has set in, and neglect, drugs and gangs are now rampant in many First Nations communities.

They spoke of the need for young people to learn about their identity – something that the education, health and child care systems have not taught First Nations youth.

The need was identified for additional tools and resources to support families and prevention, reiterating that the goal is to reunify families. They questioned why there are many resources for foster parents but none for when children are with their parents.

Comments were made about a lack of subsidies for caregivers in customary care arrangements as were concerns about equity of rates for foster parents on reserve vs. off reserve, where foster caregivers receive $1,200 per month. First Nations' biggest issue is poverty; First Nations children go into care because of poverty and neglect.

In terms of notification, in their view a letter from a CAS is not enough; First Nations workers and administration are often too busy to respond. They suggested that CASs should contact the band and continue to reach out to them. It is important to resolve these issues without having to go to the judicial system and incur additional costs.

4. Provincial and Federal Involvement

FIRST NATIONS VIEWS

First Nations participants noted that significant community commitment and participation would be required to assist in customary care placement but there are no dedicated resources.

They noted that once apprehended, First Nations children do not do well in school and move on to correctional institutions in alarming numbers and stated that it costs an average of $120,000/year to keep them in these institutions. Governments need to look at making investments in other ways.

First Nations participants pointed out that if home studies show that First Nations homes are below standard, government has a role to play in providing funding to meet the standards. They expressed the concern that when First Nations children go into CAS care they often go on to become institutionalized as young offenders in youth correctional facilities. Only having a cultural component helps stem the tide. Yet, they noted, governments claim they are lacking funding, and they ask First Nations for more

research, when evidence of the effectiveness of First Nations' approach is shown, it still does not generate funding.

They stated the legislation must be tailored to be culturally appropriate, to provide equity and to support discretionary application of the provisions.

CAS VIEWS

One key issue that was identified was CAS amalgamation. CAS participants commented that the landscape is changing because of CAS amalgamation.

They also flagged jurisdiction, noting that the ministry has been working with CASs regarding CAS jurisdictional alignment. It was suggested that this has been delaying progress on transferring jurisdiction in the amalgamation of some CASs.

V. LESSONS LEARNED: WHAT HAS WORKED, STRATEGIES FOR CHANGE

The participants broke off into two groups to discuss lessons learned in promoting First Nations' and CASs' use of customary care and to identify possible recommendations from these perspectives. Each group was a mixed group made up of participants representing First Nations, CASs and Aboriginal CASs. See Appendix II for a roll-up of comments from the two groups.

In summary, the following were the major themes.

Protocol Agreements

Protocol agreements, discussed earlier, were identified as important vehicles for encouraging CASs to go beyond their own geographical catchment area. These agreements can explain the distinctions between customary care and other arrangements, thus improving CASs' understanding. If focused on action and on addressing deeper issues, protocol agreements can be useful tools. However, the process of negotiating protocols can take a long time.

From the discussion came the suggestion that once a First Nation has negotiated a protocol, it should remain with the First Nation. It would then be portable to other CASs the First Nation may deal with, and thus serve to educate other agencies regarding customary care.

The portability of a customary care protocol could allow different agencies to work with one another to ensure the protocol could continue from one CAS to another.

Accountability processes would need to be built in to hold the parties accountable to meeting the terms of the protocols.

It was suggested that OACAS and the Association of Native Child and Family Services Agencies of Ontario (ANCFSAO) sponsor workshops where protocols and practices could be demonstrated.

Education Toolkit

The discussion pointed to the need for a customary care toolkit or process guide with background information, policy documentation and other resources, to educate CAS workers (both Aboriginal and non-Aboriginal) on customary care and enhance their practical understanding of First Nations conditions and right to self-determination. It was suggested that such a toolkit could provide practical information to CASs regarding how to facilitate creating new relationships with First Nations, support and sustain ongoing working relationships, and work in different ways with families to encourage more participation in formal arrangements with CAS.

It was also acknowledged that in fact, a great deal of work has already been done to develop these kinds of resources, and that rather than further toolkit development, what may be needed is further work to ensure that trainers are fully trained in their use and are comfortable incorporating these resources into the curriculum.

Separate from the education toolkit, there was a need for parent and family resources for families working with children in care and trying to heal.

Staff Training

It was stated numerous times in the discussions that staff require training at regular intervals to refresh their understanding and to capture new staff given agency staff turnover.

First Nations also noted the need for Band Rep training and support for the court process. Funding to support Band Rep functions was a priority issue.

First Nations Training

It was suggested that front line staff in First Nations communities also undergo training on customary care to raise awareness of customary care and the role of the CAS, to remove the fear of the unknown and to clarify how accountability works in customary care arrangements. It was noted that this could build First Nations capacity in customary care, which is unique to each community and thus may be implemented differently from one community to the next.

Policy Issues

Several additional policy issues were raised. These included equity for First Nations foster parents; concern expressed by some about perceived CAS liability; and the need to clarify responsibility versus legal guardianship in customary care arrangements.

VI.SUGGESTIONS FOR FURTHER CONSIDERATION

The items listed below are a summary of the suggestions that emanated from the First Nations and CAS participant discussion. The intent of the discussion session was for CASs and First Nations to work together collaboratively towards achieving better outcomes regarding customary care in Ontario. The Tripartite Technical Table will be reviewing the suggestions in terms of their applicability to an action plan for increasing the use of customary care.

The suggestions from the participant discussion included the following:

Communications

1. That CASs consider ways and means of utilizing positive culturally appropriate initial contact methods such as introduction by spirit name and clan.
2. That the process of CAS notification of First Nations require continued efforts to contact the First Nation to ensure notification and ongoing information sharing.
3. That a communications package for CASs on customary care describe the knowledge and expertise available within First Nations as the key partners in customary care and encourage CASs to work with First Nations and empower Part X of the CFSA (see also #10 below).

Partnership

4. That CASs work with Aboriginal CASs, First Nations and families and include them in the plan of care.
5. That Aboriginal CAS prevention programs in parenting and anger management be utilized by CASs.
6. That a component of risk assessment be to look at the risks of putting the child into care.

Band Representative Support and Training

7. That the Band Representative function be supported and funded to ensure appropriate professional representation in court.
8. That the frequency of Band representative training be increased.
9. That early intervention and support of families be funded at the front end, to reinforce traditional customary care through prevention before CAS and institutions have to get involved.

Customary Care Toolkit/Process Guide

10. That a customary care toolkit/process guide for CASs be jointly compiled and assembled from existing resources, that provides: information regarding First Nations inherent, treaty and Aboriginal rights to self-determination and jurisdiction; guidance to CASs in monitoring customary care arrangements to ensure they comply with legislative and regulatory requirements while respecting First Nations cultural ways and customs; and information on the type and level of funding available to support their efforts in customary care and details regarding funding access.
11. That the above-noted customary care toolkit provide communications guidelines describing First Nations expertise in customary care and outlining how CASs can enhance communications with First Nations to work together on finding placements and supports for children and families.

Professional Development

12. That staff knowledge and awareness be recognized as essential and enhanced on an ongoing basis through adequate training on customary care involving First Nations expertise.
13. That a process be facilitated for supporting customary care professional exchanges between more experienced and less experienced CAS and agency staff to enhance understanding of customary care implementation.
14. That workshops be held for CASs on negotiating protocol agreements with First Nations and utilizing them to facilitate working relationships with First Nations.

15. That a common interpretation of the CFSA and customary care agreements be jointly developed, spelling out the steps that have to happen, the standards and mandate that must be met.

16. That a tripartite table examine and clarify policy issues that are perceived to be obstacles to the implementation of customary care, such as issues of responsibility versus legal guardianship, application of customary care for 16 and 17 year olds, equity in on-reserve and off-reserve placements, CAS liability and other relevant issues.

APPENDIX I - Roundtable session Roll-up

Experiences in working together to promote Customary Care: Challenges and Opportunities
FIRST NATIONS COMMENTS
• Some First Nations have a good relationship with CAS, however CASs do not have a clear understanding of customary care. Customary care isn't only when the child is with a Native family. Customary care is an inherent right for our children whether with a Native or a non-Native family
• One obstacle is monitoring and policing the arrangement. CAS is willing to take listen and work with First Nations ideas
• First Nations communal rights take precedence over our individual rights • Customary care is defined by the First Nation, so there is not a template for all Aboriginal customary care. The term "Aboriginal" should be replaced with Anishinaabe etc. To meet cultural needs, you can't apply one model for Haudenosaunee, Anishinaabe, Mushkegowuk, Lenaape • Families need a lot of support and prevention; they need more resources. The goal is to help families reunify, keep them together • One call or letter to a First Nation does not equal compliance with the CFSA
• Customary care has been replaced by kinship care but customary care is not funded. In those arrangements parents receive subsidy. There are funding issues re: getting boarding rates
• Travel to remote communities is an additional challenge • Communities have gone through a lot of change; over time going from having no running water to today's world. Values have changed; family structure has changed. Now there is neglect; gangs, drugs. A lot of youth and even adults have lost their language. The impacts of residential schools continue • The early years are important for children in the communities
• Not one system (school, child welfare) taught me who I was – the Elders did. Without that, our identity is lost • Legislation must be tailored to what we see as culturally appropriate. We need equity. Why should foster parents on reserve receive less than off reserve? Child welfare in its purest form is customary care. There needs to be a focus on "discretionary". Government needs to hear all this. We are losing our languages and traditions. This government has taken steps such as a commission, so I believe things can change. We need funding and legislation
• Customary care is not a program. It is empowering a way of life. It is not necessarily recognized by any agency. It has a lot to do with the extended family. We need the provincial and federal governments to recognize customary care. There are issues around kinship care. The bonding of the child starts with apprehension and placement in foster care. It becomes hard to separate the child from the foster family. Meanwhile, it takes an average of 39 meetings before anything is resolved
• We are negotiating a protocol agreement with our CAS. Customary care goes on in First Nations communities. The alternative - litigation - is divisive, expensive and permanently alienates families from workers due to its adversarial approach. Biases also occur; in one

case a worker cited the mother and grandmother's use of their language and cultural practices as reasons why they would be unsuitable as a placement

- First Nations families are hesitant to take children in given CAS involvement - historic distrust is ongoing. Families have had negative experiences with residential schools and don't want to accept arrangements where CAS would continue to be involved – CAS is seen as 'the wolf at their door' and this would mean inviting the 'wolf' into their house
- There are lots of resources in foster care, but none for when children are with their parents. For struggling parents, asking for resources would be viewed as negative
- Significant community commitment and participation would be required to assist in customary care placement but there are no dedicated resources

- Children are the most valuable resource. Foster care provides $1,200 a month. First Nations' biggest issue is poverty; our children go into care because of poverty and neglect. If we could keep them, look at the cost savings. Once apprehended, our children don't do well in school; they move on to correctional institutions in alarming numbers. It costs an average of $120,000/year to keep them in these institutions. We need to look at making investments in other ways. We also have issues with mental and emotional health due to residential schools, the '60s Scoop and now the millennium scoop. We need to get the message out to all the agencies that First Nations know what they are doing in terms of customary care. We want to encourage non-Native agencies to work with us to implement customary care, to empower Part X of the CFSA, to protect our own Indigenous and treaty rights, and to use our new relationship to help spread the word. First Nations leaders will be pleased if we can do these things

- Ontario is heavily legislated. First Nations have not given up jurisdiction of our children. We have been conditioned to follow CFSA but it is hard to implement in our communities. The "wolf at the door" creates more dissension than it does help in resolving family issues. The impact of residential school is multi-generational and has led to cultures being lost. This continues with apprehensions which cause a disconnect and loss of identity, as opposed to traditional ways of providing family supports and seeing grandparents, aunts and uncles doing everything to accommodate a child
- In customary care it is significant that the timelines are removed. It takes most families a lot longer than six months to heal (given the legacy of 500 years of oppression). Customary care shows that there are family members willing to help
- A letter from CAS is not enough; First Nations workers and administration are often too busy to respond. CASs should contact the band and continue to reach out to them. It is important to resolve these issues without having to go to the judicial system where costs are escalating

- Want to get clearer on where we want to go, better ideas, and also how we can *prevent* apprehension and give parents the necessary tools and resources to love and protect their own. We want all of our children to grow up understanding their culture, family roles and responsibilities, and knowing that we have options

- There is an outflow of children from our families and communities to who knows where. The UN Convention on the Rights of the Child guarantees opportunities for children to have their identity, to grow up in a family and a community, the right to their culture and language. Governments get caught up in so many issues that the social issues get lost. If we don't foster this, we won't have a community at all. In customary care the family has an inherent understanding of where that child is coming from

- Relationship is key. The CFSA was not developed by us and doesn't reflect our needs. Our own cultures, traditions and ceremonies are unwritten. For example in our naming ceremonies, some of the witnesses at the ceremony are identified who would take on

responsibility to look after that child if they had to. Customary care is like this; the responsibility is acknowledged as being first with the family, then the extended family, then the community and then the nation. There is unspoken knowledge and understanding of your own First Nation identity. It would be hard for a First Nation child to be in a non-Native setting where people don't understand the First Nations mannerisms

- Customary care has good timelines that reflect the goal: to get the child back to the parents. There is a lack of resources for customary care and child welfare: people get pushed into kinship care because it offers financial support for caregivers. We need to build relationships and trust, and challenge those rules that are not in the interests of the child

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- Customary care has been talked about since 1984 but you can't define it, regulate it – it's up to the communities. Our working group on customary care identified the principle that customary care has to be culturally significant. They established four pillars: the first is prevention services as the first defence. The second is protection, if prevention fails. The third is healing, working with children and parents, teaching skills, offering healing for substance abuse. One of the recommendations of the RCAP report noted that First Nations have the inherent right to make laws on child welfare. The goal is reunification of the family; if this is not possible then custom adoption. The 2005 and 2010 reviews of the CFSA have provided an opportunity to dialogue, but now the momentum needs to keep going. Government needs to invest now in customary care

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- Our First Nation has had a good relationship with CAS for years; we started talking about customary care over 8 years ago
- Our people will straighten up in their own time as long as we work with them
- We developed our own youth treatment; it is successful
- If home studies tell us our homes are not good enough, government should provide us with the funds to meet the standards
- When our children go into CAS care they go on to youth facilities. The only thing that helps is when we have a cultural component. Yet we keep hearing governments say they are lacking funding, and they ask us for more research; when we show evidence of the effectiveness of our approach, governments tell us you're right, but we still don't have any funding

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- We have a good relationship with CAS but we can keep working on it. The children's spirit is who we are working to nurture. As First Nations we've learned how to be resilient
- If the first point of contact is the home assessment, it is shame-based rather than empowerment. A house can still be acceptable even if it doesn't have 2.5 bathrooms. The first point of contact could be different, for example where the parents/family members share their spirit name, clan etc.
- Legislation is open to anyone's interpretation. There has to be trust and willingness around the table. We teach our children everyday to trust their teachers and others. Our parents are intimidated by others coming and saying what they're doing wrong, instead of what they're doing right. Our band rep does a lot but is only one person. In contrast there are several CAS workers
- There is opportunity to explore working together to get more resources for our communities. *Mino bimaadzewin* – living a good life – means we provide opportunity for our children to grow up and be the best they can be, make their own choices to go where they want, and we don't let them down

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- It is easy working with our CAS (we have a protocol agreement). They provide good training for new workers. We want more Band rep support – we used to meet quarterly but now it is only once a year. Customary care has positives, but sometimes we feel the mom is never going to get well; the children keep asking, how long do I have to stay here? We have several customary care homes and children. It is a good process but there are many

concerns; we must also deal with aunts, uncles, caregiver support. We need training in the Band rep court process
- We need consistency between how each CAS treats a First Nation (this varies)

ABORIGINAL CAS COMMENTS

- Elders have taught us it is our inherent right to care for our children, reinforced through the treaties. In our territory we have been practicing customary care for a long time. Elders tell us we need to protect it. It is defined by the First Nation – each one for themselves. Kinship care is not customary care – maybe mainstream practitioners are more comfortable with kinship care. But customary care is the spiritual and cultural transmission of knowledge for our next generation
- We have been able to use the *Act* to implement customary care in our way. Problem: we have started practicing customary adoption and the ministry wants to know we are keeping our children safe and not at risk. Despite this problem over customary adoption we are going ahead with it. Also, when we place children in group homes our lawyer advises us to use other arrangements but we still prefer to move forward through customary care
- In some areas of the province they do not practice customary care, prefer not to. Some people think customary care is "less than". We use a safe home declaration (you place a child there until the home study is done). Some agencies aren't comfortable with this but when you know the families you can have this trust relationship
- Aboriginal foster care agencies aren't allowed to practice customary care because they are not a CAS
- Customary care isn't just for age 0 to 12, it's for a whole lifespan

- We have been using customary care agreements for over 20 years. We have developed our own system or service continuum with 7 steps, equivalent to 7 different arrangements and types of legal orders. They range from prevention and teachings through to traditional adoptions. Over the years we have been very successful in customary care. We have been consistent and we have provided evidence-based information in implementing customary care. 85 percent of our children are in customary care, and 90 percent of these children are in First Nation homes with extended family members or in other First Nations communities in our territory. We are willing to share more information on this. We have also developed a 5 phase service model based on a traditional concept of child care that includes empowering steps, using a decolonizing approach, implementing customary care, using traditional concepts and action steps, and employing a case management system and accountability in each phase. The safety and security of our children is at the core of our traditional child care concept and this is the whole purpose of child welfare. Our communities have been active in developing this system and making it successful. Our agencies use a decentralized approach based on First Nations customs
- Our challenge has been in integrating and having to be accountable to the ministry's system, especially when we are going through audits and providing quarterly reports. We do fulfill the requirements. We started harmonizing our documents to reflect a blend of the two systems. For example, if an assessment was directed by the ministry, such as OnLAC (AAR) we would harmonize the documents to ensure we have non-intrusive, helpful tools that don't hurt our children and families, that are culturally sensitive and user friendly, rather than the traditional AAR type assessments. We use our own processes. Our board and leadership would not accept the use of standard risk assessment tools or policies in which 99 percent of our families would be identified as high-risk. We won't assimilate to be one size fits all; we are building an alternative system. We are still developing our continuum model and harmonizing our documents. Our children are in their own First Nations

territories, able to use their language and knowing their Anishinaabe identity. The term "customary care" is within our language; it did not originate within the English language. At times there have been conflicts with other agencies due to a lack of understanding around customary care. We need to be flexible and trust ourselves regarding how we practice customary care in our territories
• Our grandmas would always take in children or send support over to a family that needed help. Processes have always been in place - a community can outline the process they go through, identifying the names on the mother's side first and then the father's side to determine where a child should go. All of the child's needs are considered, including short and long term for the whole lifetime. We will always be that person's family; they will always remember how they were treated • Communities are experiencing intergenerational trauma. New systems in the communities (health, education, social) have created confusion. Our people became dependent on services and thinking changed. As you implement customary care, you need to understand these changes in First Nations, and consider who made these standards of child care and what was their reason
• Customary care is "according to band custom" but we are all at different levels of capacity, have different cultures and are dealing with impacts of residential schools etc. We have hundreds of children in care yet do not have a relationship of mutual respect and dialogue with all the agencies. We are growing and there is high staff turnover. First Nations are fearful and resist working with us but need our help and support. Children in care receive a lot of things, such as hockey lessons etc, whereas in customary care the children aren't provided any of this. We grew up on the land but now First Nations are losing their culture; we are fighting to keep and revitalize and teach it. Agencies should start looking at our agency, the First Nations and the families as a part of the plan; give families the supports they need; strengthen partnerships and use our prevention programs, parenting and anger management. Risk assessments should include looking at the risks of putting the child into care. • The Band Rep program must be supported with funding (non-lawyers and workers have to go to court)
• Our customary care practice is a few years old. We have a draft manual. Customary care is the least intrusive for our families. We still use foster homes as customary care homes. There are grey areas in customary care. We have terminated a lot of court involvement in favour of customary care but there are legal obstacles. For example customary care arrangements are not recognized as a legal document by passport offices, and there are difficulties with consents for medical treatment and other legal documentation regarding "who is the legal guardian" – the caregiver, the agency or the First Nation? Some First Nations back away from customary care arrangements out of concern over liability issues. We need to know if the ministry will recognize customary care arrangements for 16-17 year olds • We have had successes with children in customary care over a period of six years through our protection unit. The children had ongoing access to the mother as she went through her healing. When audited as to why this was done, it was noted that the worker believed the mom would be able to get her kids back. A lot more needs to be done to understand customary care in its many forms (for example, traditional and non-traditional customary care). It's your right as a First Nations person to do a customary care arrangement, but as soon as the agency is called you enter a formal customary care arrangement where there is no clear definition

• Minimum standards for approving customary care homes mean that some do not get approved. There are many issues related to who should sign. For example, if the two parents are from two different First Nations, which First Nation is the agreement with? If it is with a single mother, the father's signature and his First Nation's signature are still required. Children affiliated with a First Nation but who don't qualify for status can still be in customary care agreements if the First Nation is willing to sign for that child. If a parent leaves and can't be located, does the First Nation have the signing authority for school consent forms and in case of emergency. We need to develop this so that everything can be covered off
• We work with First Nation communities across Canada. We have several successful customary care agreements. They take a lot of time, effort and trust. First Nations believe that if the child cannot be with his parents, he should be with family, or within the community. Because of timelines of children coming into care, we try to get First Nations to make agreements with foster homes to avoid the court process. Why can't we go to the First Nation for example and say, here is your child, can you find him a home? Kinship out of care is good but there is no funding. We have to work hard to find the funding. Staff need education and more communications with First Nations. As a newly mandated CAS we were audited four times in the first year. Our agency has so many relationships • There hasn't been an opportunity for front line workers to come together to talk about customary care – for example, by having groups of workers from southern and northern agencies do an exchange. Internally there is strong accountability to communicate thoroughly with First Nations via continued calls and speaking directly with the Chief if required. We found that many homeless youth had been adopted into non-Native homes; now almost all our adoptions are in Aboriginal homes
CAS COMMENTS
• We have never done any customary care arrangements; the fact that there are no First Nations in our area is an excuse. As long as we make the call or send the letter and get no response, that is enough. There is huge lack of understanding about what customary care is. There is a lack of trust, and there is fear with regard to the need for flexibility. In our agency we need rules but with customary care there are no rules. Our misunderstanding of customary care has led to biases in our organization, for example the perception of customary care as "less than". Learning is crucial – being willing and open to learn. The friendship centre and Aboriginal agencies are willing to help us navigate the culture and enhance our understanding, but they are not recognized under the CFSA as "Native communities" and are not funded. They could help us improve our relationships if they were funded (another participant noted that friendship centres do not speak for First Nations)
• We are learning; we need to wrap our heads around this. We want trust. Keeping an open mind is important; hard when mandated things get in the way. We have learned taking a risk might be justified, for example when the caregivers might not meet the approval criteria. We contract with First Nation family services to complete the home study. There are issues regarding the identification process: eligibility for Part X and family members from off the territory. The steps that have to happen are unclear; in mainstream there are some necessary rules. Standards and mandate fall in line with this. Staff knowledge and awareness is key (this must be ongoing since there are not a lot of customary care agreements) • In terms of outcome, we need the long term plan spelled out and tracked - the reintegration plan. Let's develop content regarding a common interpretation of the CFSA and customary care agreements

• We are constantly pulled back into the CFSA legislative and technical requirements, policies, regulations, frameworks and tools developed by the mainstream political system. We struggle constantly with accountability pressures. The message from the corporate level isn’t consistent across the board; sometimes it is absent or unclear. What is meant by the “safety and wellbeing of the child” may be unclear at the political level. Given the diversity, there is ongoing need to communicate with the front line. As a multi-service agency involved with different ministries, we see issues getting birth certificates or issues with the education or health care systems. If our agency had approval from the political system to go down this road of customary care, the will might be different
• How to move customary care forward has been a longstanding issue as well as how to serve Aboriginal / Anishinaabe / Haudenosaunee children more meaningfully. Our CAS had Aboriginal children from all across Canada; it took years to build relationships. At first they thought about one out of every 500 children was of Aboriginal descent but once they got involved and brought in Aboriginal staff, the number of Aboriginal children turned out to be about 10 times higher because they were able to identify them, they talked about their heritage • Regarding the notion that there is no money for customary care, in fact there is - some CASs have been accessing it for some time • Without rules it is hard to figure out how to make customary care work. People are more likely to move forward when in their hearts they see it as a cause to fight for. It is unconscionable to use rules and procedures as a rationale for not implementing customary care. CASs need to work with First Nations so that more are convinced to get involved, figure out how to get by the rules and regulations for the best interests of the children. We need to figure out how to restore inner strength, resilience, joy and cultural awareness in First Nations children and how to assist agencies in making this happen
• We see no reason why CASs wouldn’t do customary care; it is a win-win and we have done it for 8 or 9 years. Since our protocol with the First Nation there have been no apprehensions. This represents a substantial cost saving to the ministry for the number of children in care. Because of this we are taking the unusual step of entering negotiations with another First Nation community located outside of our area. The key is the relationship. Having a protocol for customary care requires taking risks and must be built on trust • The Part X court training supported by OACAS is mandatory for all staff every three years to ensure they have that level of understanding. This training is presented by the First Nation
• Local First Nations advised us that customary care is an internal First Nations process. We had discussions on customary care and First Nations liked the opportunity to stop the clock via Part X out of court agreements. One barrier is that parents would rather work with prevention instead of CAS workers and structures. We have had many potential but few actual agreements. Early intervention and support of families should be funded at the front end, to reinforce traditional customary care before CAS and institutions have to get involved

APPENDIX II

GROUP DISCUSSIONS

Session participants broke out into two groups to discuss lessons learned in terms of their experiences around what has worked and recommended strategies for change. Each group had representatives from First Nations, Aboriginal and non-Aboriginal CASs and the federal or provincial governments. The following were their comments.

GROUP ONE
• Protocol agreement: to encourage CASs to go beyond their own geographical catchment areas; to explain the differences and increase understanding. Processes to negotiate protocol agreements are always stalled; there are references to the legislation and jurisdiction. Protocol agreements are not just a piece of paper; they must be action-focused and address deeper issues. They need to change and evolve to reflect the working relationship
• CASs need to treat First Nations with respect. Realize that First Nation staff are equally or more qualified given their knowledge of their families and communities. In order to work together, they need to respect First Nations authority as the key partner (not just another "party")
• This must come through training on First Nations history and impacts of past events, how First Nations communities work. Training should be delivered so that it goes beyond the rules and regulations and gives participants a deeper level of understanding on why customary care is being implemented. First Nations have a right to self-determination and are effective at taking care of the children. Challenges in terms of community conditions need to be understood
• New workers need an understanding of the communities with whom they are to be working; how to operate in a relationship of respect by taking the lead from the First Nation worker; and how to incorporate this into the customary care agreement to avoid a narrow interpretation of the rules and regulations
• Understanding the First Nations conditions they are likely to encounter, leads to basic human cultural competency. It is difficult to get CAS staff to make this shift in thinking - understanding that the First Nation tells them, they do not tell the First Nation. Paradigm shifts are not easy – they change world views. Ongoing relationship is needed to continuously talk about it, to address the power imbalance and get to "working together." Engagement with the Band rep and other community representatives is important but may not necessarily change the power dynamics
• Champions are needed on both sides of the fence: First Nations and non-Aboriginal CASs. We don't have time to just keep talking. We need to look at what we have been doing that works; what the barriers are; how to get CASs and First Nations together, for example by inviting CASs to the communities. It comes down to sharing power
• Leadership and mentorship need to occur. Champions are needed. CASs need to be informed internally that First Nations are assuming responsibility for the children; the threat of liability must be removed
• First Nations should be able to keep the protocol agreements and transfer them to other CASs with which they work
• OACAS should host annual workshops where practices, protocols etc. can be shared to

show how it can be done, train CAS leadership. First Nations should be involved in providing the training
• Customary care is a changing dynamic. Protocols are not the only thing to focus on; they are only one tool. Agreements are interim measures to support the transfer from CAS to First Nation responsibility. The process of learning should occur through training every two years, not every ten years. Families are in need of help, whereas in the legislation only the child is represented. First Nations poverty, housing and water all need to be addressed with resources so that children can stay in the home
• First Nations child welfare law is under development and evolving. The communal right of First Nations takes precedence over individual rights. The McIvor decision supports citizenship law, so that even if a child does not have Indian status, he still has a right to be brought up according to the customs of the First Nation community. Policies are living documents that change over time
• Staff that have been developing a relationship are more effective with the children. The portability of customary care protocols could allow staff from various agencies to explain how to apply the protocol and support each other. This requires champions; it also builds future leaders
• Repatriation adds to the complexity for First Nations; it requires working with other provinces, territories or states. Repatriation requires champions and funding for workers to ensure First Nations are notified of children in care out of province or country. First Nations will not lose another child
• First Nations identity is crucial – knowing who we are, cherishing the culture, the Elders, the medicines. Having an Elders Council in place is helpful for providing advice to the community and practitioners
• CAS staff turnover results in the need for constant training
• Colleges and universities should be encouraged to include First Nation-specific topics in their social services curriculum; then it will become part of the qualifications for practitioners
• CASs should have more accountability to follow the terms of protocol agreements. Templates can be shared that outline the steps. Customary care is not consistent across all CASs but processes to develop the protocols can be consistent. A first step would be for each CAS to develop customary care protocols. The protocol agreement covers the relationship, but not exclusive to customary care. It sets up the relationship to explore these ideas
GROUP TWO
• Access to customary care funding must be equitable for First Nations
• There are a lot of rules around customary care within First Nations, but they are expressed and monitored differently than in CASs. There is also a lot of flexibility. Where it has been practiced a long time there are layers of accountability; these may not be written or recorded in the same way but should still be recognized as accountability. Liability is an issue for CAS but where First Nations have set up structures, liability is not an issue
• We need education for CAS workers as a first step to remove fear of the unknown. You can have a formal or an informal relationship
• First Nations communities also need to be made more aware of CAS role. Some First Nations see customary care as taking the first steps to the end goal; it also builds First Nations capacity. All models should be looked at
• First Nations would like tools on customary care: analysis and checklist; documents; protocol agreement language
• CASs have difficulties picking up the child in care piece

• First Nations families are often unwilling to engage with CAS
• CAS needs to look at the range of support for families providing customary care, as well as how to help families trying to recover and heal
• Promote partnerships with families for repatriation
• CAS focus is on rules, whereas elders and community members are hesitant about making rules because the situation will likely change; this is a different way of thinking
• We often hear there are no rules in First Nations, however in First Nations we know what is expected and what we are supposed to do. First Nations' inherent rights should be recognized. Need a balance between writing down and formalizing rules, and sharing an understanding
• First Nation communities should determine their own idea of what customary care means to them, as a starting point. It starts with discussing, "how do you do things?" Understand that there will be differences. Utilize the knowledge and experience from the community level
• A toolkit would be useful to help First Nations get clearer on the process and more invested for better outcomes. It would also clarify customary care for Chief and Councils, some of whom see it as coming from CAS. A toolkit could be shared with First Nations and CASs – everyone has different models
• The legislative framework is already there under Part X for customary care, so there is no reason for CASs to make legislative barriers an excuse. There are implementation barriers, such as having the Passport office or school recognize customary care agreements as a legal document permitted under Part X of CFSA. Legal guardianship should be document and clarified in the customary care agreement, i.e. that the parent did not give up legal guardianship
• CASs do not consider customary care children to be "in care". The agreement is an arrangement about payment and who takes responsibility, but not custodianship or guardianship
• Toolkits should help with how to create and facilitate relationships. There is also a need for ongoing case conferencing to share progress with each other
• There should also be a toolkit for Band reps to pursue placements and protect them from CASs. The Band rep function should be resourced
• Capacity building is needed at the First Nation community level to support customary care. Aboriginal units are being established in non-Aboriginal CASs, however the Native provisions under Part X were to give the authority and jurisdiction to First Nation agencies
• First Nations should not have to become mandated just to be recognized to provide care for First Nations children

APPENDIX III

LIST OF PARTICIPANTS

Nicole Anthony	INAC, Ontario Region
Lillian Baibomcowai-Dell	Chiefs of Ontario
Mary Ballantyne	OACAS
Cindy Bannon	Fort William First Nation
Karen Bannon	Fort William First Nation
Jim Baraniuk	Algoma CAS
Lawrence Baxter	Nishnawbe-Aski Nation
Cathy Creighton	Weechitewin Family Services
Phil Digby	INAC, Ontario Region
Jocelyn Formsma	Ontario First Nations Young Peoples Council
Deb Gollnick	Waterloo CAS
Basil Greene	ANCFSAO, Elder
Katherine Henzel	Chippewas of Saugeen
Brandi Hildebrand	Mohawks of the Bay of Quinte
Nancy Johnson	Facilitator and Recorder
Rosalind Johnston	Nog-da-win-da-min CFS
Mark Kartusch	Hastings CAS
Peter Kiatipis	MCYS
Kathy Kishiqueb	Weechi-it-te-win Family Services
Richard Lambert-Belanger	Timmins CAS
Marie Lands	Grand Council Treaty #3
Deborah Leach	MCYS
Bill Leonard	Kenora-Rainy River CAS
Esther Levy	MCYS
Diane Maracle-Nadjiwon	Independent First Nations
Trina McGahey	Association of Iroquois and Allied Indians
Kelly Noah	Delaware First Nation
Marianne Ostberg	Dilico Child and Family Services
Adrienne Pelletier	Union of Ontario Indians
Valerie Peters	Delaware First Nation
Grand Chief Randall Phillips	PC Social Portfolio
Marsha Roote-Skye	Chippewas of Saugeen
Arliss Skye	Six Nations
Magda Smolewski	MAA
Mike Stephens	Chatham-Kent CAS
Theresa Stevens	ANCFSAO
Geoff Stonefish	Association of Iroquois and Allied Indians
Jamie Toguri	Native Child and Family Services of Toronto
Virgil Tobias	Councillor, Delaware Nation