Court File No. CV-14-0018

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

HOLLY PAPASSAY, TONI GRANN, ROBERT MITCHELL, DALE GYSELINCK and LORRAINE EVANS

Plaintiffs/Moving Parties

and

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ONTARIO

Defendant/Responding Party

Proceeding under the *Class Proceedings Act, 1992*

VOLUME III OF VI: MOTION RECORD OF THE DEFENDANT, HER MAJESTY THE QUEEN IN THE PROVINCE OF ONTARIO
(Motion for Certification, returnable January 24, 2017)

June 14, 2016

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This is **Exhibit "22"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Ontario

Crown Ward Review

Annual Report 1999

Ministry of Community and Social Services
Provincial Services Branch
November 2000

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1.0 - Introduction

Crown Ward Review is an annual process undertaken by the Ministry's Child Welfare Review Unit (CWRU), in co-operation with each child welfare agency and the MCSS regional offices. The Children in Care manual states that "the goal of the Crown Ward Review is to determine that an adequate plan of care is developed for each Crown ward and is intended to stimulate improvement in the overall service delivery to children."

The specific objectives of the Crown Ward Review are:

- To monitor compliance with the legislation and regulations in relation to the care of each Crown ward;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the Crown ward;
- To issue directives regarding non-compliance and to make recommendations about particular cases, general policy and practices and to encourage and monitor their implementation;
- To give Crown wards with enough understanding, an opportunity, through questionnaires and interviews, to comment on the care they are receiving, contacts with their biological families, case plans and current circumstances;
- To provide information on useful methods employed in other Societies and jurisdictions.

The Crown Ward Review findings are based on the review of Society files, questionnaires completed by Crown wards and through client interviews. In complex and/or high-risk cases, Society caseworkers and managers may also be consulted.

Each case file is reviewed in the year following 24 months of Crown wardship and every year thereafter.

Individual case reports are intended to provide feedback to case workers, Society managers and program supervisors on key areas of service delivery and issues specific to compliance and standards. A summary report is completed for each Society reviewed and provides an overview of systemic strengths and areas requiring improvement or refinement. This information can be useful to the Society's board, management and to the MCSS regional office for planning purposes and for performance outcome monitoring.

1.10 – Scope of the Review

In 1999 the case files of 2,714 children who are Crown wards were reviewed. This represents a 9% increase in the number of cases reviewed from the 2,483 case files reviewed in 1998. Table 1 illustrates the number of cases reviewed each year since 1995.

Table 1 – Cases Reviewed

Year	Cases Reviewed	Cases First Review
1995	1,371	543 (40%)
1996	1,353	497 (37%)
1997	1,323	446 (33%)
1998	2,483	603 (24%)
1999	2,714	713 (26%)

1998 was the first year in which all eligible Crown wards were reviewed on an annual basis. This accounts for the large increase (88%) in the number of cases reviewed in 1998 compared to 1997. The number of first reviews increased from 24% in 1998 to 26% in 1999.

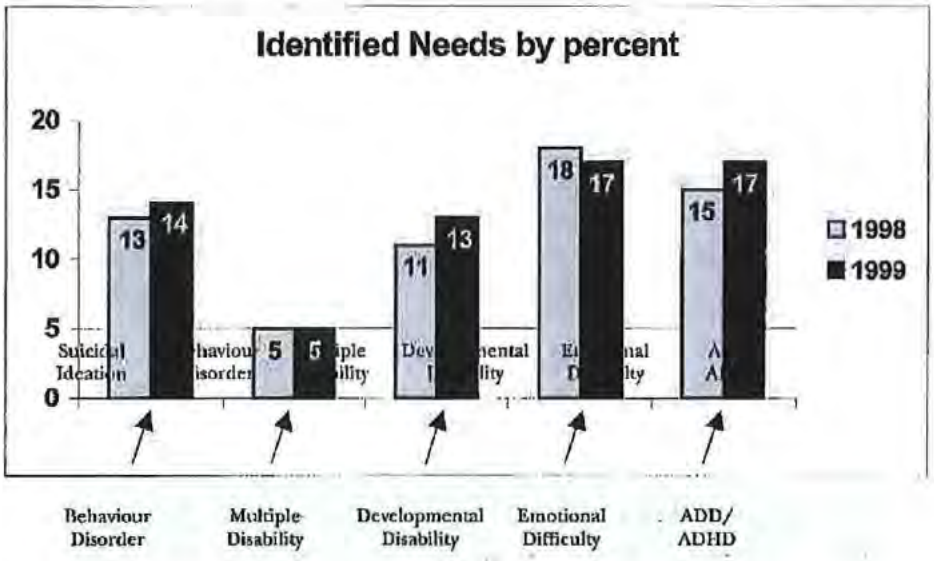
2.0 - Profile of Children who are Crown Wards

In 1999, the average age of children at the time of their Crown wardship was 7.8 years, which is the same as 1998. The average age of the children at the time of the review was 13 years, which is also the same as 1998. In 1999, the proportion of males who were made Crown wards was 58% and 42% were females. This is comparable to 1998 when 57% were males and 43% were females.

2.10 - Identified Needs/Characteristics

Of the 2,714 children reviewed in 1999, 1,996 or 73% have been diagnosed by external professionals as having special needs. This has increased from 70% in the 1998 review. Chart 1 compares some of the more frequent identified special needs by percent and category for 1999.

Chart 1 - Identified Characteristics



The identified children have complex behavioral, emotional and physical needs that, in many instances, affect their ability to meet the normal challenges of their day-to-day lives. The impact on resources required to meet these needs can be significant. Programs such as treatment foster care models, special supports and training for foster parents, foster home relief, respite care

and the services of youth workers are examples of the programs that are currently in place in many agencies. Societies have continued to place and support children in family settings whenever possible.

2.20 - History of Abuse

A significant number of children have suffered physical and/or sexual abuse in their families of origin. In 1999, 24% suffered from sexual abuse before their admission to care and 31% experienced physical abuse. This is consistent with 1998 data. Assessment and treatment programs, both individual and group, are being made available to assist these children in coping with, and addressing the trauma of their early life experiences.

One hundred and sixty-five (6%) of the children reviewed in 1999 experienced further abuse while in care by people in care-giving roles as well as other residents in care. Upon further investigation, it was determined that the abuse was historical and that proper safeguards had been put in place to ensure the safety and protection of these children. In 1998, 125 (5%) of the children reviewed had experienced further abuse while in care.

2.30 - Native Heritage

In 1999, 405 or 15% of the children reviewed were identified as having Native heritage. This is an increase from 1998 when 321 or 13% were of Native heritage. In 1999, 10% of the children held status under the Indian Act. This is comparable to 1998. Eligibility for status had not been determined for 2% of the children reviewed in both 1999 and 1998. Table 2 provides comparisons for the past five years.

Table 2 – Children of Native Heritage

Year	Native Heritage	Status	Eligibility to be Determined
1995	169 (12%)	111 (8%)	23 (1%)
1996	170 (13%)	119 (9%)	49 (4%)
1997	185 (14%)	131 (10%)	8 (0.6%)
1998	321 (13%)	218 (9%)	49 (2%)
1999	405 (15%)	263 (10%)	65 (2%)

In 1999, 28% of the children identified as having Native heritage resided in Native homes and 51% had contact with their communities. Although these findings are lower than 1998 when 30% resided in Native homes and 56% had contact with their communities, the actual numbers have increased as follows:

- 111 of the children were placed in Native homes in 1999 (up from 98 children placed in Native homes in 1998); and,
- 206 of the children had contact with their communities in 1999 (up from 180 children who had contact with their communities in 1998).

The majority of the children identified as having Native heritage (75%) were in the care of Non-Aboriginal Children's Aid Societies. One quarter (25%) were in the care of Aboriginal Children's Aid Societies. Table 3 compares the placements in Aboriginal Societies to the placements in Non-Aboriginal Societies.

Table 3 – Placements of Native Children

	Native Heritage	Native Placements	Contact with Band or Community
Aboriginal Societies	103 (25%)	60 (58%)	85 (83%)
Non-Aboriginal Societies	302 (75%)	51 (17%)	121 (40%)
Total	405	111	206

As part of its efforts to review placement practices, the Child Welfare Review Unit closely monitors the efforts of Children's Aid Societies to place children in culturally appropriate homes.

The Child Welfare Review Unit consulted with representatives of the Native Children's Aid Societies in 1999 regarding the Crown ward review process and monitoring tool. As a result, the Child Welfare Review monitoring tool was expanded for 2000 to include additional information such as:

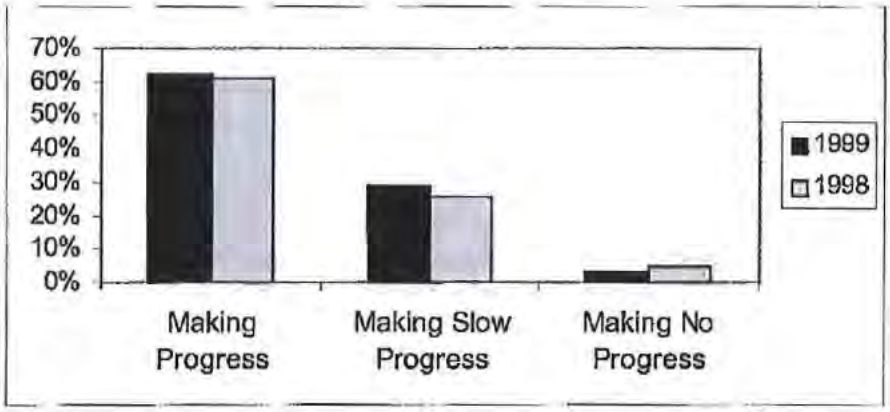
- Involvement of the child's band or native community in planning for the child;
- Efforts to involve the child's band or native community in planning;
- Efforts to promote the child's participation in his or her cultural practices;

- Efforts to promote the child's participation in his/her spiritual needs;
- Placement of the child in the child's home community;
- Efforts to provide the child contact with their home community; and
- The child's awareness of his or her rights and entitlements under the Indian Act.

2.40 - Education

In 1999 almost all the children of school age (94%) were attending school in the previous 12 months, and special educational supports were in place for 49% of the children enrolled in school. These findings are comparable to 1998. Societies were continuing to make efforts to ensure that the children were placed in appropriate educational programs, and that additional supports were provided where necessary. The result is that in 1999 approximately 58% of the children enrolled in school were making good progress, and an additional 27% were progressing although at a slower pace. (Chart 2 illustrates progress compared to 1998).

Chart 2 – Progress At School



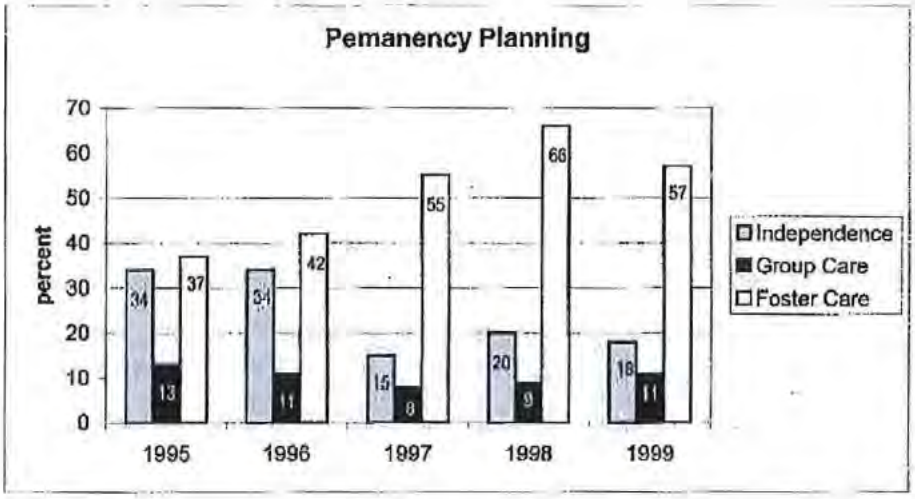
3.0 - Findings

The 1999 review reflects some improvement in the area of permanency planning, more children in foster care, more children being considered for adoption, more exercised access taking place, more children who had experienced only one placement since their Crown wardship, and an increase in worker contact.

3.10 - Permanency Planning

In 1999 the permanency plan for 85% of the children reviewed was long- term care, including foster care, residential group care, and independent living. This is comparable to 1998. Adoption was being considered for 4% of the children in 1999 compared to 3% in 1998. The permanency planning was noted to be appropriate in 89% of the cases reviewed in 1999 compared to 85% in 1998. Societies are continuing to use respite care, child and youth counselors and other services in order to support foster parents in caring for these children on a long-term basis. (See Chart 3 for a comparison by year since 1995).

Chart 3 - Permanency Planning



3.20 - Access

In 1999 access orders were granted by the courts in 76% of the cases reviewed. This is comparable to 1998. An access order is a legislative barrier to adoption. Exercised access was taking place for 65% of the children reviewed compared to 53% in 1998. Access was primarily exercised by mothers (55%). Fathers exercised access with 27% of the children. In 20% of the cases both parents exercised access. The majority of the children reviewed (76%) had access with their siblings and many (40%) had access with their extended families. (Table 4 illustrates access by mothers, fathers, extended family and siblings in 1999 compared to 1998).

Table 4 – Exercised Access

Year	Mother	Father	Extended Family	Siblings
1998	52.8%	25.9%	35.5%	73.2%
1999	55.2%	27.4%	39.5%	75.6%

Overall, access was well managed by Societies in the best interests of the children. Sixteen recommendations in total (less than one percent of the recommendations made in 1999) were made to review access.

3.30 - Placements

Societies are continuing to put a renewed emphasis on placing children in less structured and less intrusive settings, such as foster care. Some children with special needs, who may previously have been placed in an outside resource, are now being cared for in specialized foster homes. Societies have continued to make concentrated efforts in the recruitment, training and support of foster parents. In 1999, 62% of the children reviewed were placed in foster care compared to 60% in 1998. This includes regular foster care, specialized foster care, and provisional foster care but does not include children in OPI foster homes. (See Table 5 for a comparison of placement type by percent).

Table 5 – Placement Type

Placement Type	1998	1999
Regular Foster Care	45%	44%
Specialized Foster Care	11%	12%
Children's Aid Society Group Home	2%	2%
Emergency Receiving Home	1%	1%
Outside Paid Institution Foster Home	10%	10%
Outside Paid Institution Parent Model	3%	3%
Outside Paid Institution Group Home	12%	13%
Young Offender Facility	2%	2%
Children's Mental Health Centre	1%	1%
Independent Living	7%	6%
Provisional Foster Care	6%	7%

Semi-independent living programs assist older adolescents in learning to become self-sufficient. Partnership with community agencies, schools, employment training, life-skills, support groups and youth workers have proven effective in helping young people make the transition to independence.

3.40 - Placement Changes

Placement stability remains a key factor in the provision of continuity of care for children and for their on-going security and optimum development. Children reviewed in 1999 experienced an average placement length of 24.0 months while in care. This has declined since 1998 when the average placement length was 25.9 months. The decline may be attributed to the number of children identified as having special needs. These figures do not reflect the number of changes in placements that children experienced prior to Crown wardship.

In 1999, 1,135 or 42% of the children reviewed had remained in the same placement since becoming Crown wards, 21% had experienced one placement change and 37% had experienced three or more changes. This has improved slightly since 1998 when 41% of the children were in the same placement since their Crown wardship and 38% had experienced three or more changes. (See Table 6 – Placement Changes.)

Table 6 - Placement Changes (since Crown wardship)

Number of Placements Since Crown Wardship	1998	1999
One Placement	41%	42%
Two Placements	21%	21%
Three or More Placements	38%	37%

Although the average placement length has declined overall, the average placement length was considerably greater for those children who were made Crown wards at a younger age. (See Table 7 - Average Placement Length by Age)

Table 7 – Average Placement Length by Age (at the time of Crown wardship)

Age at time of Crown Wardship	Percentage of Crown wards	Average Placement Length
Under Seven	38%	33.6 months
Seven to Twelve	51%	21.0 months
Over Twelve	11%	11.1 months

3.50 – Changes in Worker Assignments

The number of worker contacts and the length of caseworker assignment have an important impact on the continuity of relationships for children and youth. These relationships are ones that children count on to assist them in understanding the complex issues that are associated with being in care. Children often seek support and guidance from their caseworkers, particularly in times where there may be difficult changes and decisions to make.

In 1999, the children experienced an average of one contact every 28 days. This is an increase from an average of one contact every 32 days in 1998.

In 1999, the average length of caseworker assignment was 23.4 months since the time of Crown wardship. This is comparable to an average of 23.8 months in 1999. Nineteen per cent of the children in 1999 had retained the same caseworker since becoming Crown wards, 38% have had two or more caseworkers and 43% have had three or more caseworkers. (See Table 8 - Changes in Worker Assignment)

Table 8 - Changes in Worker Assignment

Number of Workers	1998	1999
One Worker	21%	19%
Two Workers	37%	38%
Three or More Workers	42%	43%

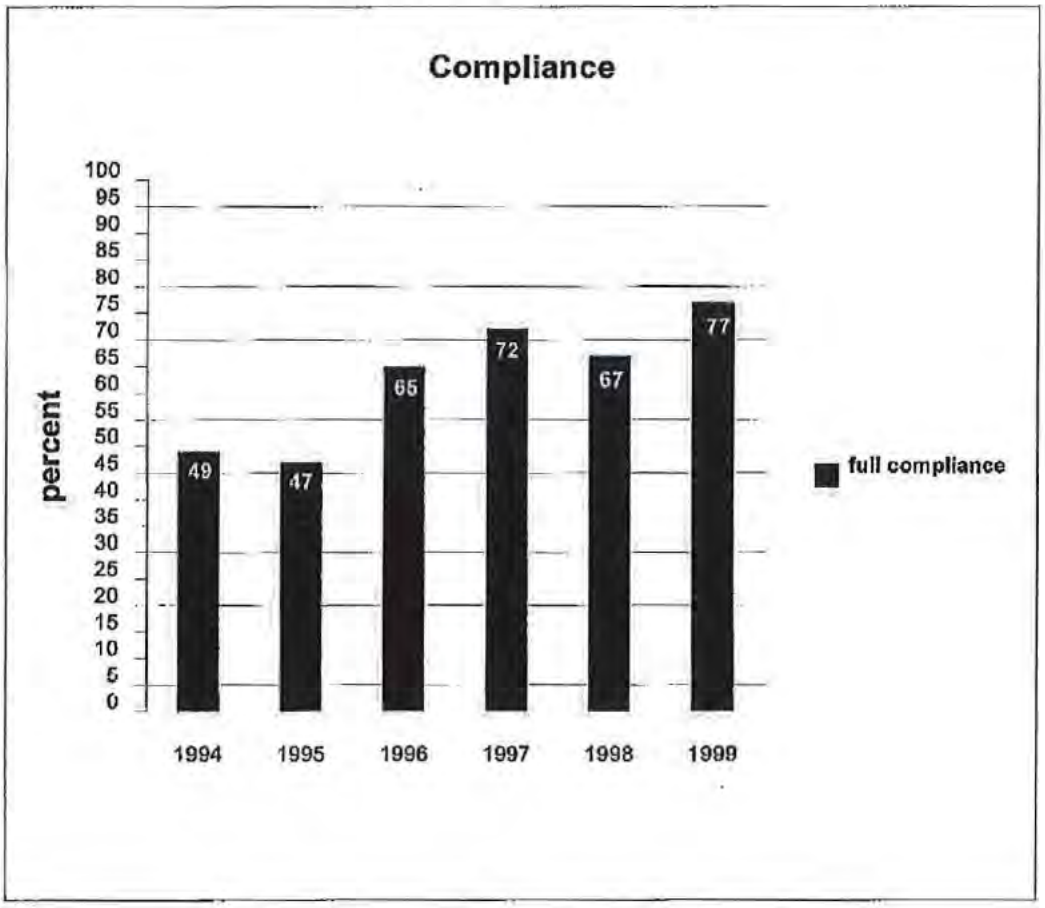
4.0 - Legislative Compliance

Results of the 1999 Crown Ward Review indicate an overall 77% full compliance rate. This is a significant improvement from the compliance rate of 67% in 1998. In 1999, there were 986 directives issued compared to 1,239 directives issued in 1998. An average of 0.36 directives were issued per case as compared to an average of 0.5 in 1998. (Table 9 compares the overall compliance ratings for the past 5 years and Chart 4 illustrates the improvement graphically)

Table 9 – Overall Case Compliance and Directives Issued

Year	Cases Reviewed	Cases in Full Compliance	Directives Issued	Average # Directives
1995	1,371	646 (47%)	1,469	1.07
1996	1,353	885 (65%)	864	0.64
1997	1,323	948 (72%)	617	0.46
1998	2,483	1,609 (67%)	1,239	0.50
1999	2,714	2,095 (77%)	986	0.36

Chart 5 - Overall Case Compliance



4.10 - Statutory Contacts With Children

Statutory contacts are personal visits made by caseworkers with the children. Minimally, visits are required within 7 and 30 days after a placement occurs and every 90 days thereafter. Children must be provided with an opportunity to meet with their worker in private. In 1999, there was a 93% compliance rate for the minimum 90-day visits and a 97% compliance rate for private visits. These rates are an improvement from the 1998 findings of 91.5% compliance for the 90 day visits and 96% compliance for private visits.

4.20 – Plans of Care

For children placed in foster care, regular reviews of their plans of care are required every 90 days. These are to be documented in the child's case file, and are to be endorsed in a timely fashion by supervisors. In 1999, plans of care were completed on time and therefore in compliance in 96% of the cases reviewed. In addition, there was timely supervisory endorsement of plans of care in 91% of the cases reviewed. These figures indicate improvement compared to 1998 when plans of care were completed on time in 94% of the cases reviewed and there was timely supervisory endorsement of the plans of care in only 89% of the cases reviewed.

5.0 - Service Recommendations

As noted earlier in this report approximately 73% of the children reviewed in 1999 have been identified as having special needs. There continue to be many clinical challenges in trying to assist these young children and youth. The service recommendations in 1999 reflect the ongoing need to enhance and update recordings, to obtain the required documentation, and to re-assess the child's individual needs.

5.10 – Case Planning

In 1999, 29% of the recommendations were to enhance and/or update documentation. This includes plans of care, quarterly recordings and social histories. The number of recommendations in this area has increased from 26% in 1998.

Plans of care that are outcome-focused, time-limited, measurable and achievable are essential to provide quality services to children to address their identified needs. Recommendations are issued when these planning elements are lacking.

Recommendations to enhance and/or update documentation also refer to social histories and quarterly recordings. Quarterly recordings are intended to capture events and relationships in a child's life. Social histories are particularly useful when young people are requesting information about their families of origin or are confused about, or unaware of, why they were admitted to care.

5.20 – Documents

In 1999, 26% of the recommendations were to obtain documents for the file. This is an increase from 22% in 1998. Approximately nine percent of the recommendations in this category were to obtain clinical reports, which are important for case planning and tracking progress. The remaining recommendations in this category relate to supplementary medical and academic reports.

5.30 – Reassessing Child's Needs

In the 1999 review, 7% of the recommendations made were to consider having a child assessed, or in some cases, reassessed. This is comparable to 6.5% in 1998. To assist the caseworker, care provider and child, it is important the appropriate external professionals complete assessments and that treatment recommendations are reviewed and incorporated into the plan of care.

6.0 – High Risk Cases

Children and youth are considered to be high risk when their behaviours or patterns of behaviours place them at risk of harming themselves or others. High risk cases were first identified in the 1998 Crown Ward Review. In 1999, 306 or 11% of the young people reviewed were deemed to be high risk. This is comparable to 1998 when 304 children and youth or 12% were deemed to be high risk. Individual high risk cases were brought to the attention of each Society, and flagged for the Ministry Regional Office. In the majority of the cases the Societies were aware of the situation and dealing with it. The reviewers recommended further action in 68 cases (22%).

7.0 - Responses from Crown Wards

In 1999, a total of 1263 questionnaires (47%) were received from children and youth whose case files were reviewed, and 280 of the children (10%) requested and received interviews. This is similar to the response rate in 1998.

The main concern consistently reported by the children was what will happen to them when they turn 18 years of age. They were worried about money, where they would live, how they would get along, being able to continue school, finding a job, and whom they could turn to for emotional support. A number of the children reported worries about their health, sexuality, drugs and alcohol, and getting along with other children in their homes.

Issues pertaining to family and access continue to be reflected in the responses of the children similar to last year. Although many of the children indicated overall satisfaction in living with their foster families and felt their foster families wanted them, some indicated a desire for more information regarding their families of origin, some indicated a hope to return to live with either or both of their parents, and some indicated a desire for increased contact with their siblings.

8.0 – Summary

The 1999 Crown Ward Review has demonstrated significant improvement in the delivery of service to the children and youth in care who are Crown wards of the Province of Ontario.

- Overall compliance has increased significantly from 67% in 1998 to 77% in 1999.
- Worker contact has increased from an average of one contact every 32 days in 1998 to an average of one contact every 28 days in 1999.
- More children are benefiting from regular reviews and timely supervisory endorsement of their plans of care.
- Two thirds of the children are living in a family setting.
- In the great majority of cases, family contacts have been well managed. Children have greater access to their family members, with exercised access increasing from 53% in 1998 to 65% in 1999.
- Over 90% of the children are making progress at some level at school.

Although improvements have been made in these areas there continue to be improvement required in the area of case planning.

- More attention is required to enhance and update documentation, including plans of care, quarterly recordings and social histories.
- More effort is required to obtain all relevant documents for every child's file, including clinical reports, and other supplementary academic and medical reports.
- More attention is required to the clinical needs of the children, including complete assessments and treatment recommendations incorporated into the plans of care.

We are pleased with the increase in compliance and appreciate the cooperation of the staff of the Children's Aid Societies across the province in the completion of the 1999 Crown Ward Review.

Addendum

Adoption Probation

There were 59 children on adoption probation reviewed in 1999. These children have been Crown wards for a minimum of 24 months.

Thirty of the children were male and 29 were female. The average age of the children on adoption probation was seven years. The average length of the adoption probation placement was 15.5 months. Most of the children (76%) were identified as having special needs, and over half (56%) were on adoption subsidies.

Twenty-five of the children had been on adoption probation for less than six months, and there were plans to finalize the adoption within the next six months for all of these children except two. Twenty-five of the children had been on adoption probation for more than 12 months, and there were no plans to finalize the adoption within the next six months for 15 of these children. Table A1 below provides an overview of the length of time on probation and plans to proceed with adoption within the next six months.

Table A1 - Adoption Probation

Number of Children	Length of Time on Adoption Probation	Plans to Proceed with Adoption within next Six Months
25	0 – 6 months	22
9	6-12 months	4
25	Over 12 months	10

1999 was the first year that the Child Welfare Review Unit reviewed Crown wards on adoption probation. It was difficult to find all of the information required, and the information was typically spread out among several different files.

The reviewers noted lack of documentation regarding contacts and dates, lack of documentation as to reasons for delays in adoption, uncertainty about case planning, and lack of clarity regarding post adoption services.

For the 2000 review of children on adoption probation, additional information will be collected, including:

- Name of supervising agency/licensee;
- Notification of extension on file;
- Written notice to the child's band;
- Registration of the placement on file;
- Social history of the child on file;
- Medical history of the child on file;
- Social/Medical history of the birth mother and family on file;
- Social/Medical history of the birth father and family on file;
- Acknowledgement of adoption probation on file;
- Record of seven day visit;
- Record of 30 day visit;
- Record of minimum 90 day visits by a social worker.

The expanded review of children on adoption probation will increase the focus on accountability for decision-making.

Children's Aid Societies will need to consolidate the information into one file, and the Child Welfare Review Unit will work with Societies to ensure that they are aware of the documentation required.

This is **Exhibit "23"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Ontario

Child Welfare Review

Combined Summary Report 2000 - 2001 - 2002

Crown Ward Review
Child In Care Review
Adoption Probation Review

Ministry of Children and Youth Services

Management Support Branch

April 2004

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Crown Ward Review

1.1.0 - Introduction

The Crown Ward Review is an annual process undertaken by the Ministry of Children and Youth Services' Child Welfare Review Unit, in co-operation with each child welfare agency and ministry regional offices.

The specific objectives of the Crown Ward Review are:

- To monitor agency compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the Crown ward;
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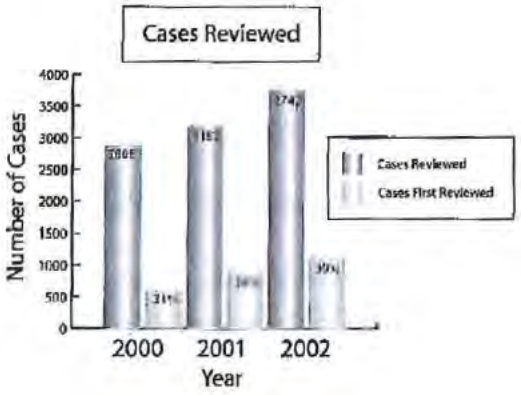
The Crown Ward Review findings are based on the review of society files, questionnaires completed by Crown wards and through client interviews. In complex and/or high-risk cases, society caseworkers and managers may also be consulted. Each case file is reviewed in the year following 24 months of Crown wardship and every year thereafter.

This report is a summary of the Crown Ward Review. The review also provides individual case reports to caseworkers, society managers and ministry program supervisors so they can have feedback on key areas of service delivery and issues specific to compliance and standards. This information can be useful to the society's board, management and to the ministry's regional office for planning purposes and for performance outcome monitoring.

1.1.10 - Scope of the Review

Chart 1 - Cases Reviewed



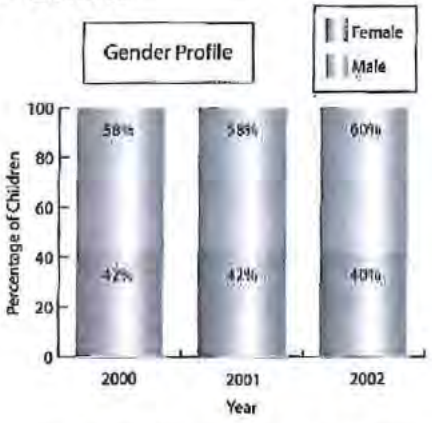
The number of Crown wards reviewed for the first time has consistently increased over the past three years (Chart 1).

1.2.0 - Profile of the Children

1.2.10 - Gender

In 2000 and 2001, 58 percent of the children reviewed were male and 42 percent were female. In the 2002 review, 60 percent of the children reviewed were male and 40 percent were female (Chart 2).

Chart 2 - Gender



1.2.11 - Age

Table 1 provides a breakdown of the average age and numbers/percentage of children reviewed at the time of their Crown wardship and at the time of review.

Table 1 - Age Profile

Year	Average Age		Number of Children 0 -9		Number of children 10 -12		Number of children 13 -17	
	At time of Review	At time of Crown Wardship	At time of Review	At time of Crown Wardship	At time of Review	At time of Crown Wardship	At time of Review	At time of Crown Wardship
2000	13.6	8.4	429 (15%)	1881 (65%)	616 (21%)	644 (23%)	1824 (64%)	344 (12%)
2001	13.5	8.4	530 (17%)	2076 (65%)	685 (22%)	722 (23%)	1968 (62%)	385 (12%)
2002	13.4	8.5	617 (17%)	2396 (64%)	836 (22%)	877 (23%)	2289 (61%)	469 (13%)

1.2.12 - Identified Needs

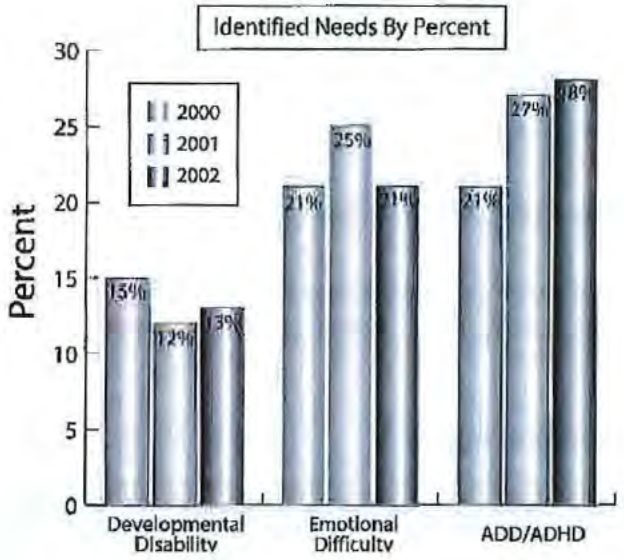
The *Child and Family Services Act* defines a special need as, "a need that is related to or caused by a behavioural, developmental, physical, mental or other handicap."

Identified special needs include diagnoses such as Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, as well as significant physical, emotional and developmental disabilities. The overall number of children identified as having special needs has increased consistently since 2000 (as noted in Table 2). Chart 3 compares some of the more frequently identified special needs by per cent and category for 2000 to 2002.

Table 2 - Special Needs

Year	Cases Reviewed	Percentage Special Needs
2000	2,869	78%
2001	3,183	81%
2002	3,742	82%

Chart 3 - Identified Characteristics



1.2.13 - Psychotropic Medication and Therapy

Psychotropic medication is prescribed as part of a treatment plan to address special needs, such as Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder.

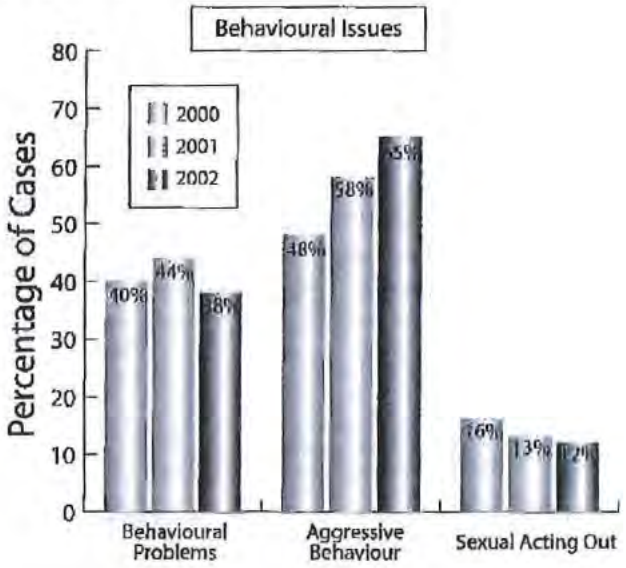
Table 3 - Psychotropic Medication and Therapy

Year	Percentage Psychotropic Medication	Percentage Children In Therapy
2000	38%	35%
2001	39%	36%
2002	42%	34%

1.2.14 - Behavioural Issues

Beginning in 2000, behavioural issues were identified separately from clinical diagnosis. Of the children identified with behavioural problems, there was a marked increase in reported behavioural difficulties, especially in the area of aggressive and/or assaultive behaviour, from 2000 to 2002.

Chart 4 - Behavioural Issues



1.2.15 - Young Offender Involvement

Information on children who were involved in illegal activities, which resulted in charges being laid under the *Young Offender Act,* now the *Youth Criminal Justice Act* is being reported for the first time.

Table 4 - Young Offender Involvement

Year	Percentage YOA Involvement	Prior YOA Involvement	History of YOA Placement
2000	15%	16%	10%
2001	15%	15%	10%
2002	15%	14%	9%

1.2.16 - High Risk

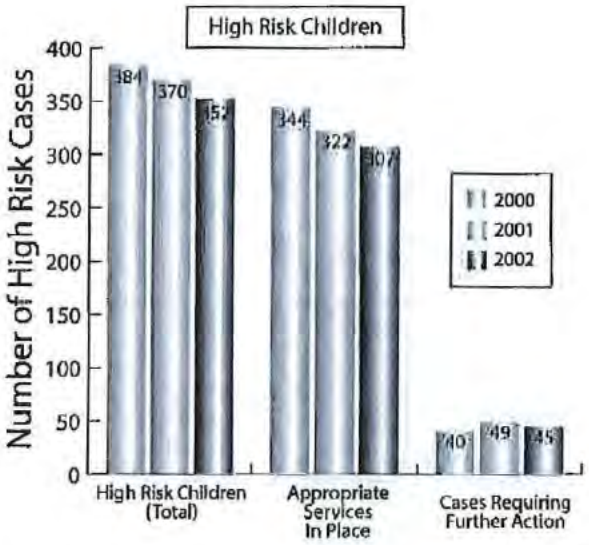
Children are identified as high risk when their behaviour may result in harm to themselves and/or others.

High-risk behaviour includes children who exhibit the following:

- Aggressive or suicidal behaviour
- Serious emotional problems
- Sexual acting out
- Serious psychiatric disorders and/or substance abuse problems

- Children involved in criminal activity
- Children who frequently run from their placements.

Chart 5 - High-Risk Children



All high-risk cases and any recommendations made regarding specific high-risk situations are highlighted for each society and the ministry's regional office as part of the on-site review.

In those situations identified that required further action, recommendations were made to societies for follow-up reporting to ensure that all methods of assistance to the children had been explored.

1.2.17 - History of Abuse

Assessment and treatment programs, both individual and group, were made available to assist children in coping with and addressing the trauma of their early life experiences.

Chart 6 - History of Abuse

Of the children reviewed who experienced abuse while in care, it was determined that the majority of the reported abuse in resources was historical and societies had put proper safeguards in place to ensure the future safety of these children.

1.2.18 - Native Heritage

Children of Native heritage have rights identified under the *Indian Act* and within the *Child and Family Services Act* which impact on service delivery. It is within this context that the following information is monitored.

Chart 7 - Children of Native Heritage

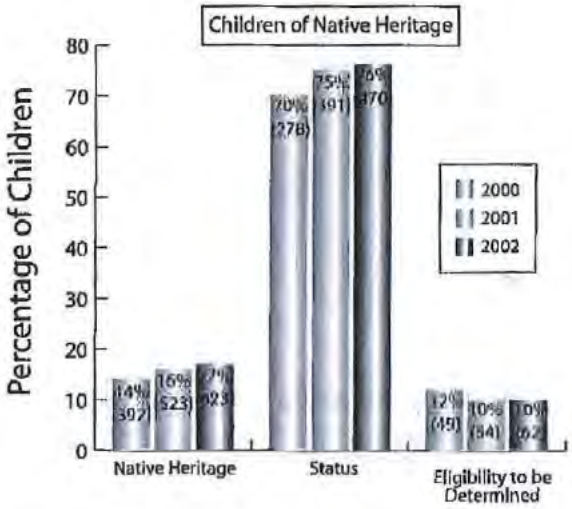


Chart 7 identifies the percentage of children reviewed that were of Native heritage, the percentage of Native children with known status under the *Indian Act* and the percentage of Native children whose status was yet to be determined.

Table 5b - Placements of Native Children

Placements of Native Children	2000	2001	2002
Total Number of Native Children	397	523	623
Children Served by Aboriginal CAS	124 (31%)	214 (41%)	236 (38%)
Children Served by Non-Aboriginal CAS	273 (69%)	309 (59%)	387 (62%)
Total Number of Children Placed in Native Homes	119 (30%)	167 (32%)	203 (33%)
Children Placed in Native Homes and Served by Aboriginal CAS	76 (16%)	122 (57%)	142(23%)
Children Placed in Native Homes and Served by Non-Aboriginal Societies	43 (16%)	45 (15%)	61(10%)

Table 5c - Services to Native Children

	2000	2001	2002
Total Number of Native Children	397	523	623
Children Aware of Their Native Heritage	266 (67%)	410 (78%)	513 (82%)
First Nation Representation in Court Proceedings	222 (56%)	266 (51%)	358 (57%)
Children Placed in Home Communities	71 (18%)	75 (14%)	99 (16%)
Children Maintaining Contact With Home Community	147 (37%)	190 (36%)	219 (35%)
First Nation Representation in Case Planning	71 (18%)	109 (20%)	138 (22%)
Efforts by Societies to Involve First Nation Representation in Case Planning	143 (36%)	184 (35%)	146 (23%)
Children Involved in Aboriginal Cultural Practices	234 (59%)	316 (60%)	457 (74%)
Spiritual needs of Children Being Addressed	206 (52%)	299 (57%)	442 (71%)

1.2.20 - Education

In 2000, 77 per cent of the children reviewed were making some level of progress in school, compared to 88 per cent in 2001 and 2002.

Table 6 - Educational Progress

Year	Number of Children Attending	Progressing Well	Progressing Slowly	Promotion At Risk
2000	2665 (93%)	1253 (44%)	952 (33%)	218 (8%)
2001	2952 (93%)	1397 (47%)	1197 (41%)	231 (8%)
2002	3468 (93%)	1695 (49%)	1368 (39%)	205 (6%)

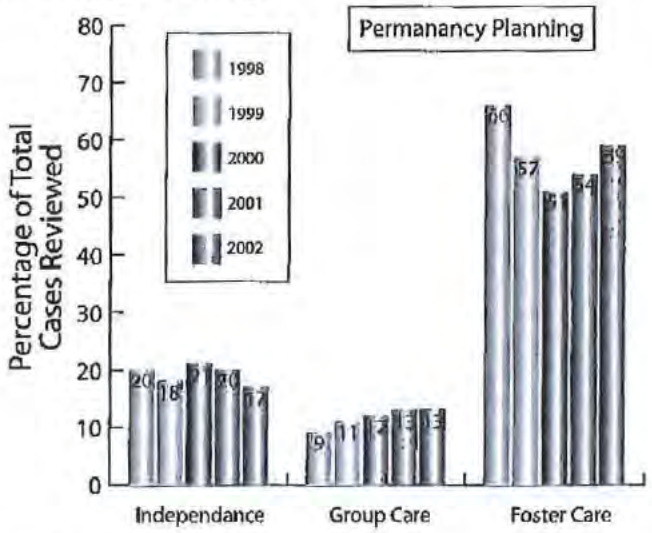
Children not attending school were either not required to attend school because they were too young (e.g. toddlers) or were beyond the age of compulsory school attendance.

1.3.0 - Findings

1.3.10 - Permanency Planning

In 2000, the permanency plan for 86 per cent of the children reviewed was long-term care, which included foster care, residential group care, and independent living. This is comparable to 2001. In 2002, long-term care was the permanency plan for 90 per cent of the children. Societies were continuing to use respite care, child and youth counsellors and other services in order to support foster parents in caring for these children on a long-term basis. Adoption was being considered for three per cent of the children in 2000, 2001 and 2002. For the remaining children reviewed, the case plans indicated a return home to parents (1 percent), a transfer to adult services (1.5 percent) or were unclear (8.5 percent) in all three review years.

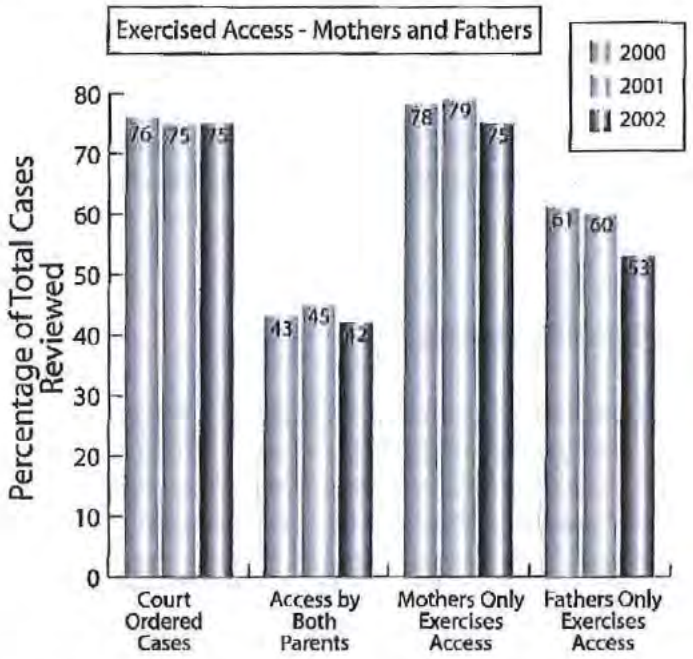
Chart 8 - Permanency Planning



1.3.11 - Access

An access order is a legislative barrier to adoption in Ontario.

Chart 9 - Exercised Access



In cases where there was Court ordered access for both parents, access was exercised by both parents 43 per cent of the time in 2000, 45 per cent in 2001 and 42 per cent in 2002. In those situations where access was court ordered for mothers only, mothers in 78 per cent of the cases in 2000, 79 per cent in 2001 and 75 per cent in 2002, exercised access. Where there was a court order in place for access by fathers only, fathers exercised access in 61 per cent of the cases in 2000, 60 per cent in 2001 and 53 per cent in 2002.

Table 7 - Exercised Access - Extended Family and Siblings

Year	Extended Family	Siblings
2000	41%	76%
2001	41%	76%
2002	41%	75%

Of the total number of case recommendations made in 2000, 153 were to review access arrangements. In 2001, 139 recommendations were made in this regard and 138 in 2002. Overall, access was well managed by societies and in the best interests of the children.

1.3.12 - Placements

Societies have continued to make concentrated efforts in the recruitment, training and support of foster parents. The proportion of children placed in society-operated foster care (regular and specialized) has remained constant over the past three years. The proportion of children placed in outside paid resources increased slightly.

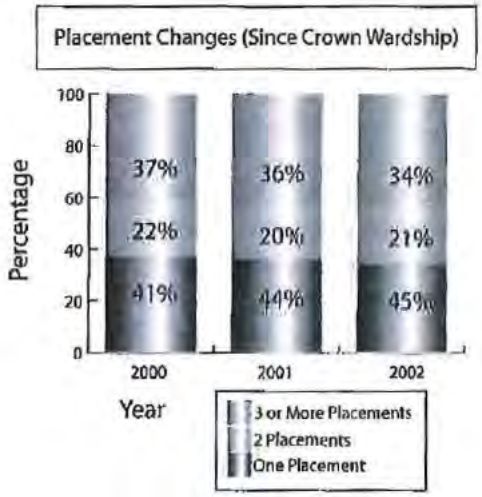
Table 8 - Placement Type

Placement Type	2000	2001	2002
Regular Foster Care	36%	35%	33%
Specialized and Treatment Foster Care	16%	17%	18%
Children's Aid Society Group/Parent Model Home	2%	2%	2%
Emergency Receiving Home	1%	<1%	1%
Outside Paid Institution Foster Home	11%	11%	11%
Outside Paid Institution Parent Model	5%	4%	5%
Outside Paid Institution Group Home	14%	15%	16%
Young Offender Facility	2%	2%	2%
Children's Mental Health Centre	1%	1%	1%
Independent Living	7%	5%	4%
Provisional Foster Care	5%	6%	6%
Community Caregiver/Parents	0%	2%	1%

1.3.13 - Placement Changes

Placement stability remains a key factor in the provision of continuity of care for children and for their ongoing security and optimum development. The average length of placement for Crown wards reviewed in 2000 and 2001 was 23.4 months. In 2002, placement length declined to an average of 22.4 months.

Chart 10 - Placement Changes



Although the average length of placement declined overall, the average length of placement was considerably greater for those children who were made Crown wards at a younger age.

Table 9 - Average Placement Length by Age

Age at time of Crown Wardship	Percentage of Crown Wards			Average Placement Length		
Year	2000	2001	2002	2000	2001	2002
Under Seven	37%	37%	35%	33.7 months	32.9 months	26.4 months
Seven to Twelve	50%	51%	53%	20.5 months	20.6 months	27.3 months
Over Twelve	13%	12%	12%	12.1 months	10.8 months	20.8 months

1.3.14 - Changes in Caseworker Assignment

The number of caseworker contacts with children and the length of caseworker assignment have an important impact on the continuity of relationships for children. These relationships are important to assist children in understanding the complex issues that are associated with being in care. Children often seek support and guidance from their caseworkers, particularly in times when there are difficult changes occurring and decisions to make.

Table 10 - Length of Caseworker Assignment

	2000	2001	2002
Length of Caseworker Assignment	22.3 months	22.1 months	21.6 months
Average Number of Contacts with Children	12.8	11.6	11.5

In 2000, caseworkers met with children an average of once every 28 days. The figure for 2001 was one visit every 28 days and in 2002, visits between caseworkers and children occurred on average every 32 days.

Chart 11 - Changes In Caseworker Assignment

1.4.0 - Legislative Compliance

A reviewer issues a directive whenever a statutory requirement has not been met. The society must provide a written response to the Child Welfare Review Unit within 60 days, which addresses the issue and indicates how the situation has been corrected or will be corrected in the future.

Table 11a compares the overall compliance ratings for the past three years. Table 11b provides a breakdown of compliance rates by each standard. The overall compliance rate is calculated by determining the number of cases in full compliance

Table 11a - Overall Case Compliance and Directives Issued

Year	Cases Reviewed	Cases in Full Compliance	Directives Issued	Average # Directives per Case Reviewed
2000	2,869	2,209 (77%)	1,123	0.39
2001	3,183	2,422 (76%)	1,522	0.48
2002	3,742	2,860 (76%)	1,576	0.42

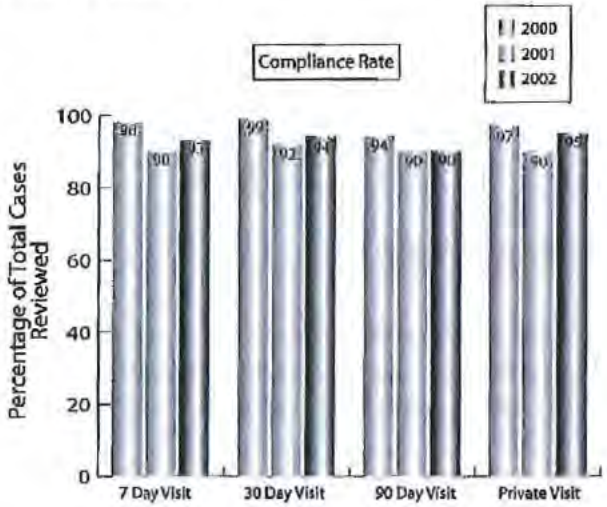
Table 11b - Compliance and Directives Issued per Standard

Standards	Level of Compliance 2000	Level of Compliance 2001	Level of Compliance 2002
1. Record of Contacts			
7 day visit	92.1%	90.3%	92.8%
30 day visit	95.2%	91.9%	93.7%
Minimum 90 day visits by caseworker	93.6%	90.2%	89.9%
Private visits	96.6%	92.6%	95.4%
2. Documentation			
Child's family history	98.7%	98>4%	97.8%
Annual medical exam	97%	96.9%	96.5%
Annual dental exam	97.3%	96.9%	97.4%
3 month review of plan of care	94.5%	93.1%	92.1%
Review of plan of care within 30 days of move	93.8%	91.9%	94.8%
Review of plan by Supervisor	90.7%	89.9%	89.7%
Plan of care addresses specific needs	96.9%	98.0%	99.3%
Annual school reports	99.7%	99.5%	99.2%
Discussion of rights	97.7%	97.6%	98.2%
Plan of care - residential resources	98%	98.4%	99.4%
Serious Occurrence Report	73%	86.0%	69.5%

1.4.10 - Statutory Contacts With Children

Statutory contacts are personal visits made by caseworkers with children. At minimum, visits are required within seven and 30 days after a placement occurs and every 90 days thereafter. Children must also be provided with an opportunity to meet with their caseworkers in private.

Chart 12 - Compliance Rates



The 2001 review found a significant decline in the rate of compliance in all areas of statutory contact. The results of the 2002 review noted an increase in compliance with seven and 30-day statutory visits and private visits. The compliance rate for 90-day visits continues to require additional attention by societies.

The ministry's regional offices are advised of issues, such as a decline in statutory contact, by means of the post review meeting following the completion of an agency's Child Welfare Review, as well as receiving individual agency summary reports prepared by the Child Welfare Review Unit. These two processes provide an overview of systemic consistency and areas requiring attention by each society.

1.4.11 - Plans of Care

For children placed in society foster homes, reviews of their plans of care are required every 90 days and within 30 days of any change in placement. Reviews of plans of care require documentation in the child's case file and are to be endorsed in a timely fashion by supervisors. In 2000, plans of care were completed on time and therefore in compliance in 95 per cent of the cases reviewed. The findings of the 2001 review noted a decrease in timely reviews of plans of care to 93 percent. In 2002 plans of care were completed on time in 92 per cent of the cases reviewed.

In 2000 there was timely supervisory endorsement of plans of care in 93 per cent of the cases reviewed. In 2001, timely supervisory reviews decreased to 90 per cent compliance. In 2002 supervisor endorsement of plans of care was 90 percent.

1.4.12 - Serious Occurrences

In 2000, information regarding serious occurrences was collected for the first time as part of the annual review. The ministry's serious occurrence reporting procedures establish a consistent process for ensuring communication of serious occurrences so that service providers and the ministry are aware of the occurrence and agree to any appropriate follow up. The procedures for reporting serious occurrences are intended to support the issues management processes of service providers and allow the ministry to monitor their performance.

Table 12 - Serious Occurrence Reporting

Year	Number of Serious Occurrence Reports	Serious Occurrence Reports Not On File
2000	654	176 (27%)
2001	704	100 (14%)
2002	648	64 (10%)

1.5.0 - Service Recommendations

Service recommendations are made by reviewers and relate to case management issues identified in the review of a child's file. There is no legal obligation for the society to act upon these.

The service recommendations in this reporting period reflect the ongoing need to update recordings, to obtain the required documentation, to consider counselling, and to re-assess the children's individual needs.

1.5.10 - Case Planning

Plans of care that are outcome-focused, time-limited, measurable and achievable are essential to provide quality services to children to address their individual needs. The Child Welfare Review Unit issues recommendations when these planning elements are lacking.

Recommendations to enhance and/or update documentation also refer to social histories and quarterly recordings. Quarterly recordings are intended to capture events and relationships in a child's life. Social histories are particularly useful when children request information about their families of origin or want to know more about the reasons why they were admitted into care.

In 2002, 46 per cent of the total case recommendations made were to enhance and/or update documentation including plans of care, quarterly recordings and social histories. The number of recommendations made in this area increased from 34 per cent in 2000 and 38 per cent in 2001.

1.5.11 - Documents

Documentation, such as medical and dental reports, Crown wardship orders, school reports and clinical reports are important documents for case planning and measuring

progress in response to goals and objectives. The Crown Ward Review audits files to ensure such documentation is on file. In 2002, 22 per cent of the total case recommendations issued were to obtain documents for the file. In 2001, 15 per cent of recommendations were made to file similar documentation and in 2000, 17 per cent of recommendations made were in this area

1.5.12 - Reassessing Child's Needs

To assist the caseworker, care provider and child, it is important that appropriate external professional's complete assessments and those treatment recommendations are reviewed and incorporated into the plan of care. In 2002, 2.5 per cent of the total case recommendations issued were to consider having children assessed, or in some cases, reassessed. In the 2000 and 2001 reviews, four per cent of the total recommendations made pertained to having children's needs assessed or reassessed.

1.6.0 - Responses from Crown Wards

Table 13 - Responses from Crown Wards

Year	Cases Reviewed	Questionnaires Received	Number of Interviews Requested
2000	2,869	1,421 (50%)	267 (9%)
2001	3,183	1,487 (47%)	293 (9%)
2002	3,742	1,522 (41%)	273 (7%)

Children were generally satisfied with their placements and the service the societies were providing to them. Children reported that their caseworkers visited them regularly and provided assistance to them. Responses indicated that most children were aware of their rights and responsibilities as Crown wards. Most children indicated they were involved in planning that affected them. Many children reported being worried about what would happen when they turned eighteen. Some children said they were worried about school, their health, their birth families and/or their relationships with other foster children.

As part of the questionnaire, each child was asked whether he or she would like to meet with one of the reviewers to discuss his or her concerns or experiences in care. For the most part, the information shared in these meetings was similar to the information provided in the confidential questionnaires.

1.7.0 - Summary

The 2000 - 2001 - 2002 Crown Ward Reviews noted several improvements in the delivery of service to the children and youth in care who were Crown wards of the Province of Ontario. These included:

- Overall compliance varied little over the past three years - 77 per cent in 2000, and 76 per cent in 2001 and 2002.
- The proportion of children reported to be high risk decreased from 13 per cent in 2000 to 12 per cent in 2001 and nine per cent in 2002. The reviews indicated that these cases continued to be well managed.

- In 2002 increased compliance was noted in seven-day, 30-day and private visits with children. Compliance with 90-day statutory visits was 90 per cent and continues to require the societies' attention.

- The proportion of Native children residing in Native homes continued to increase, from 30 per cent in the 2000 review, 32 percent in 2001 and 33 per cent in 2002.

- The proportion of Native children aware of their cultural heritage and participating in Aboriginal cultural practices increased significantly since 2000.

- The permanency plan for the majority of the children continued to be long-term care (84 per cent in the 2000 review, 86 per cent in 2001, 90 per cent in 2002).

- The majority of children continued to make academic progress at some level at school. There was a noteworthy improvement in this area from 77 per cent in 2000 to 88 per cent in 2001 and 2002.

The following observations are provided for consideration:

- The proportion of children diagnosed with special needs continued to increase from 78 per cent in the 2000 review, 81 per cent in 2001 and 82 per cent in 2002.

- The proportion of children reported to be receiving psychotropic medication increased from 38 per cent in the 2000 review, 39 per cent in 2001 and 42 per cent in 2002.

- There was a slight increase in children living in Outside Paid Resources from 30 per cent in 2000 and 2001, to 32 per cent in 2002.

- The proportion of Native children having contact with their First Nation representatives or home communities decreased, from 37 per cent in 2000, 36 per cent in 2001, to 35 per cent in 2002.

- The average length of placement continued to decline from 23.4 months in 2000 and 2001, to 22.4 months in 2002. The average length of caseworker assignment also continued to decline, from 22.3 months in 2000, 22.1 months in 2001 to 21.6 months in 2002.

- A significant number of directives and recommendations were made in regard to the timeliness and quality of recordings on file (46 per cent of the recommendations made to enhance plans of care, social histories and quarterly recordings in 2002, 38 per cent in 2001 and 34 per cent in 2000).

Part II: Child In Care Review

Introduction

The Child In Care Review is an annual process undertaken by the Ministry of Children and Youth Services', Child Welfare Review Unit, in co-operation with each child welfare agency and ministry regional office. The review began as a pilot project in 1999. Information was collected throughout 2000 from 52 of the 53 societies. In 2001 all of the societies were reviewed. The results of the pilot led to changes to the template based on feedback from the agencies and reviewers. One such change was the inclusion of children who had been Crown wards for less than 24 months. The Child In Care Review was fully implemented in November 2000.

The Child In Care Review findings are based on the review of society files, both the child's file and, in certain circumstances, the family service file. In complex and/or high-risk cases, society caseworkers and managers may also be consulted.

Each case file is randomly selected for review based on a pre-determined formula. A sample size of ten per cent of children in care files with a minimum of four files per society is used. It is important to note that in a random sample of this size the results can be generally indicative of trends, but it is difficult to draw defining conclusions from the data.

Scope of the Review

Table 1 - Cases Reviewed

Year	Cases Reviewed
2000	695
2001	1,024
2002	1150

As with the Crown Ward Review, statistics related to access are calculated as a percentage of cases with access orders. Statistics related to directives and recommendations are calculated as a percentage of the total number of directives/recommendations issued.

Profile of the Children

Overview

The status of the children in care reviewed in each category were as follows:

Chart 1: Legal Status of Children in Care

Age/Gender

Fifty-three per cent of the children reviewed were males and forty-seven per cent were females in both 2000 and 2001. In 2002, 55 per cent of the children were male and 45 per cent were female.

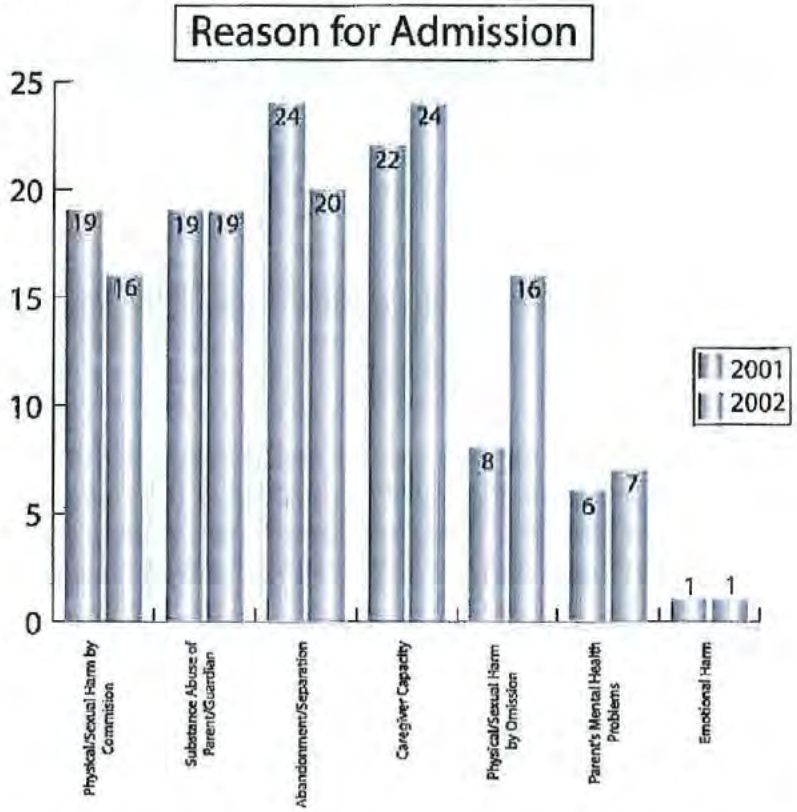
Table 2 - Age Profile

Year	Age at Admission	Age at Review
2000	8.1 years	9.2 years
2001	8.5 years	9.9 years
2002	8.4 years	9.9 years

Reasons for Admission

Chart 2 provides the findings for children's admission into care for 2001 and 2002.

Chart 2 - Reasons for Admission



There were increases in four categories: Caregiver Capacity, Physical/Sexual Harm by Omission, Parent's Mental Health Problems and Emotional Harm. Comparable data for 2000 was not available as the initiation of the Ontario Risk Assessment Model resulted in additional data being collected in 2001.

Year	Planned Admission	Emergency Admission	Prior Admission to Care
2001	19%	81%	39%
2002	17%	83%	42%

Identified Needs and Characteristics

According to the *Child and Family Services Act* a special need is defined as, "a need that is related to or caused by a behavioural, developmental, emotional, physical, mental or other handicap." It is important to note that special needs cover a range of characteristics within each of the above categories.

Table 4a lists the primary characteristics of children identified as having special needs.

Table 4a - Identified Characteristics

Primary Characteristic	2000	2001	2002
Children with Special Needs (percentage of total cases reviewed)	396 (57%)	627 (61%)	722 (63%)
Emotional Difficulties	87 (22%)	130 (21%)	134 (19%)
Attention Deficit Disorder/ Attention Deficit/Hyperactivity	75 (19%)	135 (21%)	152 (21%)
Developmental Disability	63 (16%)	95 (15%)	135 (19%)
Psychiatric Difficulties	32 (8%)	67 (11%)	75 (10%)

Table 4b - Psychotropic Medication and Therapy

Year	Percentage Psychotropic Medication	Percentage of Children in Therapy
2000	22 %	29 %
2001	24 %	32 %
2002	24 %	33 %

Table 4c - History of Abuse

Year	Abuse prior to Admission	Abuse in Resources
2000	252 (36%)	9 (1%)
2001	363 (35%)	20 (2%)
2002	341 (30%)	13 (1%)

Of the children who experienced abuse in resources reported in Table 4c above, upon further investigation, it was determined that the majority of the abuse occurred prior to the ministry review of the case file. The findings of the review indicated that proper safeguards had been put in place to ensure the safety of these children.

Native Heritage

In a sample of this size the results can be generally indicative of trends, but it is difficult to draw defining conclusions from the data. The data is presented, therefore, primarily for information purposes.

Table 5a provides comparative data for the past three years.

Table 5a - Children of Native Heritage

Year	Native Heritage - Percentage of all Children Reviewed	Status - Percentage of Children of Native Heritage	Eligibility to be Determined
2000	142 (20%)	98 (70%)	35 (25%)
2001	178 (17%)	121 (71%)	42 (24%)
2002	199 (17%)	131 (66%)	45 (23 %)

Tables 5b and 5c below, present the placement and service information in regard to Native children.

Table 5b - Placements of Native Children

Native Children Served	2000	2001	2002
Total Number of Native Children	142	178	203
Children Served by Aboriginal CAS	70 (49%)	84 (47%)	92 (46%)
Children Served by Non-Aboriginal CAS	72 (51%)	94 (53%)	109 (54%)
Number of Children Placed in Native Homes	66 (46%)	76 (43%)	77 (22%)
Children Placed in Native homes and Served by Aboriginal CAS	54 (42%)	59 (33%)	65 (32%)
Children Placed in Native Homes and Served by Non-Aboriginal CAS	12 (8%)	17 (12%)	14 (7%)

Table 5c - Services to Native Children

Placements of Native Children	2000	2001	2002
Total Number of Native Children	142	178	203
Children Aware of Their Native Heritage	79%	67%	74%
First Nation Representation in Court Proceedings	51%	48%	41%
Children Placed in Home Communities	3%	25%	22%
Children Maintaining Contact With Home Community	54%	54%	45%
First Nation Representation in Case Planning	38%	39%	37%
Efforts by Societies to Involve First Nation Representation in Case Planning	52%	85%	45%
Children Involved in Aboriginal Cultural Practices	58%	55%	66%
Spiritual needs of Children Being Addressed	51%	54%	61%

Education

Table 6 - Educational Progress

Year	Number of Children Attending	Progressing Well	Progressing Slowly	Promotion at Risk
2000	514	27%	29%	9%
2001	789	35%	43%	10%
2002	868	37%	47%	7%

The children not attending school were either not required to attend school because they were too young (e.g. toddlers) or were beyond the age of compulsory school attendance.

Findings of the Review

2.3.10 - Permanency Planning

A sense of permanence is an important contributor to the achievement of emotional and psychological well being for children. It is beneficial for children, however, to have a permanency plan developed as soon as possible following a child's admission into care. Table 7 identifies the results of the 2000, 2001 and 2002 reviews in regard to permanency planning.

Table 7 - Permanency Planning

Permanency Permanency Planning	2000	2001	2002
Return Home	276 (40%)	281 (27%)	304 (26%)
Long term Foster Care	142 (20%)	275 (27%)	315 (27%)
Adoption	61 (9%)	122 (12%)	197 (17%)
Adult Services	5 (<1%)	3 (<1%)	4 (<1%)
Long Term Residential Group Care	20 (3%)	67 (7%)	82 (7%)
Independence	20 (3%)	63 (6%)	73 (6%)
Not Clear	171 (25%)	213 (21%)	175 (16%)

The Child In Care Review recommended review of permanency planning in ten per cent of the cases in 2000, eight per cent in 2001 and eight per cent in 2002.

Access

Table 8 reports the findings in regard to access for children in care. Overall, access was well managed by societies.

Table 8 - Access

Access	2000	2001	2002
Court Ordered Access	58%	63%	57%
Court Ordered No Access	2%	6%	12%
Court Silent	5%	3%	4%
Access By Agreement	20%	15%	16%
Access Exercised	71%	63%	60%
Sibling Access Exercised	81%	81%	80%

Placements

Table 9 - Placement Type

Placement Type	2000	2001	2002
Regular Foster Care	54%	49%	43%
Specialized and Treatment Foster Care	7%	6%	5%
Children's Aid Society Group/Parent Model Home	3%	3%	3%
Emergency Receiving Home	2%	4%	3%
Outside Paid Institution Foster Home	6%	9%	10%
Outside Paid Institution Parent Model	2%	3%	2%
Outside Paid Institution Group Home	14%	14%	13%
Young Offender Facility	1%	1%	2%
Children's Mental Health Centre	1%	1%	1%
Provisional Foster Care	4%	5%	7%
Independent Living	1%	2%	1%
Parental Home	3%	2%	2%
Community Caregiver	1%	1%	5%

Placement Changes

Factors that may effect placement stability include:

- the prevalence of emergency placements
- the circumstances of admission to care (risk of abuse, out of parental control, substance abuse by parents, neglect)

- the predominance of children with diagnosed special needs and/or behavioural issues

When children are admitted to care with less than 24 hours notice because of a family crisis, societies often have limited information upon which to base their placement decisions. It takes time to assess the child's placement needs and further time to secure an appropriate resource.

Table 10 - Placement Continuity

Number of Placements Since Admission	2000	2001	2002
One Placement	50%	45%	38%
Two Placements	33%	29%	32%
Three or More Placements	17%	26%	30%
Average Number of Placements	N/A	2.2	2.3
Average Length of Placement	6.9 months	7.8 months	8.4 months

Changes in Caseworker Assignments

Caseworker continuity is a factor that can have an impact on the emotional, social and behavioural progress of children in care. Table 11 notes that children were experiencing more frequent changes in caseworker assignments.

Table 11 - Changes in Caseworker Assignment

Number of Number of Caseworkers	2000	2 001	2002
One Caseworker	41%	33%	30%
Two Caseworkers	42%	40%	41%
Three or More Caseworkers	17%	27%	29%

Legislative Compliance

2.4.10 - Overview

A reviewer issues a directive whenever a statutory requirement has not been met. The society must provide written response to the Child Welfare Review Unit within 60 days, which addresses the issue and indicates how the situation has been corrected or will be corrected in the future.

Table 12a provides information regarding the overall compliance rate and directives issued for the reporting period. Table 12b lists directives issued and rate of compliance per standard. The overall compliance rate is calculated by determining the number of cases in full compliance.

Table 12a - Overall Case Compliance and Directives Issued

Year	Cases Reviewed	Cases In Full Compliance	Directives Issued	Average # Directives per case Reviewed
2000	695	285 (41%)	1049	1.5
2001	1024	545 (53%)	1313	1.3
2002	1150	696 (61%)	1286	1.1

Table 12b - Compliance and Directives Issued per Standard

Standard	Level of Compliance 2000	Level of Compliance 2001	Level of Compliance 2002
1. Record of Contacts			
7 day visit	82.6%	92.1%	92.1%
30 day visit	83.8%	91.2%	90.7%
Minimum 90 day visits by caseworker	88.1%	87.3%	88.9%
Private visits	89.2%	91.7%	92.9%
2. Documentation			
Admission social history	95.9%	93.2%	95.2%
Child's family history	95.2%	93.0%	95.6%
Admission medical exam	61.3%	87.1%	89.5%
Admission dental exam	86.3%	87.2%	90.2%
Annual medical exam	95.0%	93.4%	94.0%
Annual dental exam	96.7%	93.0%	94.5%
21 day assessment of needs	82.1%	91.8%	90.3%
30 day plan of care	87.6%	94.9%	94.9%
3 month review of plan of care	88.0%	88.1%	89.5%
Review of plan of care within 30 days if child moves	84.1%	90.5%	93.2%
Review of plan by Supervisor	74.4%	78.6%	84.6%
Plan of care addresses specific needs	91.0%	94.2%	96.7%
Annual school reports	94.9%	96.9%	98.5%
Discussion of rights	91.8%	95.8%	97.4%
Plan of care - residential resources	96.5%	96.9%	97.5%
Serious Occurrence Report	50.0%	66.0%	95.3%

Results of the 2000 Child In Care Review, indicated an overall compliance rate of 41 per cent. Legislative compliance in 2001 was 53 per cent and 61 per cent in 2002, which represents a 20 per cent improvement from the 2000 Child in Care Review.

Attention to documentation is an important process in case management. Missing admission documentation accounted for 25 per cent of the directives in 2000. This included admission medical and dental reports, admission social history, child's family history, and 21-day assessment of needs. In 2001, incomplete documentation accounted for 36 per cent of the directives issued and in 2002, 30 per cent of the directives issued.

Statutory Contacts With Children

Statutory contacts are personal visits made by caseworkers with the children. The Child In Care Review monitors visits that take place within seven and 30 days after a placement occurs and every 90 days thereafter. Children are also provided with an opportunity to meet with their caseworkers in private. Table 13 reports the findings in this area for 2000 - 2002.

Table 13 - Statutory Contacts with Children

Year	7 Day Visit	30 Day Visit	90 Day Visit	Private Visit
2000	88%	89%	92%	93%
2001	92%	91%	87%	92%
2002	92%	91%	89%	93%

In 2000, missed or late statutory contacts (seven-day visit, 30-day visit, minimum 90-day visits and private visits) accounted for 25 per cent of the directives.

Directives issued for missed or late statutory contacts (23 per cent) declined in the 2001 review, but increased to 27 per cent of all directives issued in 2002. Maintaining statutory contact with the children in care should remain a priority for societies.

Plans of Care

For children in care, plans of care are to be developed within 30 days, and regular reviews of these plans of care are conducted every 90 days, as well as within 30 days if the child moves. These are to be documented in the child's case file, and are to be endorsed in a timely fashion by supervisors.

Plans of care accounted for 28 per cent of the total number of directives issued in 2000. This included late plans of care, lack of supervisory review of plans of care and plans of care that did not address the specific needs of the children. Plans of care continued to account for the majority of directives issued (31 per cent) in 2001 and 2002 (33 per cent).

Serious Occurrences

The ministry's serious occurrence reporting procedures establish a consistent process for ensuring communication of serious occurrences so that service providers and the ministry are aware of the occurrence and agree to any appropriate follow-up action.

Service providers are responsible for ensuring that the services are provided in ways that promote the health, safety and welfare of clients being served. Service providers are required to submit information to the ministry that demonstrates that the delivery of services is consistent with the relevant legislation and expectations set by the ministry. The procedures for reporting serious occurrences are intended to support the issues management processes of service providers and allow the ministry to monitor their performance

Table 14 - Serious Occurrence Reporting

Year	Number off Serious Occurrence Reports	Serious Occurrence Reports Not On File
2000	136	83
2001	216	142
2002	206	44

Service Recommendations

Service recommendations are suggestions made by reviewers that relate to case management issues identified in the review of a child's file. There is no legal obligation for the society to act upon these.

A total of 1,632 recommendations were made in the 2000 Child In Care Review. Recommendations were made in 82 per cent of the cases reviewed. In 2001, a total of

1924 recommendations were made in 71 per cent of the cases reviewed and 1712 recommendations were made in 742 cases in 2002.

Thirty-three per cent of the recommendations made in 2000, 39 per cent in 2001 and 36 per cent in 2002 were to enhance and/or update documentation, including plans of care, quarterly recordings and social histories.

Missing documentation (Society wardship order, school report, medical report, dental report, clinical report, and other resource reports) accounted for 18 per cent and 17 per cent of the recommendations made in 2000 and 2001 respectively and 19 per cent in 2002.

Summary

The findings of the Child in Care Review were as follows:

- More than two-thirds (69 per cent) of the children were placed in foster care in 2000 and 65 per cent were similarly placed in 2001. In 2002, 61 per cent of children were residing in a foster-care based program.

- Overall compliance rate was 41 per cent in 2000, which improved to 53 per cent in 2001 and 61 per cent in 2002.

- Directives were issued in 57 per cent of cases reviewed in 2000, 45 per cent in 2001 and 39 per cent in 2002. The most frequent directives related to plans of care, missed or late statutory contacts, and admission documentation.

- Recommendations were made in 82 per cent of cases reviewed in 2000 and 71 per cent in 2001 and 65 per cent in 2002. The most frequent recommendations related to the enhancement of recording practices, obtaining documents for the file, reassessing children's needs and reviewing permanency planning.

- The permanency plan for 40 per cent of the children reviewed in 2000 was to return home, however in 2001, the review noted that a return home was planned for only 27 per cent of children and 26 per cent in 2002.

- 56 per cent of the children were making some progress in school in 2000. In 26 per cent of the cases reviewed, progress could not be determined, either because information was not available from the child's previous educational year or for case-specific reasons. In 2001, 78 per cent of the children were making educational progress and 84 per cent in 2002.

- There was a continued improvement in compliance in serious occurrence reporting.

PART III: Adoption Probation

Introduction

The goal of the Adoption Probation Review is to determine that an adequate plan of care is developed for children in care placed on adoption probation. The Review is also intended to stimulate improvement in the overall service delivery to children.

The specific objectives of the Adoption Probation Review are:

- To monitor compliance with the *Child and Family Services Act* and its regulations in relation to the care of each child on adoption probation;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the child;
- To issue directives regarding non-compliance and to make recommendations about particular cases, general policy and practices and to encourage and monitor their implementation;
- To provide information on useful methods employed in other Societies and jurisdictions.

Scope of the Review

The findings of the Crown Ward Review of children placed on adoption probation are reported separately from those files of children reviewed as part of the Child In Care Review.

There were 91 children on adoption probation reviewed in 2000. These children had been Crown wards for a minimum of 24 months. In 2001, 96 children were reviewed as part of the Crown Ward Review and 39 children were reviewed as part of the Child In Care Review. Of the 39 children reviewed in the Child In Care Review, 38 were Crown wards and one child reviewed was on adoption probation by consent. In 2002, 102 Crown wards were reviewed and 48 children in care on adoption probation were reviewed.

As with the Crown Ward Review, statistics related to directives/recommendations are calculated as a percentage of the total number of directives/recommendations issued.

Profile of the Children

Age

Table 1 - Age at the Time of Review

	2000	2001		2002	
	Crown Ward Review	Crown Ward Review	Child In Care Review	Crown Ward Review	Child In Care Review
Number of Children Reviewed	91	96	39	102	48
Average Age at Wardship	3.6 years	4 years	2.3 years	3.8 years	2.1 years
Average Age at Review	7 years	7.5 years	3.2 years	6.4 years	3.2 years

The Child In Care population in 2001 and 2002 had an average age at the time of review of 3.2 years, while the children reviewed as part of the Crown Ward Review, had an average age at the time of review in 2000 of 7.0 and 7.5 years in 2001. In 2002 the age of the Crown ward population declined to 6.4 years.

Gender

Table 2 - Gender Profile

	2000	2001		2002	
	Crown Ward Review	Crown Ward Review	Child In Care Review	Crown Ward Review	Child In Care Review
Female	49	49	14	51	23
Male	42	47	25	51	25
Total	91	96	39	102	48

Findings of the Review

Adoption Plan

Table 3 reports on plans for the adoption finalization of Crown wards and Children in Care.

Table 3 - Adoption Probation

	2000	2001		2002	
	Crown Ward Review	Crown Ward Review	Child in Cared Review	Crown Ward Review	Child In Care Review
Finalize Within 6 Months	47	41	31	38	35
Finalize After 6 Months	44	55	8	60	10
Notification of Extension on File	36	16	0	7	3

Where the plan was to extend the probation period beyond six months, notification of extension was on file for 36 of the 44 cases where required in the 2000 Crown Ward Review and 16 of the 55 cases in 2001 and seven of 60 cases reviewed in 2002. The Child In Care Review did not have any documentation on file in this regard in 2002 and three of ten reports were on file in 2002. This is an area that requires attention by the societies.

Table 4 reports the findings of the length of time the children had been placed on adoption probation.

Table 4 - Length of Time on Adoption Probation

	2000	2001		2002	
Length of Time on Adoption Probation	Crown Ward Review	Crown Ward Review	Child In Care Review	Crown Ward Review	Child In Care Review
0 - 6 months	34	26	23	30	25
7 - 12 months	18	22	13	28	15
Over 12 months	39	48	3	44	8

Legislative Compliance

A reviewer issues a directive whenever a statutory requirement has not been met. The society must provide written response to the Child Welfare Review Unit within 60 days, which addresses the issue and indicates how the situation has been corrected or will be corrected in the future.
The overall compliance rate is calculated by determining the number of cases in full compliance.

Table 5 - Legislative Compliance

Year	Cases Reviewed	Cases In Full Compliance	Directives Issued	Average # Directives per Case Reviewed
2000 Crown Ward Review	91	81%	33	.4
2001 Crown Ward Review	96	78%	36	.4
2001 Child In Care Review	39	90%	4	.1
2002 Crown Ward Review	102	82%	31	0.31
2002 Child In Care Review	48	87%	10	0.21

The main directives issued in both the Crown Ward and Child in Care Reviews pertained to missed statutory contacts with children. Other directives were as follows:

- files to be reviewed by agency supervisors
- file missing documentation
- social medical history of birth mother and family on file
- social medical history of birth father and family on file
- written notice to First Nation representative on file for files of Native children; and
- registration of placement on file.

Summary

Within the Crown Ward Review there were 91 Crown wards on adoption probation reviewed in 2000, 96 in 2001 and 102 in 2002. In 2001, the Child Welfare Review Unit added files from its review of children in care to the Adoption Probation Review. Thirty-nine files were reviewed in 2001 with the inclusion of adoption probation cases in the Child In Care Review and 48 files were reviewed in 2002.

Results of the 2000 Adoption Probation Review indicated an overall compliance rate of 81 per cent for Crown wards. The overall rate of compliance declined to 78% for Crown wards reviewed in 2001, but increased to 82% in 2002. The overall rate of compliance for the 39 children reviewed, as part of the Child In Care Review was 90 per cent in 2001 and 87% in 2002.

The majority of directives issued continue to be in regard to missed statutory contacts with children. Children's aid societies need to ensure that children are visited by their caseworkers on a regular basis.

In addition to the need to meet statutory contact requirements, children's aid societies also need to attend to the filing of required documentation.

The Child Welfare Review Unit will continue to work with societies to ensure that they are aware of the documentation required, building on the work of the past three years.

This is **Exhibit "24"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Ontario

Child Welfare Review

Combined Summary Report 2003 - 2006

Crown Ward Review

Adoption Probation Review

Ministry of Children and Youth Services

Management Support Branch

August 2007

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Crown Ward Review

1.1.0 - Introduction

The Crown Ward Review is an annual process undertaken by the Ministry of Children & Youth Services' Child Welfare Review Unit, in co-operation with each child welfare agency and Ministry regional offices.

The specific objectives of the Crown Ward Review are:

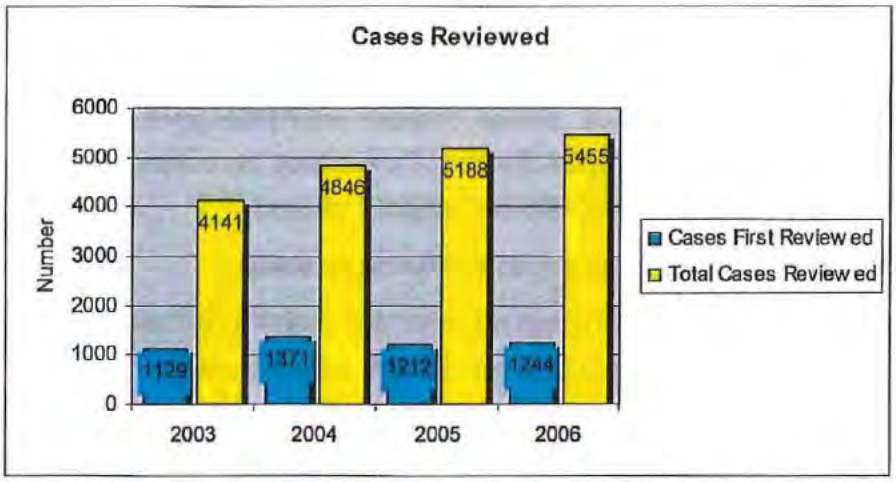
- To monitor agency compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the Crown ward;
- To issue directives regarding non-compliance and to make recommendations about particular cases, general policy and practices and to encourage and monitor their implementation;
- To give Crown wards with enough understanding, an opportunity, through questionnaires and interviews, to comment on the care they are receiving, contacts with their biological families, case plans and current circumstances;
- To provide information on useful methods employed in other societies and jurisdictions.

The Crown Ward Review findings are based on the review of society files, questionnaires completed by Crown wards and through client interviews. In complex and/or high-risk cases, society caseworkers and managers may also be consulted. Each case file is reviewed in the year following 24 months of successive Crown wardship and every year thereafter.

Following each Crown Ward Review individual case reports are provided to society caseworkers. An agency summary report that highlights key areas of each agency's service delivery and issues specific to compliance and standards is also forwarded to society managers and Ministry program supervisors. This information may be useful to the society's board, management and to the Ministry's regional office for planning purposes and for performance outcome monitoring.

1.1.10 - Scope of the Review

Chart 1 – Cases Reviewed

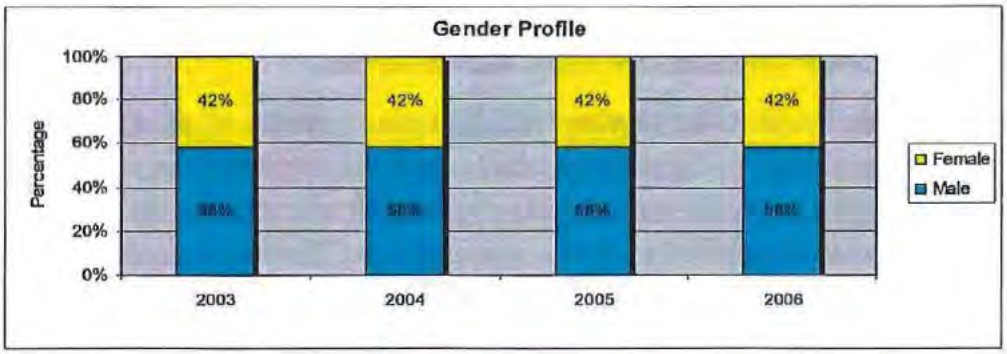


As of December 31, 2006, there were 9,272 Crown wards in the province. In 2006, there was a three per cent increase in the number of Crown wards reviewed for the first time compared to the 2005 Crown Ward Review. The total number of Crown wards reviewed in 2006 represented a five per cent increase over the 2005 review and a thirty-two per cent increase from 2003.

1.2.0 - Profile of the Children

1.2.10 – Gender

Chart 2 – Gender



In 2006, fifty-eight per cent of the children reviewed were male and forty-two per cent were female.

1.2.11 - Age

Table 1 provides a breakdown of the average age and numbers/percentage of children and youth reviewed, at the time of their Crown wardship and at the time these case files were reviewed.

Table 1 – Age Profile

Year	Average Age		Number of Children 0 - 9		Number of Children 10 -12		Number of Children 13 -17	
	At Time of Review	At Time of Crown Wardship	At Time of Review	At Time of Crown Wardship	At Time of Review	At Time of Crown Wardship	At Time of Review	At Tme of Crown Wardship
2003	13.4	8.5	700 (17%)	2644 (64%)	952 (23%)	996 (24%)	2489 (60%)	501 (12%)
2004	13.4	8.6	837 (17%)	3039 (63%)	1090 (22%)	1166 (24%)	2919 (60%)	641 (13%)
2005	13.4	8.5	824 (16%)	3306 (64%)	777 (15%)	909 (18%)	3587 (69%)	973 (19%)
2006	13.6	8.5	816 (15%)	3514 (64%)	822 (15%)	963 (18%)	3817 (70%)	978 (18%)

1.2.12 - Identified Needs

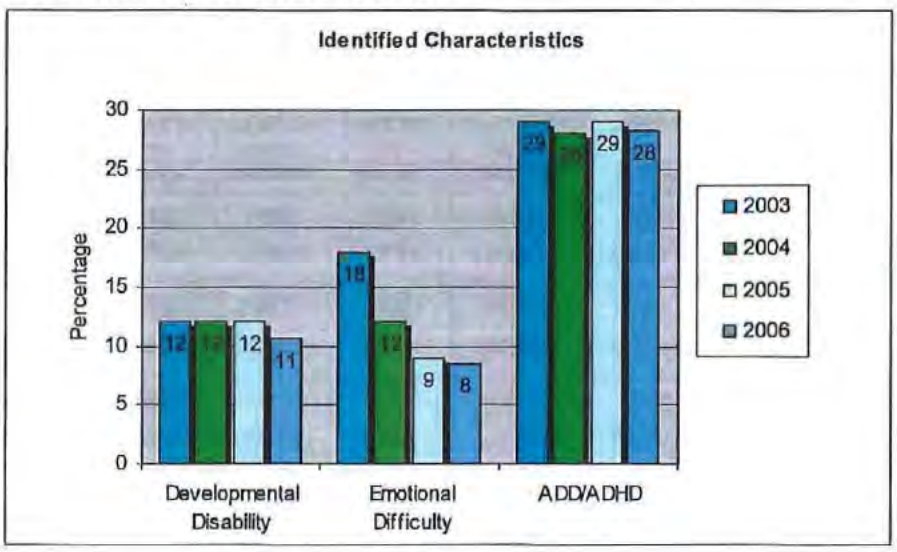
The *Child and Family Services Act* defines a special need as, "a need that is related to or caused by a behavioural, developmental, physical, mental or other handicap." Identified special needs include diagnoses such as Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (ADD/ADHD), as well as significant physical, emotional and developmental disabilities. As noted in Table 2, the number of children identified as having special needs increased over the reporting period although the percentage remains stable. Chart 3 compares some of the

more frequently identified primary special needs of this population, by percentage, from 2003 to 2006.

Table 2 – Special Needs

Year	Cases Special Needs	Percentage Special Needs
2003	3447	83%
2004	3982	82%
2005	4255	82%
2006	4456	82%

Chart 3 - Identified Characteristics



1.2.13 - Psychotropic Medication and Therapy

Psychotropic medication is prescribed as part of a treatment plan to address children's special needs, such as Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder.

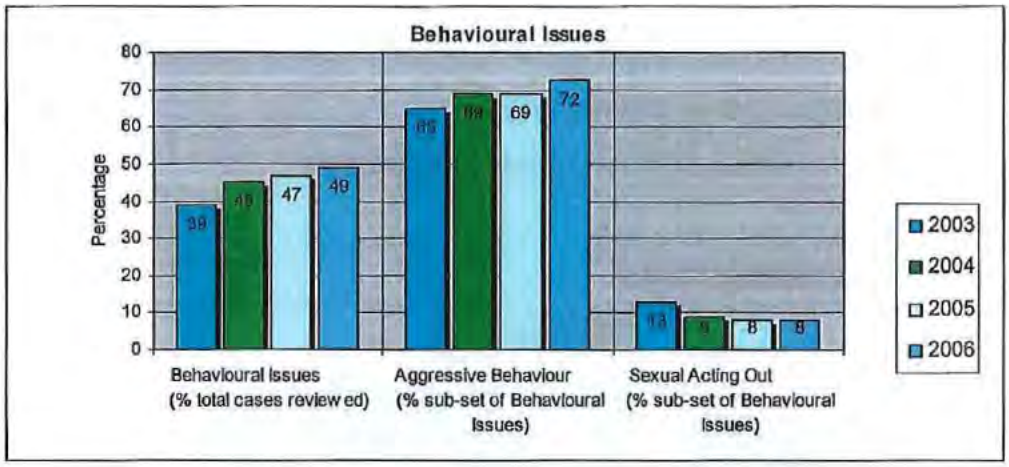
Table 3 – Psychotropic Medication and Therapy

Year	Psychotropic Medication	Children In Therapy
2003	1863 (45%)	1408 (34%)
2004	2184 (45%)	1502 (31%)
2005	2386 (46%)	1505 (29%)
2006	2509 (46%)	1572 (29%)

1.2.14 - Behavioural Issues

Beginning in 2000, behavioural issues were identified separately from clinical diagnosis. From 2003 to 2006 there was a fifteen per cent increase in the percentage of children that demonstrated behavioural issues. Children that exhibited aggressive and/or assaultive behaviour increased seven per cent from 2003 to 2006.

Chart 4 – Behavioural Issues



1.2.15 – Youth Criminal Justice Act Involvement

The percentage of Crown wards involved in illegal activities that resulted in charges being laid under the *Youth Criminal Justice Act,* declined during the current reporting period.

Table 4 - Young Criminal Justice Involvement

Year	Current YCJA Involvement	Prior YCJA Involvement	History of YCJA Placement
2003	14%	12%	7%
2004	13%	13%	7%
2005	11%	12%	7%
2006	11%	10%	6%

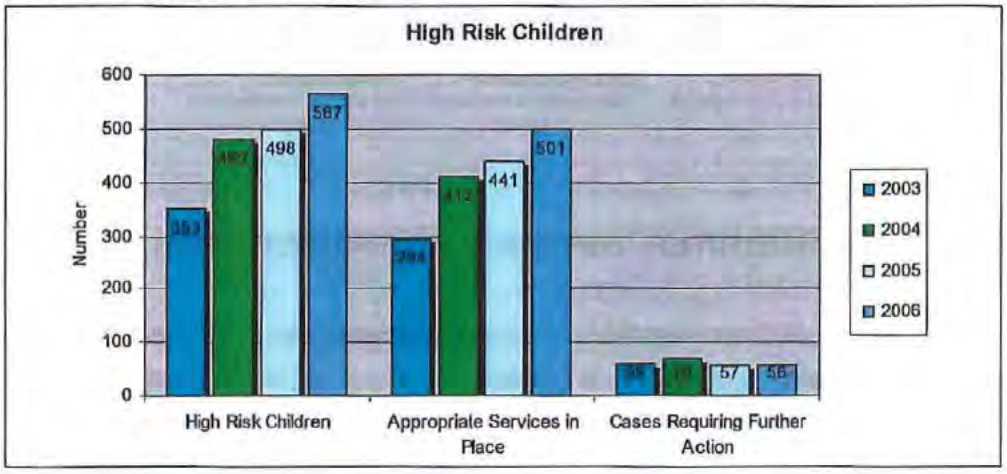
1.2.16 - High Risk

Children are identified as high risk when their behaviour may result in harm to themselves and/or others.

High-risk behaviour includes children who exhibit the following:

- Aggressive or suicidal behaviour
- Serious emotional problems
- Sexual "acting out"
- Serious psychiatric disorders and/or substance abuse problems.
- Children involved in criminal activity
- Children who frequently run from their placements.

Chart 5 – High-Risk Children



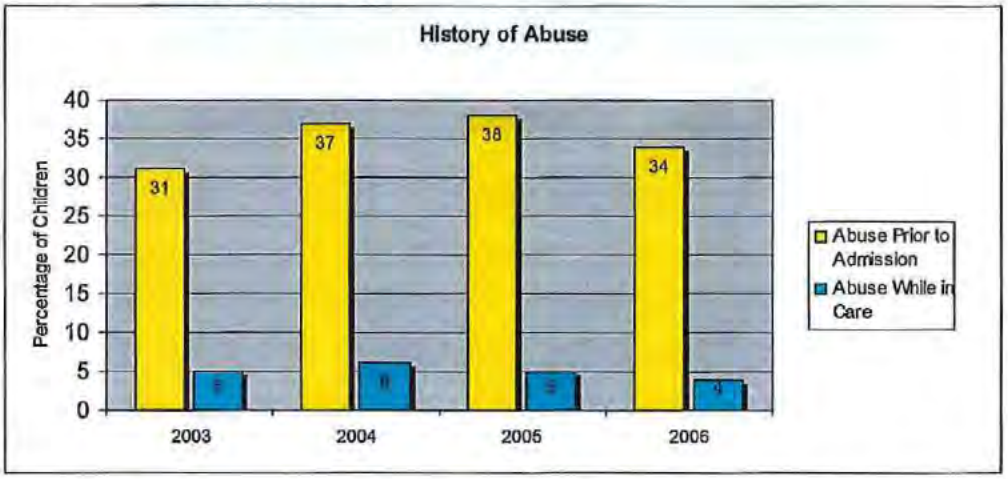
All high-risk cases and any recommendations made regarding specific high-risk situations were highlighted for each society and the Ministry's regional office as part of the on-site review.

In those situations identified that required further action, recommendations were made to societies for follow-up reporting to encourage agencies to explore all methods of assistance to the children and youth. The actual numbers of Crown wards identified as high risk increased sixty-one per cent between 2003 and 2006, however the percentage of Crown wards considered high risk remains relatively constant at ten per cent of the children reviewed. Appropriate services were in place for eighty-eight per cent of the high-risk cases reviewed in the 2006 reporting period.

1.2.17 - History of Abuse

Assessment and treatment programs, both individual and group, were made available to assist children in coping with and addressing the trauma of their early life experiences.

Chart 6 – History of Abuse



Of the children reviewed who experienced abuse while in care, it was determined that most of the reported abuse was historical and societies had put proper safeguards in place to address the future safety of these children.

1.2.18 - Native Heritage

Children of Native heritage have rights identified under the *Indian Act* and there are special provisions within the *Child and Family Services Act* that impact on service delivery. It is within this context that the following information is monitored.

Chart 7 identifies the percentage of children reviewed that were of Native heritage, the percentage of Native children with known status under the *Indian Act* and the percentage of Native children whose status was yet to be determined.

Chart 7 - Children of Native Heritage

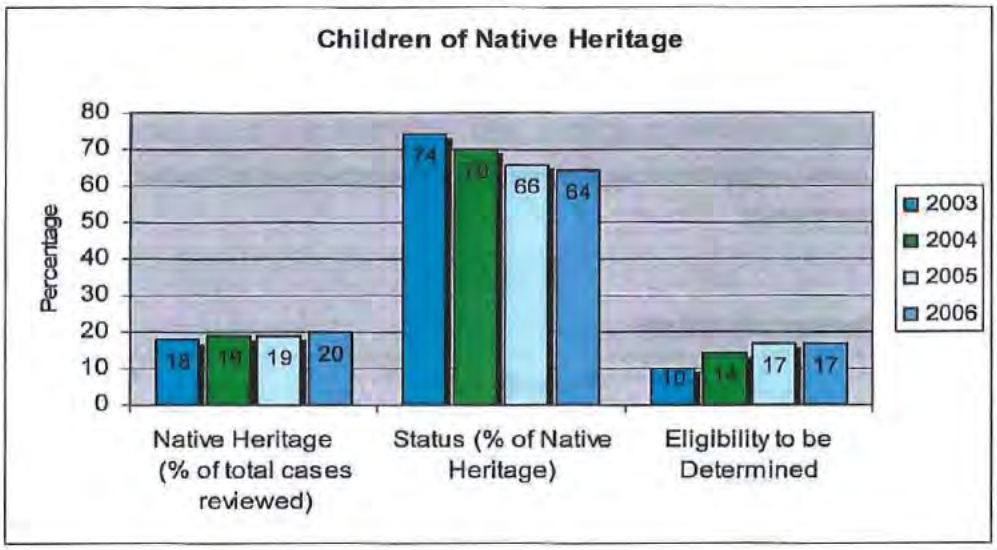


Table 5a – Placement of Native Children

Placement of Native Children	2003	2004	2005	2006
Total Number of Native Children	735	900	1,003	1097
Children Served by Aboriginal CAS	250 (34%)	302 (34%)	340 (34%)	402 (37%)
Children Served by Non-Aboriginal CAS	485 (66%)	598 (66%)	663 (66%)	695 (63%)
Total Number of Children Placed in Native Homes	216 (30%)	219 (24%)	226 (22%)	251 (23%)
Children Placed in Native Homes and Served by Aboriginal CAS	140 (19%)	132 (15%)	125 (12%)	146 (13%)
Children Placed in Native Homes and Served by Non-Aboriginal Societies	76 (10%)	87 (10%)	101 (10%)	105 (10%)

Table 5a indicates that there were 362 or a forty -nine per cent increase in the number of Native children reviewed from 2003 (735) to 2006 (1,097). In the same period there was an increase of 150 children served by Aboriginal children's aid societies, and the percentage of children served increased to thirty-seven per cent.

Table 5b – Services to Native Children

Services to Native Children	2003	2004	2005	2006
Total Number of Native Children	735	900	1003	1097
Children Aware of Their Native Heritage	630 (86%)	737 (82%)	825 (82%)	902 (82%)
First Nation Representation in Court Proceedings	412 (56%)	499 (55%)	584 (58%)	597 (54%)
Children Placed in Home Communities	86 (12%)	94 (10%)	87 (9%)	110 (10%)
Children Maintaining Contact With Home Community	221 (30%)	246 (27%)	273 (27%)	276 (25%)
First Nation Representation in Case Planning	151 (21%)	150 (17%)	168 (17%)	283 (26%)
If No, Efforts by Societies to Involve First Nation Representation in Case Planning	153 (26%)	133 (18%)	130 (13%)	95 (9%)
Children Involved in Aboriginal Cultural Practices	557 (76%)	664 (74%)	765 (76%)	845 (77%)
Spiritual needs of Children Being Addressed	520 (71%)	608 (68%)	742 (74%)	809 (74%)

1.2.19 - Education

In 2003, eighty-eight per cent of the children enrolled in a school program were progressing towards promotion. For 2006, ninety-three per cent of Crown wards that were enrolled in a school program were progressing towards promotion.

Table 6 – Educational Progress

Year	Number of Children Attending	Progressing Well	Progressing Slowly	Promotion At Risk
2003	3885 (94%)	1922 (49%)	1534 (39%)	241 (6%)
2004	4513 (93%)	2426 (54%)	1604 (36%)	313 (7%)
2005	4863 (94%)	2712 (56%)	1721 (35%)	300 (6%)
2006	5125 (94%)	2974 (58%)	1784 (35%)	275 (5%)

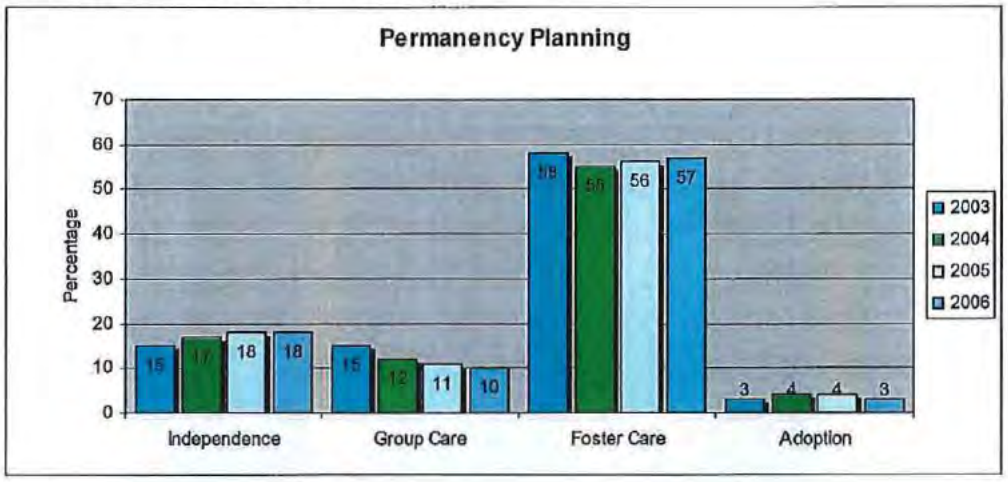
Children not attending school were either not required to attend school because they were too young (e.g. toddlers) or were beyond the age of compulsory school attendance.

1.3.0 – Findings

1.3.10 - Permanency Planning

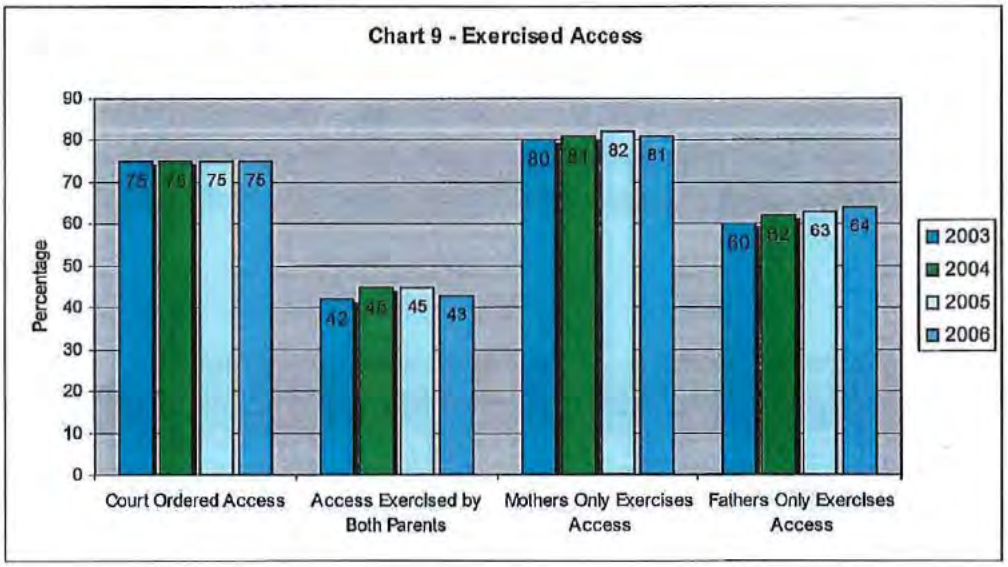
In 2006 the permanency plan for eighty-five per cent of the children reviewed was long-term care, which included foster care, residential group care, and independent living. This was similar to the findings in 2005 and a three per cent decrease from the 2003 finding. Adoption remains relatively constant at three to four per cent. For the remaining children reviewed, the case plans included either a return home to parents (1 per cent), a transfer to adult services (4 per cent) or were unclear (7 per cent) in all four review years.

Chart 8 - Permanency Planning



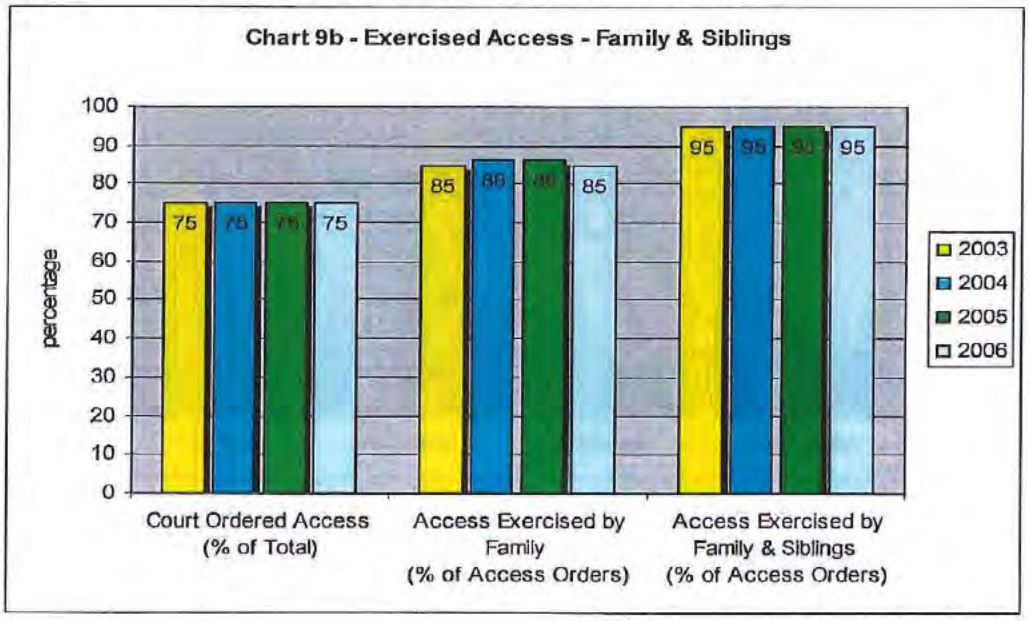
1.3.11 - Access

Chart 9 – Exercised Access



In cases where there was court ordered access for both parents, access was down two per cent to forty three per cent from forty-five per cent in 2005. In those situations where access was court ordered for mothers only, there was a slight decrease from eighty-two per cent in 2005 to eighty-one per cent. Where there was a court order in place for access by fathers only, there was a slight increase to sixty-four per cent in 2006 from sixty-three per cent in 2005.

Chart 9b – Exercised Access – Family and Siblings



Seventy-five per cent of Crown wards reviewed were subjects of access orders. Over the reporting period, this group experienced access to immediate or extended family, on average, in eighty-six per cent of the cases reviewed. When exercised access with siblings is added to access by extended family numbers, ninety-five per cent of the Crown wards reviewed were having some form of access with family members.

Table 7 – Exercised Access – Extended Family and Siblings

Year	Extended Family	Siblings
2003	40%	76%
2004	42%	76%
2005	45%	77%
2006	47%	78%

1.3.12 – Placements

The percentage of Crown wards reviewed who were placed in society-operated foster care* remained relatively consistent at fifty-eight per cent in 2003, fifty–five per cent in 2004, fifty-six per cent in 2005 and fifty-five per cent in 2006

Table 8 – Placement Type

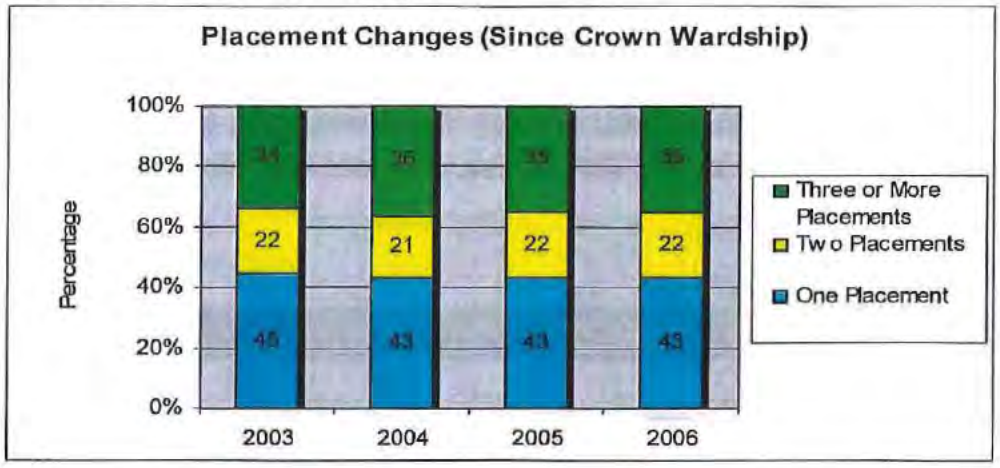
Placement Type	2003	2004	2005	2006
Regular Foster Care *	31%	29%	28%	27%
Specialised and Treatment Foster Care *	20%	19%	20%	20%
Children's Aid Society Group/Parent Model Home	2%	2%	1%	2%
Emergency Receiving Home	<1%	<1%	<1%	<1%
Outside Paid Institution Foster Home	12%	14%	15%	16%
Outside Paid Institution Parent Model	4%	4%	4%	3%
Outside Paid Institution Group Home	16%	17%	17%	16%
Young Offender Facility	1%	1%	1%	<1%
Children's Mental Health Centre	1%	1%	<1%	<1%
Independent Living	4%	5%	4%	5%
Provisional Foster Care *	7%	7%	8%	8%
Community Caregiver/Parents	2%	1%	1%	<1%

**society-operated foster care*

1.3.13 - Placement Changes

Placement stability remains a key factor in the provision of continuity of care for children and for their on-going security and optimum development. The average length of placement for Crown wards reviewed in 2003, 2004 and 2005 was twenty-three, twenty-two and twenty-two months respectively. In 2006, placement length for children averaged twenty-three months.

Chart 10 – Placement Changes



As noted in Table 9, the average length of placement varied over the reporting period, however, the average length of placement was considerably greater for those children who were made Crown wards at a younger age.

Table 9 – Average Placement Length by Age

Age at Time of Crown Wardship	Percentage of Crown Wards				Average Placement Length in Months			
Year	2003	2004	2005	2006	2003	2004	2005	2006
Under Seven	34%	35%	35%	35%	33.8	33.9	22.5	35.0
Seven - Twelve	54%	53%	47%	54%	20.7	19.5	25.3	20.6
Thirteen & Greater	12%	13%	19%	12%	10.7	9.3	12.5	10.1

1.3.14 - Changes in Caseworker Assignment

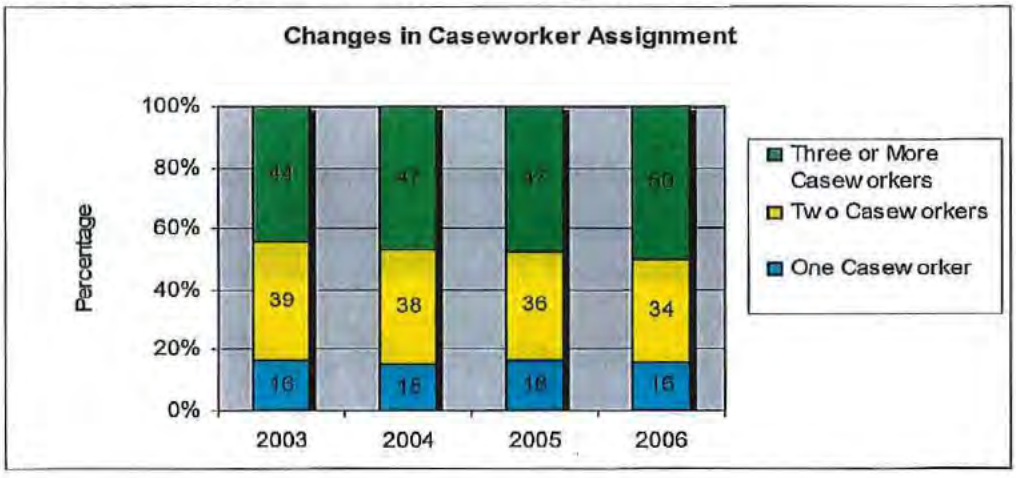
The number of caseworker contacts with children and the length of caseworker assignment have an important impact on the continuity of relationships for children and youth. These relationships are important to assist children in understanding the complex issues that are associated with being in care. Children often seek support and guidance from their caseworkers, particularly in times when there are difficult changes occurring and decisions to make.

Table 10 – Length of Caseworker Assignment

Length of Caseworker Assignment	2003	2004	2005	2006
Average Length in months	21.6	21.1	21.3	21.3
Average Number of Contacts with Children in past 12 months	11.7	12.1	12.2	12.2

Contacts between caseworkers and children occurred, on average, once per month.

Chart 11 – Changes In Caseworker Assignment



1.4.0 - Legislative Compliance

A reviewer issues a directive whenever a statutory requirement was not met. The society is required to provide a written response to the Child Welfare Review Unit within 60 days, which addresses the issue and indicates how the situation has been corrected or will be corrected in the future.

Table 11a compares the overall compliance ratings for the past three years. Table 11b provides a breakdown of compliance rates by each standard. The overall compliance rate is calculated by determining the number of cases in full compliance.

Table 11a – Overall Case Compliance and Directives Issued

Year	Cases Reviewed	Cases in Full Compliance	Directives Issued	Average # Directives per Case Reviewed
2003	4141	3374 (81%)	1172	0.28
2004	4846	3919 (81%)	1352	0.28
2005	5188	4535 (87%)	879	0.17
2006	5455	4783 (88%)	849	0.16

The compliance rates increased in overall legislative compliance, over the reporting periods with a corresponding decrease in the average number of directives per case reviewed. Table 11b provides a breakdown of compliance rates by each standard.

Table 11b – Compliance and Directives Issued per Standard

Standards	Level of Compliance			
	2003	2004	2005	2006
1. Record of Contacts				
7 day visit	95%	94%	99%	99%
30 day visit	95%	94%	99%	99%
Minimum 90 day visits by caseworker	91%	91%	96%	96%
Private visits	97%	97%	99%	99%
2. Documentation				
Child's family history	99%	99%	99%	100%

	2003	2004	2005	2006
Annual medical exam	98%	97%	99%	99%
Annual dental exam	98%	98.0%	99%	99%
3 month review of plan of care	97%	97%	99%	99%
Review of plan of care within 30 days of move	97%	35%	99%	99%
Review of plan by Supervisor	95%	94%	97%	98%
Plan of care addresses specific needs	99%	99%	99%	99%
Annual school reports	99%	99%	99%	100%
Discussion of rights	99%	99%	99%	99%
Plan of care – residential resources	99%	99%	99%	100%
Serious Occurrence Report	85%	87%	99%	97%

1.4.10 - Statutory Contacts with Children

Statutory contacts are personal visits made by caseworkers with children and youth. At minimum, visits are required within seven and 30 days after a placement occurs and every 90 days thereafter. Children must also be provided with an opportunity to meet with their caseworker in private.

Chart 12 – Compliance Rates

The rates of compliance in all areas of statutory contact have remained relatively constant over the reporting period. The compliance rate for 90-day visits continues to require additional attention by children's aid societies.

The Ministry's regional offices are advised of issues, such as a decline in statutory contact, by means of the post-review meeting following the completion of an agency's Child Welfare Review. In addition, individual

agency summary reports prepared by the Child Welfare Review Unit are forwarded to both the society reviewed and the appropriate regional office. These two processes provide an overview of systemic strengths and areas requiring attention by each society.

1.4.11 - Plans of Care

For children placed in society foster homes, reviews of their plans of care are required every 90 days and within 30 days of any change in placement. Reviews of plans of care require documentation in the child's case file and are to be endorsed in a timely fashion by supervisors. In 2003 and 2004 plans of care were completed on time in ninety-seven per cent of the cases reviewed. For 2005 and 2006 the compliance rate for the timely completion of plans of care increased to ninety-nine percent

In 2003, there was timely supervisory endorsement of plans of care in ninety-four per cent of the cases reviewed. There has been a steady improvement with compliance rates increasing to ninety-five and ninety-seven per cent in 2004 and 2005 respectively. In 2006 the compliance rate is ninety-eight per cent.

1.4.12 - Serious Occurrences

The Ministry's serious occurrence reporting procedures establish a consistent process for communication of serious occurrences between service providers and the Ministry. The procedures for reporting serious occurrences are intended to support the issues-management processes of service providers and allow the Ministry to monitor their performance.

Table 12 – Serious Occurrence Reporting

Year	Number of Serious Occurrences	Serious Occurrence Reports Not On File
2003	998	154 (15%)
2004	1428	187 (13%)
2005	1573	228 (14%)
2006	1784	190 (11%)

1.5.0 - Service Recommendations

Service recommendations are made by reviewers and relate to case-management issues identified in the review of a child's file.

The service recommendations in this reporting period relate to case planning including the need to update recordings; obtain required documentation; consider counselling for children and youth; and review permanency planning.

1.5.10 - Case Planning

Plans of care that are outcome-focused, time-limited, measurable and achievable are essential to the provision of quality services to children that address their individual needs. The Child Welfare Review Unit issues recommendations when these planning elements are lacking.

Recommendations to enhance and/or update documentation also refer to social histories and quarterly recordings. Quarterly recordings are intended to capture events and relationships in children's lives. Social histories are particularly useful when children request information about their families of origin, or want to know more about the reasons they were admitted into care.

In 2003, forty-one per cent of the total case recommendations issued were to enhance and/or update documentation including plans of care, quarterly recordings and social histories. The number of recommendations made in this area increased to forty-nine per cent in 2004 and decreased to forty-six per cent in 2005 and to forty-five per cent in 2006.

1.5.11 - Documents

Documentation, such as medical and dental reports, Crown wardship orders, school reports and clinical reports are important documents for case planning and measuring progress in response to goals and objectives. The Crown Ward Review audits files to ensure such documentation is on file. For 2006, missing documentation represented nineteen per cent of the total recommendations issued down from twenty-four per cent in 2005.

1.5.12 – Professional Assessments

To assist the caseworker, care provider and child, it is important that appropriate external professionals complete assessments and that any therapeutic recommendations are reviewed and incorporated into the plan of care. In 2005 and 2006, three per cent of the total case recommendations made asked Societies to consider having children assessed, or in some cases, reassessed.

1.5.13 – Permanency Planning

One component of the Ministry's child welfare transformation project is a focus on permanency as one of the several positive outcomes for children. In 2006, three per cent of the total recommendations made were to review or enhance permanency planning for children and youth.

1.6.0 - Responses from Crown Wards

Table 13 –Responses from Crown Wards

Year	Cases Reviewed	Questionnaires Received	Number of Interviews Requested
2003	4141	1894 (46%)	296 (7%)
2004	4846	2526 (52%)	419 (9%)
2005	5188	2799 (54%)	359 (7%)
2006	5455	2712 (50%)	311 (6%)

Confidential appropriate questionnaires are distributed to all Crown wards reviewed who are seven years of age and older. Responses from the questionnaires returned to the Child Welfare Review Unit indicated that children were generally satisfied with their placements and the service the societies were providing to them. Children reported that their caseworkers visited them regularly and provided assistance to them. Responses found that most children were aware of their rights and responsibilities as Crown wards. The majority of children and youth indicated they were involved in planning that affected them. Many children reported being worried about what would happen when they turned eighteen years of age and had to leave the care of the society. Some children stated that they were worried about school, their health, their families of origin and/or their relationships with other foster children.

As part of the questionnaire process, each child was asked whether he or she would like to meet with one of the reviewers to discuss his or her concerns or experiences in care. In 2005, review staff interviewed 359 children and youth. In 2006, 311 children were interviewed. This decrease of forty-eight interviews from 2005 to 2006 represents a thirteen per cent decrease in the number of interviews requested. For the most part, the information shared in these meetings was similar to the information provided in the confidential questionnaires.

1.7.0 - Summary

The 2006 Crown Ward Review noted several improvements in the delivery of service to the children and youth in care who are Crown wards of the Province of Ontario, notably:

- Legislative compliance increased over the past four years – eighty-one per cent in 2003 and 2004, eighty-seven per cent in 2005 and eighty-eight per cent in 2006.
- The proportion of children reported to be high risk remained at about ten per cent in 2006. The reviews indicated that these cases continued to be well managed.
- In 2006 increased compliance was noted in 7-day, 30-day, 90-day and private visits with children to 99 per cent. Although compliance with 90-day statutory visits increased from 91 per cent to 96 per cent, this continues to require the societies' attention.
- In 2006 increased compliance was also noted in the timely completion of plans of care and supervisory endorsement of plans of care.
- Adoption as the permanency plan for children has remained relatively constant at three to four per cent over the past four years.
- The majority of children continued to make academic progress at some level in school. There was an improvement in this area from eighty-eight per cent in 2003 to ninety-three per cent in 2006.
- The proportion of children diagnosed with special needs remained stable since 2003 at eighty-two per cent.
- There was an increase in the average number of contacts between caseworkers and children from 11.7 contacts in 2003, to 12.3 contacts in 2006.
- There was an increase in the percentage of parents exercising court ordered access. Where access was court ordered for mother's only, exercised access by mothers increased from 80 per cent in 2003 to 81 per cent in 2006. Where access was court ordered for father's only, exercised access by fathers increased from 60 per cent in 2003 to 64 per cent in 2006.

The following observations are provided for consideration:

- The proportion of children reported to be receiving psychotropic medication has increased from forty-five per cent in 2003, to forty-six per cent in 2006.
- There was an increase in children living in outside paid resources from thirty-two per cent in 2003 to thirty-five per cent in 2006.
- There was a significant increase in the number of Crown wards of Native heritage reviewed rising from 735 in 2003 to 1,097 in 2006. In 2006, twenty per cent per cent of the children and youth reviewed were of Native heritage, compared to eighteen per cent in 2003.
- The percentage of Native children that maintained contact with their home communities decreased from thirty per cent in 2003, to twenty-five per cent in 2006, although the actual number of children increased by fifty-five over the four years.
- The proportion of Native children residing in Native homes decreased, from 29 per cent in 2003, to twenty-three per cent in 2006, although the number of children placed in Native homes increased by thirty-five over the same time period.
- A significant number of recommendations continued to be made in regard to the quality of recordings on file. Forty one per cent of the recommendations made were to enhance plans of care, social histories and quarterly recordings in 2003 and this increased to forty-five per cent in 2006.
- The average length of placement remained stable at twenty-three months over the four year period.

PART II: Adoption Probation

Introduction

The goal of the Adoption Probation Review is to determine that an adequate plan of care is developed for Crown wards placed on adoption probation. The Review is also intended to stimulate improvement in the overall service delivery to children.

The specific objectives of the Adoption Probation Review are:

- To monitor compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward placed on adoption probation;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the child;
- To issue directives regarding non-compliance and to make recommendations about particular cases, general policy and practices and to encourage and monitor their implementation;
- To provide information on useful methods employed in other societies and jurisdictions.

Scope of the Review

There were 142 children reviewed on adoption probation in 2006.

Profile of the Children

Age

Table 1 – Age at the Time of Review

Year	2003	2004	2005	2006
Number of Children Reviewed	126	142	139	142
Average Age at Wardship	3.9	4.2	4.1	4.2
Average Age at Review	6.9	7.3	7.2	7.3

The average age of the children at the time of review increased from 6.9 years in 2003 to 7.3 years in 2006.

Gender

Table 2 – Gender Profile

Gender	2003	2004	2005	2006
Female	72	66	57	63
Male	54	76	82	79
Total	126	142	139	142

Findings of the Review

Adoption Plan

Table 3 reports on plans for the adoption finalization of Crown wards.

Table 3 - Adoption Probation

Plans	2003	2004	2005	2006
Finalize Within 6 Months	59	58	47	79
Finalize After 6 Months	67	84	89	63
Notification of Extension on File	5	3	11	13

Where the plan was to extend the probation period beyond six months, notification of extension on file increased from three of the eighty-four cases reviewed in 2004 to thirteen of the sixty-three cases reviewed in 2006. Although this increase is an improvement this is an area that continues to require attention by the societies.

Table 4 reports the findings of the length of time that children were on adoption probation.

Table 4 – Length of Time on Adoption Probation

Length of Time on Adoption Probation	2003	2004	2005	2006
0 – 6 months	41	54	48	51
7 – 12 months	27	25	36	37
Over 12 months	58	63	55	54

Legislative Compliance

A reviewer issues a directive whenever a statutory requirement has not been met. The society must provide written response to the Child Welfare Review Unit within 60 days, which addresses the issue and indicates how the situation has been corrected or will be corrected in the future.

As with the Crown Ward Review, the overall compliance rate is calculated by determining the number of cases in full compliance.

Table 5 – Legislative Compliance

Year	Cases Reviewed	Cases in Full Compliance	Directives Issued	Average Number of Directives Per Case
2003	126	84%	39	0.31
2004	142	80%	43	0.30
2005	139	87%	23	0.17
2006	142	93%	10	0.07

The main directives issued in the Adoption Probation Review pertained to missed statutory contacts with children. Other directives were as follows:

- files to be reviewed by agency supervisors
- lack of social medical history of birth father and family on file
- minimum ninety day visit by social worker; and
- registration of placement on file.

Summary

Within the Crown Ward Review there were 126 Crown wards on adoption probation reviewed in 2003, 142 in 2004, 139 in 2005, and 142 in 2006. Results of the 2003 Adoption Probation Review indicated an overall compliance rate of eighty-four per cent for Crown wards. The overall rate of compliance decreased to eighty per cent in 2004, increased to eighty-seven per cent in 2005 and to ninety-three per cent in 2006.

Children's aid societies need to ensure that children are visited by their caseworkers on a regular basis.

In addition to maintaining statutory contact requirements, children's aid societies also need to ensure that required documentation is placed in the case file.

The Child Welfare Review Unit will continue to work with societies to make them aware of the documentation required, building on the work of the past four years.

This is **Exhibit "25"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc., Province of Ontario, while a Student-at-Law. Expires May 9, 2019.

Ontario

Child Welfare Review

Ontario's Crown Wards Including Adoption Probation

Summary Report 2007

Ministry of Children and Youth Services

Quality Assurance and Accountability Branch

March 2008

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PART I: Child Welfare Review

Introduction

The Child and Family Services Act (CFSA) is an act designed to promote the protection, best interests and well being of children in Ontario. The Crown Ward Review is an annual process legislated under Section 66 of CFSA and is intended to protect the most vulnerable children in the child welfare system. It ensures that the circumstances of each Crown ward, including those on Adoption Probation, are reviewed regularly by the Ministry's Quality Assurance and Accountability Branch, Child Welfare Review Unit (CWRU).

The services provided to these children are ranked according to their compliance with Ministry standards, regulations, directives and policies. The Crown Ward Review is conducted in co-operation with each child welfare agency and Ministry regional offices.

The specific objectives of the Crown Ward Review are:

- To monitor agency compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the Crown ward;
- To issue directives regarding non-compliance and to make recommendations about particular cases, general policy and practices and to encourage and monitor their implementation;
- To give Crown wards with enough understanding, an opportunity, through questionnaires and interviews, to comment on the care they are receiving, contacts with their biological families, case plans and current circumstances;
- To provide information on useful methods employed in other societies and jurisdictions.

CHILD WELFARE REVIEW PROCESS

The file of each crown ward is reviewed in the year following 24 months of successive Crown wardship and every year thereafter. Reviews continue annually until the child is discharged from the care of the society or reaches 18 years of age or if the case is before the court on a status review.

Pre-Review

Prior to the review, contact is made with the Regional Office to ascertain whether there are any specific issues that may impact the Crown Ward Reivew. As well the previous year's Agency Summary Report is examined prior to the Review to examine the findings of previous reviews.

Entry Meeting

On the first day of the Review, an Entry Meeting is held to provide the society and the CWRU a chance to exchange information, trends and issues, pertinent to the Review. This meeting is also attended by the society and regional office staff.

Audits/Reviews

Each Crown ward file is audited by a CWRU reviewer to verify legislated requirements including for example:

- A child has had regular face to face meetings with his or her society caseworker;
- Planning has been conducted every three or six months depending on the child's stability in their placement to identify his or her specific needs and monitor his or her progress,
- An annual medical and dental examination has occurred, and
- Services have been provided to maintain and/or enhance his or her overall development according to his or her ability.

The results are recorded on a template which registers an overall compliance rating. This information obtained from each child's file forms the basis for the agency report.

Contact with Crown Wards
Questionnaires

Prior to the review, Crown wards who are seven years of age or older receive a questionnaire to elicit feedback about their experience in care. Aspects of the questionnaire include: contacts with their biological families, their placements, case plans, current circumstances and their opinion about how Crown wardship could be improved. Children are also given an opportunity to request an interview with a CWRU Reviewer. All completed questionnaires are returned to the Child Welfare Review Unit.

These questionnaires are confidential unless there is information provided that the child or other person is at risk of harm or that appropriate services are not being provided to the child.

At the conclusion of the Review, as part of the Post Review Conference, the responses from the questionnaires and outcomes of the completed interviews are summarized and provided to the society

Interviews

Crown Wards may request an interview. Children interviewed are asked general questions about how the child is doing in care and whether he or she is aware of his or her rights. Specific concerns raised in the respective questionnaires are also explored as part of this process.

Post Conference Review

Preliminary findings are shared with the society at a Post Review Conference (PRC) held at the conclusion of the Review. The society determines who will be invited to this conference but it is customary for the Executive Director and management staff to attend in addition to the Regional Office Program Supervisor and the Licensing Specialist. Some agencies encourage all of their staff to attend and on occasion, the president of the Board of Directors.

A preliminary summary of the society's compliance with legislated standards is provided at that time. The PRC provides the society with an opportunity to ask questions about the results obtained and the actual review process.

Individual case reports and copies of any cases requiring review by senior management are provided to the society at the PRC. Copies of the individual case reports of high risk children and any cases requiring review or action by the Regional Office Program Supervisor are also provided to the Program Supervisor, thus reinforcing the accountability for case management for those who are most vulnerable. The Regional Office is responsible for following up with the society regarding any identified case specific or organizational issues.

Individual Case Reports

Individual case reports are prepared for each Crown ward reviewed. These reports are provided to the society and the Regional Office at the completion of the Crown Ward Review. The report provides a summary of compliance and provides directives and recommendations related to compliance and standards.

- **Directives**

  Directives are documented in individual case reports when a statutory/legislative requirement is not met. Directives regarding non compliance are issued for example, when children do not meet face-to–face with their caseworkers every 3 months; if a child has not received annual medical or dental examinations; or if planning is not completed or has failed to address a child's needs. Recommendations may be made when the file documentation does not sufficiently reflect the planning and services provided to or required by a child.

- **High Risk Designation**

  Children are identified as high risk when their behaviour may result in harm to themselves and/or others. High-risk behaviour includes children who exhibit two or more the following:

  - Aggressive or suicidal behaviour;
  - Serious psychiatric disorders and/or substance abuse problems;
  - serious emotional problems;
  - Sexual 'acting out';
  - Children involved in criminal activity;

- Children who frequently run from their placements.

The individual case report identifies the issues facing the child as well as the supports in place to address the child's needs.

If a file is identified as high risk and further actions are required for the care of the child, the society is required to address these issues to the Ministry within 30 days.

Follow Up

Societies receive individual case reports at the end of each review. Each case report is accompanied, as applicable, by an individual case report follow-up sheet which includes a summary of the directives and recommendations issued on the case. Follow up occurs as follows:

- Within 30 days of the exit meeting, agencies respond to the Child Welfare Review Unit regarding follow up for cases designated as 'high risk'. When follow up to the Program Supervisor/Regional Office is also indicated for a high risk case, agencies also respond within 30 days.

- Follow up for each directive is received by the Program Supervisor/Regional Office and the Child Welfare Review Unit within 60 days of the PRC.

- Follow up for recommendations may include evidence of the agency's consideration of any recommendation made.

- Program Supervisors respond to a directive to review a file by indicating to the Crown Ward Review Unit, in writing, that this occurred along with any comments.

Following receipt by the Child Welfare Review Unit of a society's response to the findings, a letter is sent to the Program Supervisor/Regional Office requesting sign off on the review. This sign off signifies the end of the review. Regional Offices continue to work with the societies throughout the year to address issues raised by the Child Welfare Final Agency Report.

The Current Context for the Child Welfare Reviews

Amendments to the *Child and Family Services Act* were proclaimed on November 30, 2006. The Bill strengthens the province's ability to protect and help vulnerable children, supports a safer, more responsive and more accountable system, and makes it easier for children in need of protection to be placed in a permanent home. The amendments make adoption more flexible and create more options for permanency planning.

Following the recommendations of the Auditor General's Report and amendments to the *Child and Family Services Act*, the Crown ward review process more clearly focuses on the planning services and the documentation contained in children's files. Areas of focus include:

- initial and annual updates should be made to the child's social history,
- the plan of care should take into account all available information and identify desired outcomes based on each child's specific strengths and needs,
- the plan of care should address the child's life domains, including goals which should be child centred, measurable and achievable, and
- timeliness and completion of the Society / Outside Paid Resources planning.
- the child's need for continuity and for lasting family relationships.
- a child's cultural and religious needs were to be reflected in plans of care.
- There is greater attention to efforts made by the society to encourage the participation of Aboriginal Crown wards in Aboriginal cultural and spiritual practices, as well as the participation of the Band/community in decisions or changes to a child's circumstances.

Directives will be issued:

- to address non-compliance with regulatory service requirements for a child's social history and plan of care, as outlined above, including timelines of a child's plan of care (and timely supervisory review in society-operated placements).
- if recommendations made during the 2007 file review were not addressed by Societies; this will apply to both regulatory and non regulatory issues.
- For failure to complete the Assessment and Action Record. As of December 3, 2007, children's plans of care must reflect this record as per Ministry Policy Directive 003-06, which also addressed planning on adoption probation files.

The Crown Ward reviews in 2007 were conducted in the context of child welfare transformation which is a broad spectrum of reforms to the ministry's child welfare program and the 53 children's aid societies (CASs) to:

- strengthen the province's child well-being and protection system,
- make the system more effective,
- make the system sustainable,
- make the system more accountable to the public and to government, and
- improve outcomes for children and youth.

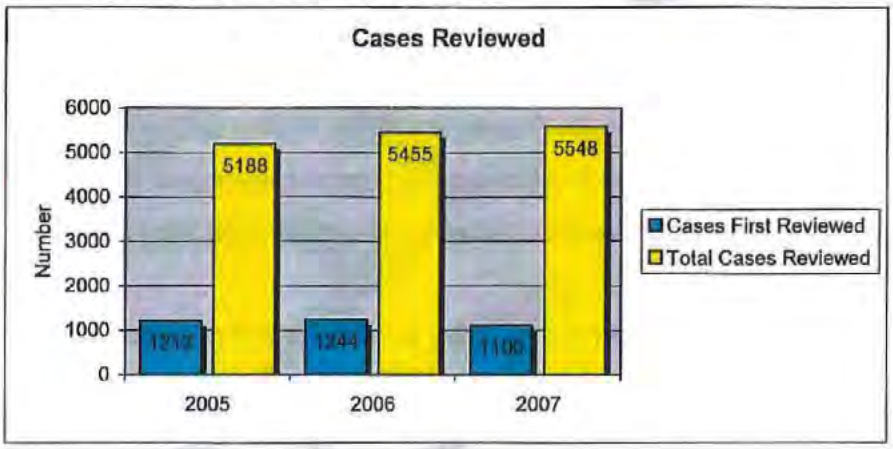
Commencing December 3, 2007, all CASs will utilize the OnLAC approach for every child and youth who has been in the care of the society longer than one year. OnLAC is an approach to caring for children who are in residential care settings outside their own homes. It is based on a developmental model and is designed to promote optimal outcomes for children and youth across seven dimensions of development: health, education, identity, family and social relationships, social presentation, emotional and behavioural development and self-care. OnLAC reflects a philosophy of caring for children that focuses on their strengths as well as their difficulties and encourages resiliency, high achievement and opportunities for growth and development. Research suggests that when OnLAC is implemented successfully, children in care experience more stability of placement, form better relationships with their caregivers and generally enjoy more success in their lives.

PART II: Crown Ward Review

Findings

Scope of the Review

Chart 1 – Number of Cases Reviewed



As of January 2007, there were 9,272 Crown wards in the province and 5,588 cases were reviewed. 1,106 cases were reviewed for the first time which is an eleven per cent decrease from 2006. The total number of Crown wards reviewed in 2007 represented a two per cent increase from the 2006 review.

Permanency Planning

In 2007 the permanency plan for eighty-four per cent of the children reviewed was long-term care, which included foster care, residential group care, and independent living. Adoption remains relatively constant at four per cent. For the remaining children reviewed, the case plans included either a return home to parents (1 per cent), a transfer to adult services (4 per cent) or were unclear (7 per cent).

Chart 2 - Permanency Plan for Selected Categories

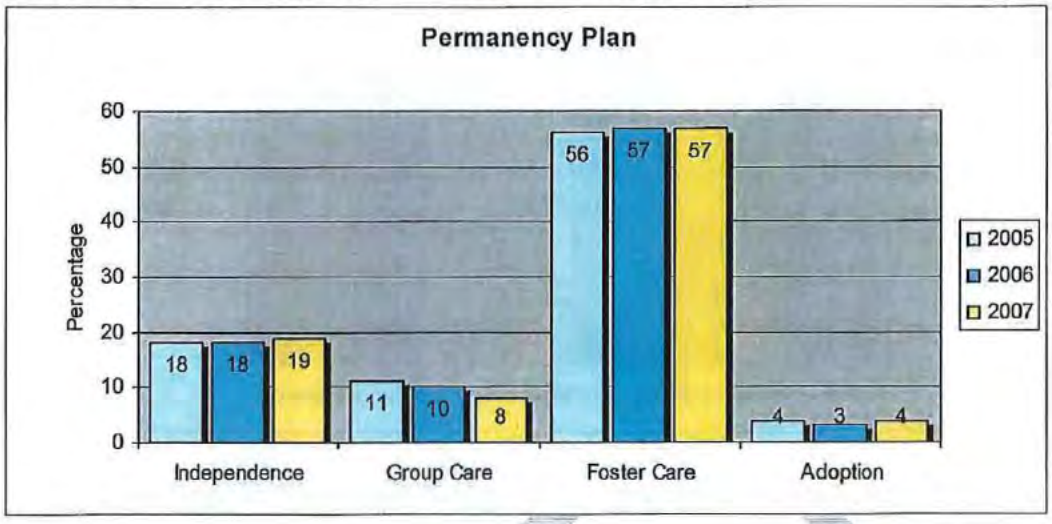


Chart 3 - Comparison of Current Placement to Permanency Plan

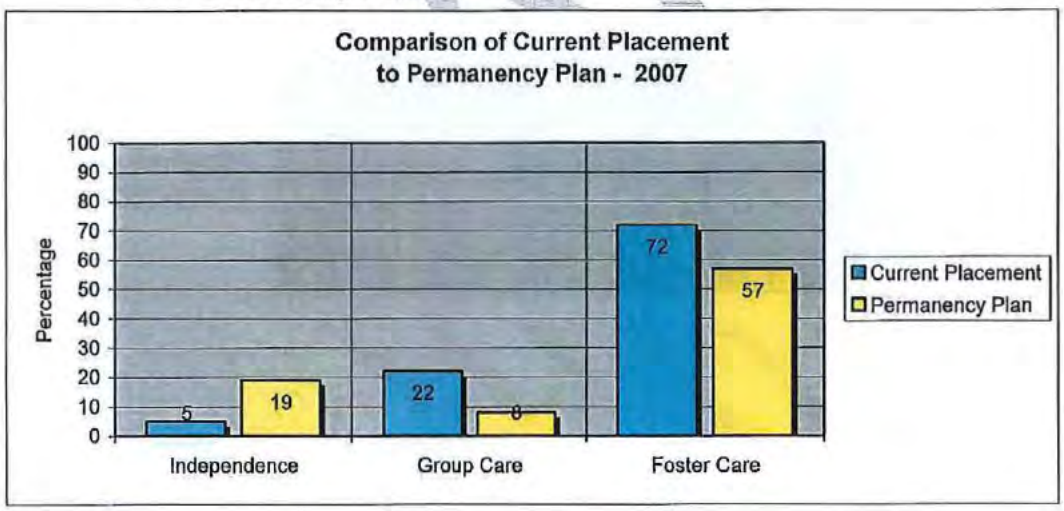
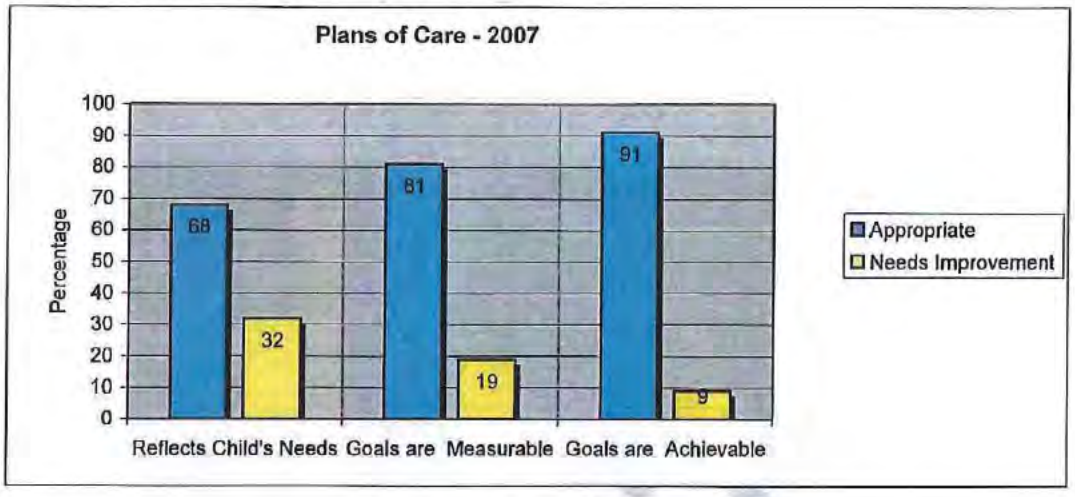
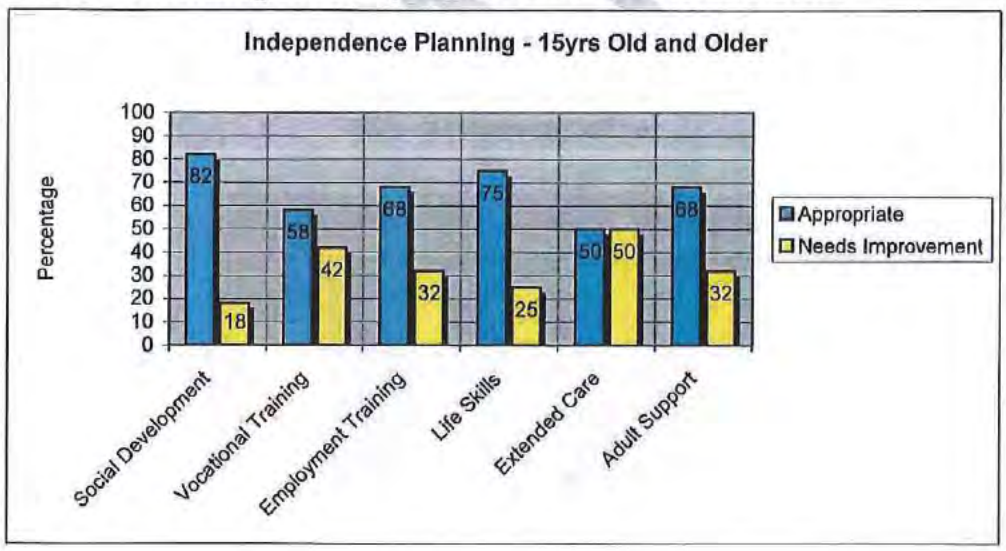


Chart 4 – Plans of Care – 2007



Of the 5,548 children reviewed, 3,767 or 68% had plans of care that reflected specific needs.

Chart 5 – Planning for Independence - 15 Yr Old and Older



As the number of adolescent Crown Wards continues to increase, focus on planning for independence will continue to require attention. The Crown ward population requires services that focus on maintaining children in stable placements and adequately prepare youth for either independence or a transition to adult services.

Placements

The majority of Crown wards reviewed reside in society-operated foster care*. This has increased by one percent in 2007.

Table 1– Placement Type

Placement Type	2005	2006	2007
Regular Foster Care*	28%	27%	25%
Specialised and Treatment Foster Care*	20%	20%	22%
Children's Aid Society Group/Parent Model Home	1%	2%	2%
Emergency Receiving Home	<1%	<1%	<1%
Outside Paid Resource Foster Home	15%	16%	17%
Outside Paid Resource Parent Model	4%	3%	4%
Outside Paid Resource Group Home	17%	16%	15%
Young Offender Facility	1%	<1%	1%
Children's Mental Health Centre	<1%	<1%	<1%
Independent Living	4%	5%	5%
Provisional Foster Care*	8%	8%	9%
Community Caregiver/Parents	1%	<1%	1%

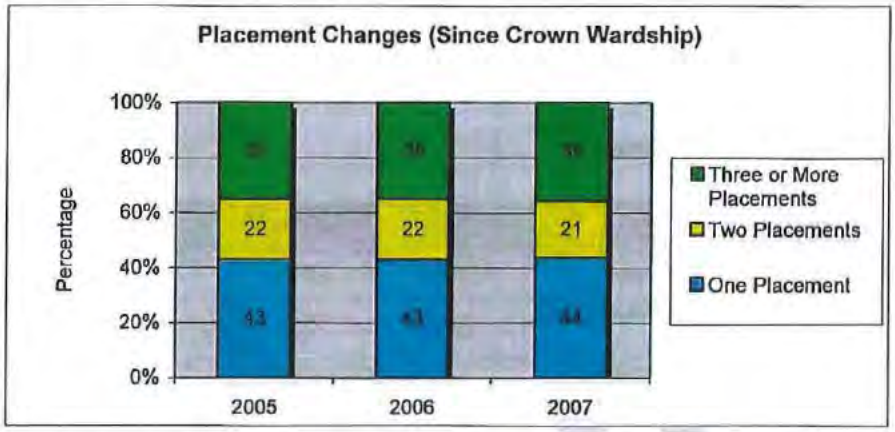
**society-operated foster care*

The use of outside paid resource foster homes continues to increase with a corresponding decrease in the use of outside paid resource group homes. More children and youth required the added supports to their placement that occurs with specialized and treatment foster care.

Placement Changes

Placement stability remains a key factor in the provision of continuity of care for children and for their on-going security and optimum development. In 2007, placement length for children averaged twenty-three months which is consistent with previous years. The number of placement changes a child experiences in care can impact the ongoing development of a child. Research suggests that a significant number of placement break downs, particularly during the teenage years, and the impact of frequent moves affects a child's ability to function as an adult (Barth, Berry and Corteney 1994).

Chart 6 – Placement Changes



As noted in Table 9, the average length of placement varied over the reporting period, however, the average length of placement was considerably greater for those children who became Crown wards at a younger age.

Table 2 – Average Placement Length by Age

Age at Time of Crown Wardship	Percentage of Crown Wards			Average Placement Length in Months		
Year	2005	2006	2007	2005	2006	2007
Under Seven	35%	35%	35%	22.5	35.0	36.1
Seven -Twelve	47%	54%	54%	25.3	20.6	21.7
Thirteen & Greater	19%	12%	11%	12.5	10.1	10.4

The length of time that a child remains in a placement greatly diminishes with the age at which the child became a Crown ward. Younger children experience greater placement stability.

Changes in Caseworker Assignment

The number of caseworker contacts with children and the length of caseworker assignment have an important impact on the continuity of relationships for children and youth. A consistent, reliable presence in children's lives provides continuity for the child. These relationships are important to assist children in understanding the complex issues that are

associated with being in care. Children require support and guidance from their caseworkers, particularly in times when there are difficult changes occurring and decisions to make. The length of caseworker assignment has declined in the past year.

Raychaba (1988) cites the high number of worker changes, coupled with infrequency of contact between the children and youth in care and their social workers, as one of the primary reasons for the "unwillingness or conditioned inability of children and youth to trust and commit in strong long term relationships with others."

In Ontario's Review of Safeguards in Children's Residential Programs (Campbell 1990), frequent worker turnover was cited as a condition that contributed to the children's inability to establish trusting relationships, and therefore decreased the likelihood of disclosing concerns about their treatment in the foster home.

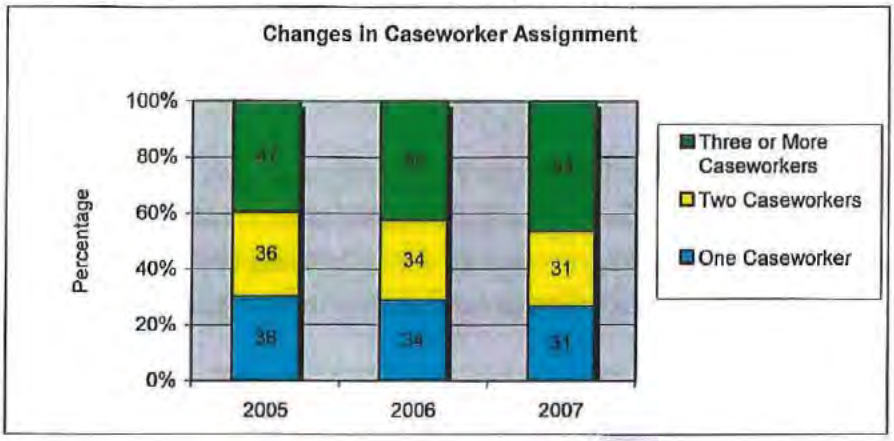
The task force on Safeguards for Children and Youth in Foster or Group Home Care feels strongly that children's and youth's safety is compromised when relationships with trusted adults are severed. A consistent, reliable presence provides continuity for the child.

Table 2 – Length of Caseworker Assignment and Contact with Children

	2005	2006	2007
Average length of caseworker assignment in months	21.3	21.3	20.9
Average Number of Contacts with Children	12.2	12.2	12.0

Contacts between caseworkers and children occurred, on average, once per month. There was a slight decrease in the number of contacts between a child and a worker.

Chart 7 – Changes In Caseworker Assignment



The percentage of children who had three or more workers since Crown wardship increased. The continuity of workers is consistently declining.

Legislative Compliance

A directive is issued when a statutory requirement is not met. Table 3 compares the overall compliance ratings for the past three years.

Table 3 – Overall Case Compliance and Directives Issued

Year	Cases Reviewed	Cases in Full Compliance	Directives Issued	Average # Directives per Case Reviewed
2005	5188	4535 (87%)	879	0.17
2006	5455	4783 (88%)	849	0.16
2007	5548	4325 (78%)	2009	0.36

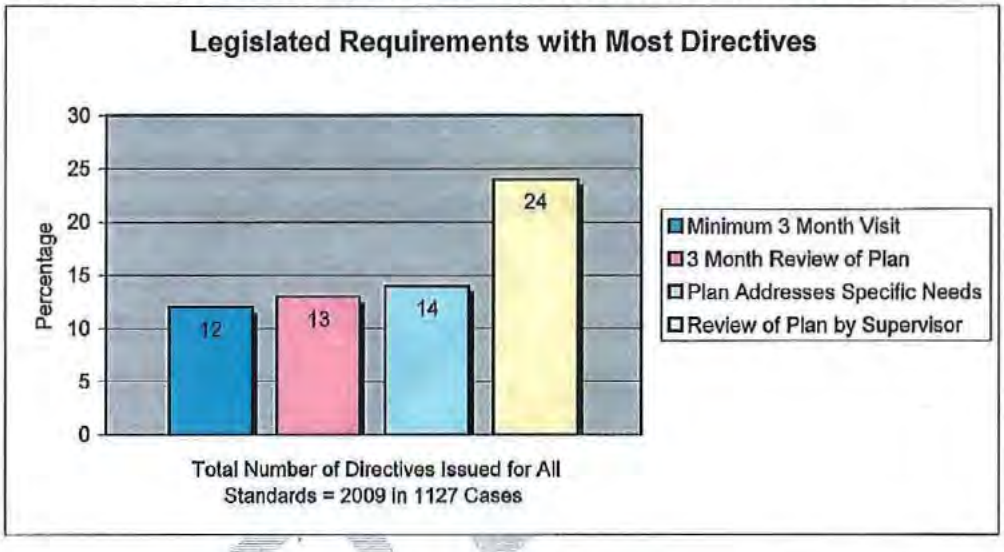
The compliance rates decreased in legislative compliance, over the three years with a corresponding increase in the average number of directives per case reviewed.

Table 4 – Cases Reviewed with Directives and the Total Directives Issued

Cases Reviewed	Cases with Directives	Directives Issued
5548	1127 (20%)	2009

Of the total 5548 cases reviewed in 2007, 4,325 or seventy-eight percent were in full compliance.

Chart 8 – Legislated Requirements with Most Directives Issued



These four legislated requirements represent sixty-three percent or 1,264 of the 2,009 directives issued.

In 2006, there was timely supervisory endorsement of plans of care in ninety-eight per cent which decreased in 2007 to ninety-one per cent.

Statutory Contacts with Children

Statutory contacts are personal face to face visits made by caseworkers with children and youth. At minimum, visits are required within seven and 30 days after a placement occurs and every three months thereafter. Children must also be provided with an opportunity to meet with their caseworker in private.

Chart 12 – Compliance Rates for Contact with Children

The rates of compliance in all areas of statutory contact have remained relatively constant over the reporting period. The attention to legislated requirements for meetings with children continues to require additional attention by children's aid societies.

Plans of Care

A child's plan of care must be developed and finalized within 30 days of the placement of a child. That plan of care must then be reviewed 3 months after the placement, 6 months after the placement and at least every 6 months thereafter or earlier if there is a material change in circumstances which necessitates a review of the plan or where there is a change in the child's placement.

Table 5 – Plan of Care

Standards	Level of Compliance		
	2005	2006	2007
3 month review of plan of care	99%	99%	95%
Review of plan of care within 30 days of move	99%	99%	99%
Review of plan by Supervisor	97%	98%	91%
Plan of care addresses specific needs	99%	99%	95%

Reviews of plans of care are to be endorsed in a timely fashion by supervisors. Over the past year, completion of plans of care in a timely fashion declined from ninety-nine percent to ninety-five percent.

Responses from Crown Wards

Table 6 – Responses from Crown Wards

Year	Cases Reviewed	Questionnaires Received	Number of Interviews Requested
2005	5188	2799 (54%)	359 (7%)
2006	5455	2712 (50%)	311 (6%)
2007	5548	2742 (49%)	289 (5%)

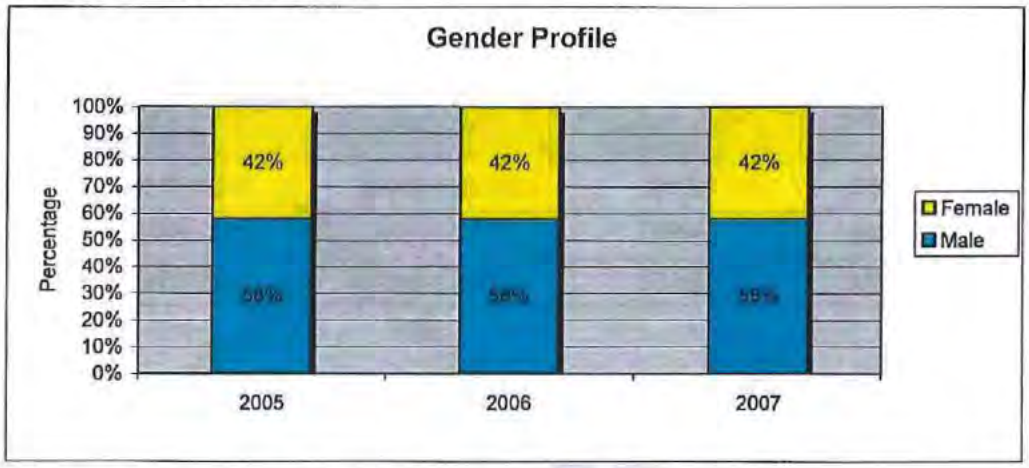
Responses from the questionnaires received indicated that children were generally satisfied with their placements and the service societies were providing to them. Children reported that their caseworkers visited them regularly and provided assistance to them. Responses found that most children were aware of their rights and responsibilities. The majority of children and youth indicated they were involved in the development of their plan of care. Many children reported being worried about what would happen when they turned eighteen years of age and had to leave the care of the society. Some children stated that they were worried about school, their health, their families of origin and/or their relationships with other foster children. Many of the children indicated that they had plans for their future which included higher education, obtain jobs as social workers, chefs, pilots, and to get married and have children.

As part of the questionnaire process, each child was asked whether he or she would like to meet with one of the reviewers to discuss his or her concerns or experiences in care. In 2006, review staff interviewed 311 children and youth. In 2007, 289 children were interviewed. This decrease of twenty-two interviews from 2006 to 2007 represents a seven per cent decrease in the number of interviews requested. For the most part, the information shared in these meetings was similar to the information provided in the confidential questionnaires.

Profile of Crown Wards

Gender

Chart 13 – Gender Profile



Fifty-eight per cent of the children reviewed were male and forty-two per cent were female, which has remained consistent over time.

Age

Table 1 provides a breakdown of the average age and numbers/percentage of children and youth reviewed, at the time of Crown wardship and at the time these case files were reviewed. The proportion of adolescents in care continues to increase, while at the same time the proportion of adolescents who become Crown wards is decreasing.

Table 7 – Age Profile

Year	Average Age		Number of Children 0 - 9		Number of Children 10 -12		Number of Children 13 -17	
	At time of Review	At time of Crown Wardship	At time of Review	At time of Crown Wardship	At time of Review	At time of Crown Wardship	At time of Review	At time of Crown Wardship
2005	13.4	8.5	824 (16%)	3306 (64%)	777 (15%)	909 (18%)	3587 (69%)	973 (19%)
2006	13.6	8.5	816 (15%)	3514 (64%)	822 (15%)	963 (18%)	3817 (70%)	978 (18%)
2007	13.7	8.4	723 (13%)	3598 (65%)	777 (14%)	1318 (24%)	4048 (73%)	632 (11%)

Education

In 2007, ninety - one per cent of the children enrolled in a school program were progressing towards promotion. Seven per cent of Crown wards enrolled in a school program were at risk of failing. Research consistently shows that children receiving child welfare services are behind their peers in all aspects of cognitive development and school performance. School performance is the simplest indicator of cognitive functioning for school aged children.

Table 8 – Educational Progress

Year	Number of Children Attending	Promotion Likely	Promotion at Risk
2005	4863 (94%)	4443(91%)	300 (6%)
2006	5125 (94%)	4758 (93%)	275 (5%)
2007	5241 (95%)	4788 (91%)	340 (7%)

Children not attending school were either not required to attend school because they were too young (e.g. toddlers) or were beyond the age of compulsory school attendance. The number of children attending school has increased although more of these children are at risk of promotion.

Table 9– Educational Profile

2007	Total Children	Represents
Enrolled in educational program	5241	95% of 5488 children reviewed
Individual Placement Review Committee (IPRC)	2633	50% of children enrolled in education program
Placed in recommended placement	2475	94% of children IPRC
Individual Education Plan	3148	60% of children enrolled in education program
Suspended in the previous 12 months	1049	20% of children enrolled in education program

Table 10 – Educational Placement

School Placement	Total Children	Represents
Pre-school/ Kindergarten	57	
Elementary Regular	1006	
Elementary Individual Education Plan (IEP)	1809	
All Elementary	**2872**	**55%** of children enrolled in education program
Secondary Advanced	166	
Secondary General	700	
Secondary Basic	93	
Secondary Individual Education Plan (IEP)	1207	
Secondary Alternative Program	204	
All Secondary	**2370**	**45%** of children enrolled in education program
All Elementary & Secondary IEP	**3016**	**58%** of children enrolled in education program

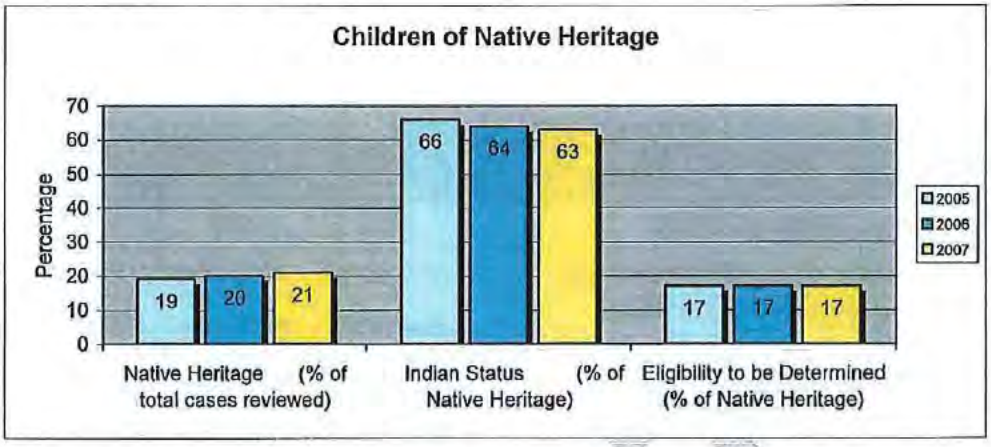
The majority of children reviewed are placed in specialized educational programs to meet their educational needs.

Native Heritage

Children of Native heritage have rights identified under the *Indian Act* and there are special provisions within the *Child and Family Services Act* that impact on service delivery.

Chart 7 identifies the percentage of children reviewed that were of Native heritage, the percentage of Native children with known status under the *Indian Act* and the percentage of Native children whose status is yet to be determined.

Chart 14 - Children of Native Heritage



There was an increase in the total number of Native children with a decrease in the number of children with known status. Although the percentage of children whose status was yet to be determined remained constant at seventeen percent the number of children increased. This continues to be an issue that requires further attention.

Table 11 – Placement of Native Children

Placements of Native Children	2005	2006	2007
Total Number of Native Children	1003	1097	1141(+44)
Children Served by Aboriginal CAS	340 (34%)	402 (37%)	401 (35%)
Children Served by Non-Aboriginal CAS	663 (66%)	695 (63%)	740 (65%)
Total Number of Children Placed in Native Homes	226 (22%)	251 (23%)	252 (22%)
Children Placed in Native Homes and Served by Aboriginal CAS	125 (12%)	146 (13%)	138 (12%)
Children Placed in Native Homes and Served by Non-Aboriginal Societies	101 (10%)	105 (10%)	114 (10%)

Table 11 indicates that there were 44 or a 4 per cent increase in the number of Native children reviewed from 2006 to 2007. In the same period there was a slight decrease of children served by Aboriginal children's aid societies, and the percentage of children served decreased

two per cent from thirty-seven per cent in 2006 to thirty-five percent in 2007.

Table 12 – Services to Native Children

Services to Native Children	2005	2006	2007
Total Number of Native Children	1003	1097	1141
Children Aware of Their Native Heritage	825 (82%)	902 (82%)	946 (83%)
First Nation Representation in Court Proceedings	584 (58%)	597 (54%)	656 (58%)
Children Placed in Home Communities	87 (9%)	110 (10%)	95 (8%)
Children Maintaining Contact With Home Community	273 (27%)	276 (25%)	265 (23%)
First Nation Representation in Case Planning	168 (17%)	283 (26%)	264 (23%)
If No, Efforts by Societies to Involve First Nation Representation in Case Planning	130 (13%)	95 (9%)	72 (6%)
Children Involved in Aboriginal Cultural Practices	765 (76%)	845 (77%)	885 (78%)
Spiritual needs of Children Being Addressed	742 (74%)	809 (74%)	846 (74%)

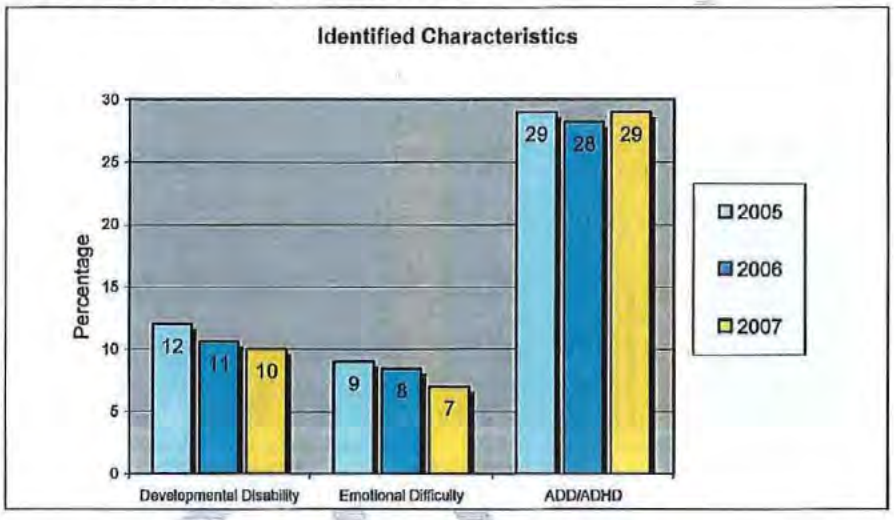
Identified Needs

The *Child and Family Services Act* defines a special need as, *"a need that is related to or caused by a behavioural, developmental, physical, mental or other handicap."* Identified special needs include diagnoses such as Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (ADD/ADHD), as well as significant physical, emotional and developmental disabilities. As noted in Table 2, the number of children identified as having special needs increased over the reporting period although the percentage remains consistent. Chart 3 compares some of the more frequently identified primary special needs of this population, by percentage, from 2005 to 2007.

Table 13 – Special Needs

Year	Cases Special Needs	Percentage Special Needs
2005	4255	82%
2006	4456	82%
2007	4562	82%

Chart 15 - Identified Characteristics



Psychotropic Medication and Therapy

Psychotropic medication is prescribed as part of a treatment plan to address children's special needs, such as Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder.

Table 14 – Psychotropic Medication and Therapy

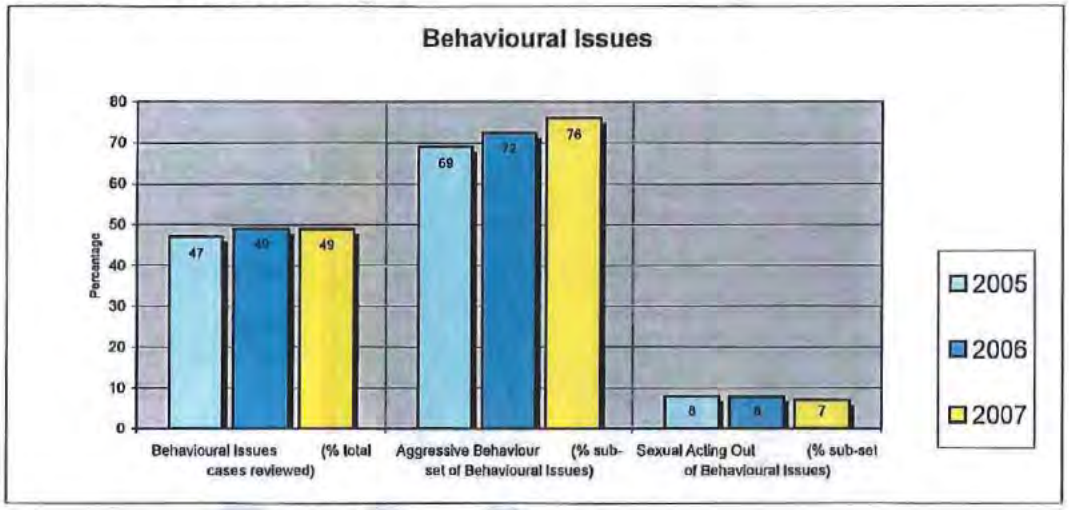
Year	Psychotropic Medication	Children In Therapy
2005	2386 (46%)	1505 (29%)
2006	2509 (46%)	1572 (29%)
2007	2591 (47%)	2133 (38%)

Societies are providing appropriate therapy to meet children's specialized needs

Behavioural Issues

Beginning in 2000, behavioural issues were identified separately from clinical diagnosis. From 2005 to 2007 there was a two per cent increase in the percentage of children that demonstrated behavioural issues. Children that exhibited aggressive and/or assaultive behaviour increased seven per cent from 2005 to 2007.

Chart 16 – Behavioural Issues



Youth Criminal Justice Act Involvement

The percentage of Crown wards involved in illegal activities that resulted in charges being laid under the *Youth Criminal Justice Act,* declined during the current reporting period. The Crown ward population involved remains consistent. Fewer Crown Wards have a history of *YCJA* placements.

Table 15 - Young Criminal Justice Involvement

Year	Current YCJA Involvement	Prior YCJA Involvement	History of YCJA Placement
2005	11%	12%	7%
2006	11%	10%	6%
2007	11%	10%	5%

High Risk

Children are identified as high risk when their behaviour may result in harm to themselves and/or others.

High-risk behaviour includes children who exhibit at least two of the following:

- Aggressive or suicidal behaviour
- Serious emotional problems
- Sexual "acting out"
- Serious psychiatric disorders and/or substance abuse problems.
- Children involved in criminal activity
- Children who frequently run from their placements.

Chart 17 – Type of High-Risk Behaviours

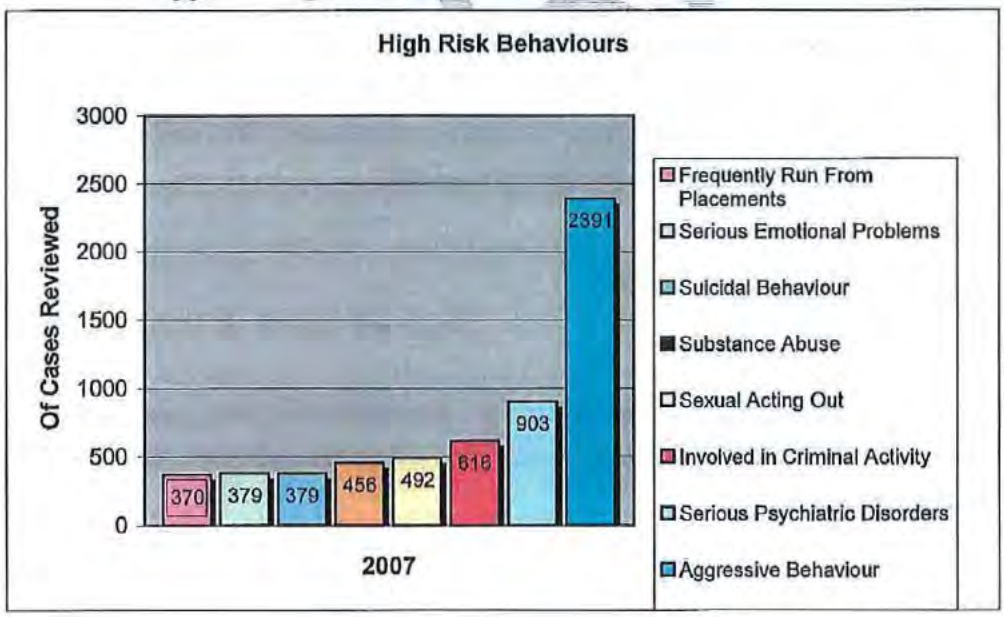
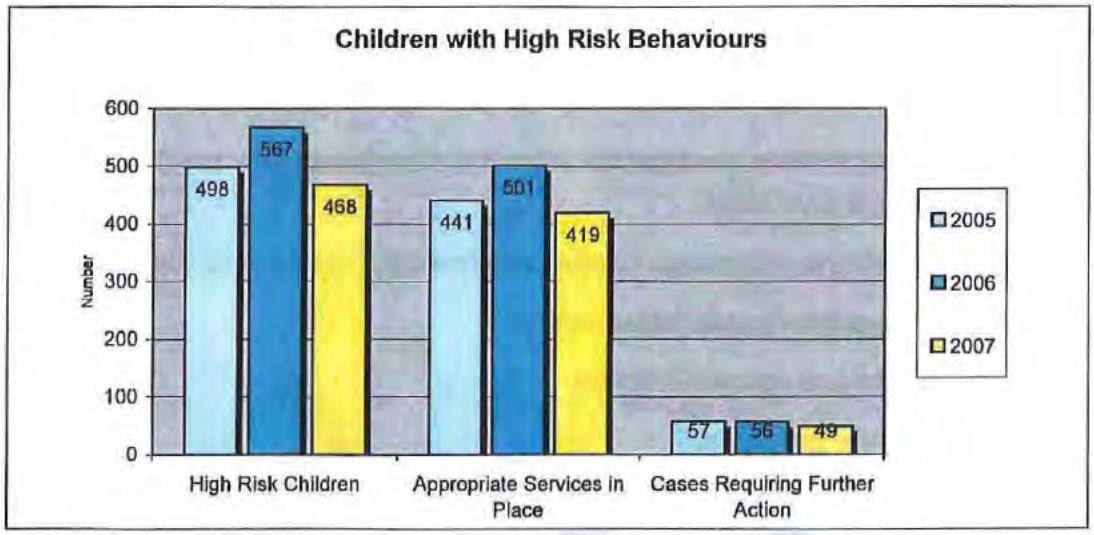


Chart 18 – Children with High Risk Behaviours



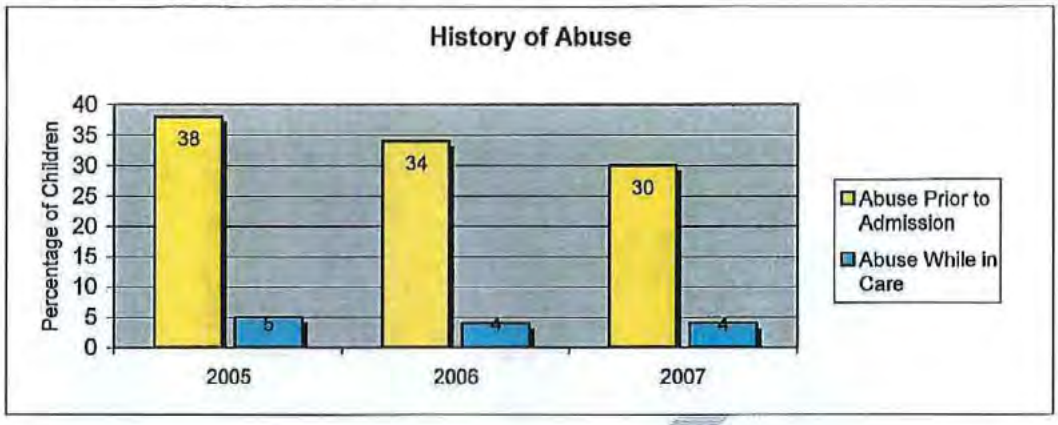
The majority of cases identified had appropriate services in place to address the behaviours.

In those situations identified that required further action, recommendations were made to societies for follow-up reporting to encourage agencies to explore all methods of assistance to the children and youth. The actual numbers of Crown wards identified as high risk decreased by ninety-nine or seventeen per cent between 2006 and 2007. Appropriate services were in place for ninety per cent of the high-risk cases reviewed in the 2007 reporting period an improvement of two per cent from 2006.

History of Abuse

Assessment and treatment programs, both individual and group, were made available to assist children in coping with and addressing the trauma of their early life experiences.

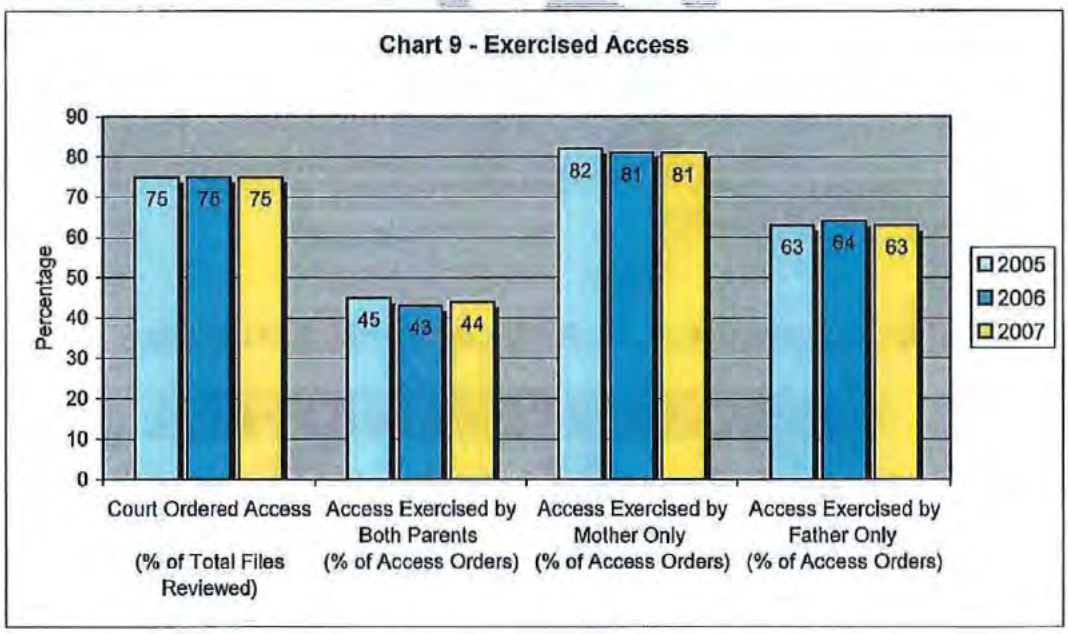
Chart 19 – History of Abuse



Of the children reviewed who experienced abuse while in care, it was determined that most of the reported abuse was historical and societies had put proper safeguards in place to address the future safety of these children. The number of children with a history of abuse continues to decline.

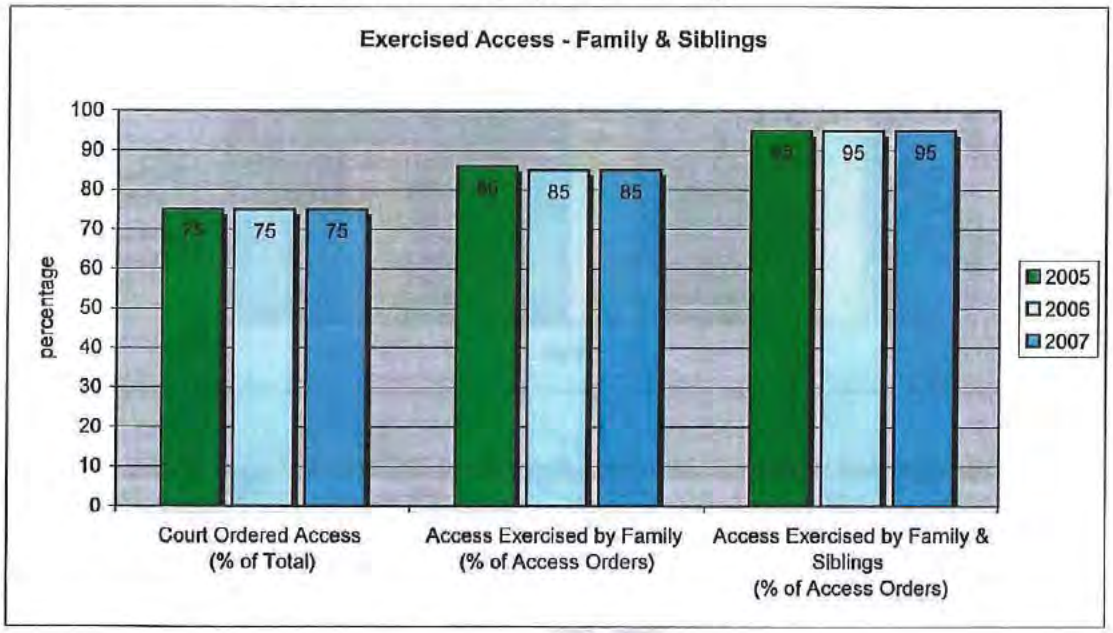
Access

Chart 20 – Exercised Access



In cases where there was court ordered access for both parents, access was up one per cent to forty-four per cent from forty-three per cent in 2006. Where there was a court order in place for access by fathers only, there was a slight decrease to sixty-three per cent in 2007 from sixty-four per cent in 2006.

Chart 21 – Exercised Access – Family and Siblings



Seventy-five per cent of Crown wards reviewed had access orders. Over the reporting period, this group experienced access to immediate or extended family, on average, in eighty-five per cent of the cases reviewed. When exercised access with siblings is added to that of access by extended family numbers, ninety-five per cent of the Crown wards reviewed (where access was ordered) were having some form of access with family members.

Table 16 – Exercised Access – Extended Family and Siblings

Year	Extended Family	Siblings
2005	45%	77%
2006	47%	78%
2007	48%	78%

Highlights

- The total number of Crown wards reviewed in 2007 represented a two per cent increase from the 2006 review.
- 1,106 cases were reviewed for the first time which is an eleven per cent decrease from 2006.
- Of the total 5548 cases reviewed in 2007, 4,325 or seventy-eight percent were in full compliance.
- Legislative compliance decreased from eighty-eight per cent in 2006 to seventy-eight percent in 2007.
- The number of Crown wards thirteen years of age and older increased in 2007 and now represents seventy-three percent of all children reviewed. This population requires services that focus on maintaining children in stable placements and adequately prepare youth for either independence or a transition to adult services.
- The number of children identified as high risk decreased in 2007. There was an increase in appropriate services available for this population.
- There was a significant increase in the number of children receiving therapy to meet their specialized needs.
- Of the 5,548 children reviewed, 3,767 or 68% had plans of care that reflected specific needs.
- Written plans of care require additional focus. Added attention is required to define child's needs and goals that are measurable. With the implementation of OnLAC, it is anticipated that there will be improvements in this area in 2008.
- The permanency plan for eighty-four per cent of the children reviewed was long-term care, which included foster care, residential group care, and independent living.
- Adoption as the permanency plan for children has remained relatively constant at three to four per cent over the past four years.
- The use of foster homes attached to an outside paid resource continues to increase with a corresponding decrease in the use of outside paid resource group homes.
- In 2007, placement length for children averaged twenty-three months which is consistent with previous years.

- More children and youth required the added supports to their placement that occurs with specialized and treatment foster care.
- The percentage of children who had three or more workers since Crown wardship increased. The continuity of workers is consistently declining.
- Contacts between caseworkers and children occurred, on average, once per month. There was a slight decrease in the number of contacts between a child and a worker.
- The majority of children reviewed are placed in specialized educational programs to meet their educational needs.
- The majority of children continued to make academic progress.
- The proportion of children diagnosed with special needs remained at eighty-two per cent.
- The number of Crown wards of Native Heritage increased to 1147 which represents twenty-one per cent of the children and youth reviewed.
- In 2006, there was timely supervisory endorsement of plans of care in ninety-eight per cent which decreased in 2007 to ninety-one per cent.
- Continued attention is required regarding the following legislated requirements: Minimum 3 month visit, 3 month review of plan of care, plan of care to address specific needs and review of plan by Supervisor. These four legislated requirements represent sixty-three percent or 1,264 of the 2,009 directives issued.

PART III: Adoption Probation

Introduction

The goal of the Adoption Probation Review is to determine that an adequate plan of care is developed for Crown wards placed on adoption probation. The Review is also intended to stimulate improvement in the overall service delivery to children.

The specific objectives of the Adoption Probation Review are:

- To monitor compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward placed on adoption probation;
- To look for adequate assessment of needs, suitable placement, supporting services, and realistic planning for and with the child;
- To issue directives regarding non-compliance and to make recommendations about particular cases, general policy and practices and to encourage and monitor their implementation;
- To provide information on useful methods employed in other societies and jurisdictions.

Scope of the Review

There were 120 children reviewed on adoption probation in 2007 a reduction of twenty-two from 142 children reviewed in 2006.

Profile of the Children

Age

Table 1 – Age

	2005	2006	2007
Number of Children Reviewed	139	142	120 (-22)
Average Age at Wardship	4.1	4.2	4.9
Average Age at Review	7.2	7.3	8.2

The average age of the children at the time of review increased from 7.3 years in 2006 to 8.2 years in 2007. Number of children on adoption probation declined in 2007

Gender

Table 2 – Gender Profile

Gender	2005	2006	2007
Female	57	63	62
Male	82	79	58
Total	139	142	120

Findings of the Review

Adoption Plan

Table 3 reports on plans for the adoption finalization of Crown wards and includes reference to required documentation where there is an extension beyond six months.

Table 3 - Adoption Probation

	2005	2006	2007
Finalize Within 6 Months	47	79	48
Finalize After 6 Months	89	63	72
Notification of Extension on File	11	13	8

Where the plan was to extend the probation period beyond six months, notification of extension on file decreased from thirteen of the cases reviewed

in 2006 to only eight in 2007. This is an area that continues to require attention by the societies.

Table 2 reports the findings of the length of time that children were on adoption probation.

Table 4 – Length of Time on Adoption Probation

	2005	2006	2007
0 – 6 months	48	51	47
7 – 12 months	36	37	33
Over 12 months	55	54	40

Sixty-one percent of the children reviewed have been on adoption probation for more than six months. The average placement length for all children is eleven months.

Legislative Compliance

A directive is issued when a statutory requirement has not been met. The society must provide written response to the Child Welfare Review Unit within 60 days, which addresses the issue and indicates how the situation has been corrected or will be corrected in the future.

As with the Crown Ward Review, the overall compliance rate is calculated by determining the number of cases in full compliance.

Table 5 – Legislative Compliance

Year	Cases Reviewed	Cases in Full Compliance	Directives Issued	Average Number of Directives Per Case
2005	139	87%	23	0.17
2006	142	93%	10	0.07
2007	120	93%	9	0.08

There were four Societies which accounted for all of the directives issued. The directives issued in the Adoption Probation Review were as follows:

- written notification to Band on file
- minimum ninety day visit by social worker
- registration of placement on file, and
- lack of social medical history of birth father and family on file.

Highlights

Within the Crown Ward Review there were 120 Crown wards on adoption probation reviewed in 2007. Results of the 2007 Adoption Probation Review indicated an overall compliance rate of ninety-three per cent. The overall rate of compliance has increased from eighty-seven per cent in 2005.

Children's aid societies need to check that children are visited by their caseworkers on a regular basis.

In addition to maintaining statutory contact requirements, children's aid societies also need to check that required documentation is placed in the case file.

The Child Welfare Review Unit will continue to work with societies to make them aware of the documentation required, building on the work of the past years.

Appendix A:

Agency Compliance Rates

SUMMARY OF CROWN WARD REVIEW COMPLIANCE 2006/2007

Region	Agency	Compliance Rate 2006	Compliance Rate 2007
Toronto Region	JF&CS	100%	91%
	NATIVE C&FS	75%	48%
	TORONTO CAS	90%	88%
	TORONTO CCAS	89%	82%
Hamilton/ Niagara	BRANT	88%	74%
	HAMILTON	93%	83%
	HAMILTON CCAS	72%	90%
	NIAGARA	97%	95%
Central	DURHAM	93%	86%
	KAWARTHA	89%	70%
	NORTHUMBERLAND	86%	85%
	SIMCOE	87%	86%
	YORK	86%	78%
Central West Region	DUFFERIN	88%	75%
	HALTON	90%	85%
	PEEL	85%	85%
	WATERLOO	64%	65%
	WELLINGTON	93%	87%
South West Region	BRUCE	85%	67%
	CHATHAM-KENT	91%	49%
	ELGIN	96%	85%
	GREY	80%	54%
	HURON	78%	85%
	LONDON	92%	76%
	OXFORD	93%	77%
	SARNIA-LAMBTON	98%	89%
	WINDSOR-ESSEX	80%	53%
South East Region	HASTINGS	87%	78%
	FRONTENAC	88%	89%
	LANARK	87%	89%
	LEEDS	87%	65%
	LENNOX	96%	89%
	PRINCE EDWARD	93%	77%

Region	Agency	Compliance Rate 2006	Compliance Rate 2007
Eastern Region	OTTAWA	84%	62%
	PRESCOTT-RUSSELL	80%	75%
	RENFREW	92%	63%
	STORMONT	90%	95%
Northern Region	JEANNE SAUVE	80%	67%
	MUSKOKA	77%	100%
	NIPISSING	89%	78%
	PAYOKUTAYNO	20%	24%
	TIMISKAMING	100%	100%
	PORCUPINE	83%	90%
Northern Region	ANISHINAABE ABINOOJII	91%	84%
	ALGOMA	100%	97%
	DILICO	89%	77%
	KENORA	92%	81%
	RAINY RIVER	93%	81%
	SUDBURY	85%	57%
	THUNDER BAY	93%	71%
	TIKINAGAN	89%	63%
	WEECHI-IT-TE-WIN	35%	56%

AVERAGE COMPLIANCE RATE FOR 2006 – 88%
AVERAGE COMPLIANCE RATE FOR 2007 – 78%

Appendix B:

CHILD WELFARE REVIEW 2007
SUMMARY OF FOLLOW UP ACTIVITIES

Summary of Findings:

- The majority of directives issued related to:
  - the completion in a timely fashion of plans of care that met a child's specific needs including timeframes and goals
  - the completion of Social Histories
  - timely endorsement of a child's plan of care by Society supervisors
  - visits with children to be competed within the required time frames

Response by Regional Offices:

- Regional Offices followed up with Societies to review and develop strategies to address systemic issues identified during the review process. The majority of Regions indicated that they would continue to follow up on these issues throughout the year.
- Regional Offices have signed off on the findings of all but one of the Child Welfare Reviews. The Regional Office has entered into a formal strategy to address the issues in that one society.

Response by Societies:

- Societies have met with their staff and board of directors to outline the issues raised and the strategies that will be used to address issues raised.
- Interventions implemented include:
  - Business practices in place by Societies have been amended to meet legislated requirements
  - Societies are working through technological challenges created by misinterpretation of legislated standards
  - Society supervisors have provided training to staff and will monitor the issues throughout the year
  - Detailed workplans have been submitted outlining strategies for increase compliance rates 2008
  - Case management systems are being upgraded to remind workers when children must be seen, plans of care developed and when supervisory sign off is required. In this way legislated time lines will be met
  - Recording formats have been changed to promote the inclusion of required information in the child's plan of care
  - Some societies have begun to audit legislative compliance to

Issues Impacting Compliance Rates:

- High rates of caseworker turn over
- weather conditions and geography have delayed statutory contacts
- societies have focused on implementation of Child Welfare Transformation

Considerations for future Reviews:

- Regional Offices will continue to monitor the success of the strategies developed to improve compliance.
- The Child Welfare Review Unit will liaise with Regional Offices prior to the next review to determine if there are concerns that exist.
- During the 2008 review, the Child Welfare Review Unit will identify issues that have been resolved as well as any that remain outstanding.

This is **Exhibit "26"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Ontario

Child Welfare Review

Ontario's Crown Wards

Summary Report 2008/2009

Ministry of Children and Youth Services

Client Services Branch, Service Delivery Division

December 2010

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Executive Summary:

The Crown ward review is an annual process undertaken by the Ministry of Children and Youth Services (hereafter referred to as "the ministry") to determine if the placement, services, educational and social needs of Crown wards in Ontario are being identified and appropriately addressed. The Crown ward review is an accountability mechanism used by the ministry to determine if children's aid societies are undertaking appropriate planning and services for each child reviewed. The review monitors compliance with legislation and regulations related to the care of children and identifies areas that need improvement.

A Crown ward is a child who has been made a ward of the Crown pursuant to a court order under the *Child and Family Services Act,* R.S.O. 1990, c. C.11. The file of each Crown ward is reviewed in the year following 24 months of successive Crown wardship and every year thereafter. Reviews continue until the child is discharged from the care of the society or reaches 18 years of age, or the case is before the court on a status review.

In May 2007, the ministry revised the Crown ward review tool to ensure consistency with the objectives of Child Welfare Transformation (including child safety, permanency and wellbeing) and to incorporate the recommendations from the Auditor General's 2006 Report regarding the need to strengthen oversight of the Crown ward review process. In particular, the Crown ward review process was revised to focus more on planning for the child.

Legislative Compliance

A file is in full compliance when all statutory/legislative requirements are met – i.e., no directives have been issued for failing to meet requirements.

On December 31st, 2009 there were 8,962 Crown wards in care in Ontario, a decrease of almost 5% from the same date in 2008 (*N*=9,416). The files of 5,594 children were eligible for review in 2008, and 5,218 were eligible in 2009. Of the total cases reviewed, 66% (or 3,432) were in full compliance in 2009. This represents an increase of almost 3%[1] from 2008 when 64% (*N*=3,577) of cases were in full compliance.

[1] All increases / decreases in this document are reported as percent changes, calculated as 2009 data-2008 data/2008 data

In 2008 there were 3,886 directives issued to children's aid societies; in 2009, the number decreased to 3,551. The majority of the directives issued (77% in 2008 and 62% in 2009) required CASs to come into compliance with the following legislative requirements: review of plan of care by supervisor; review of plan of care; child's family history; minimum 3 month visits; and plan of care addresses specific needs of the child.

The files of 131 Crown wards on adoption probation were reviewed in 2008, and 153 were reviewed in 2009. The overall rate of compliance decreased from 95% in 2008 to 76% in 2009.

PART I: Child Welfare Review

Introduction

The *Child and Family Services Act (CFSA)* is intended to promote the protection, best interests and wellbeing of children in Ontario. The Crown ward review is an annual process legislated under Section 66 of the Act to review the status of every child,

- who is a Crown ward;
- who was a Crown ward throughout the immediately preceding twenty-four months; and
- whose status has not been reviewed under section 66 or under section 65.2 during that time.

The review process ensures that the circumstances of each Crown ward, including those on adoption probation, are re-examined regularly by the ministry.

The services provided to these children are assessed according to their compliance with the legislation, regulations, ministry standards, directives and policies. The Crown ward review is conducted by the ministry. Files are reviewed in all 53 children's aid societies in Ontario.

The objectives of the Crown ward review are to:

- Monitor agency compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward;
- Determine whether there has been an adequate assessment of the Crown ward's needs, a suitable placement, supporting services, and realistic planning for and with the child as appropriate;
- Issue directives regarding non-compliance and to monitor implementation of recommendations about particular cases and general policy and practices;
- Provide Crown wards with the opportunity, through questionnaires and interviews, to comment on: the care they are receiving; contacts with their biological families; their case plans; and their current circumstances; and

- Provide information to the society under review about best practices employed in other societies and jurisdictions.

Unless the child's case is before the court for a status review, reviews continue annually until the child is discharged from the care of the society or reaches 18 years of age; the files of children who remain in the care of a CAS under an Extended Care and Maintenance agreement are not eligible for review.

A society's Crown ward review findings are based on a review of the Crown ward files, questionnaires completed by Crown wards and client interviews. In complex and/or high-risk cases, society caseworkers and managers may also be consulted.

Individual case reports are prepared for each Crown ward reviewed. These reports provide feedback to caseworkers, society managers, and ministry program supervisors on key areas of service delivery, case management and planning.

Feedback regarding the file reviewed can be in the form of a 'directive'. Directives are issued when a statutory/legislative requirement is not met. Directives regarding non-compliance are issued, for example when: children do not meet face-to-face with their caseworkers every three months; if a child has not received annual medical or dental examinations; or if planning is not completed or has failed to address a child's needs.

Recommendations are used if file documentation does not support comprehensive case planning on behalf of a Crown ward. For example, a recommendation may be made to review the child's access with his or her family if it appears that the access experience is not meeting the child's needs. Recommendations are proposals for the society's consideration to which the society must respond.

The reviewer may identify children as 'high risk'. This will occur when a child consistently exhibits behaviours that present harm to either him or herself or others. Usually a child will be designated as high risk if two or more of the behaviours listed below are evidenced. Depending upon the gravity of the behaviour, a designation may also be made if a child exhibits only one of these behaviours:

- Aggressive/assaultive behaviour
- Suicidal gestures or ideation
- Alcohol/substance abuse
- Two or more placements in previous 12 months
- School suspension/expulsion
- Serious emotional problems
- Serious behavioural problems
- Sexual "acting out"
- Serious psychiatric disorders
- Involvement in criminal activity
- Frequent running from their placements.

Societies are required to address all directives, recommendations and any direction to provide follow up for cases designated as 'high risk' as follows:

1. Within 30 days of the Post Review Conference (Exit Meeting), societies respond to the Service Review and Compliance Unit (formerly the Child Welfare Review Unit) regarding follow up for cases designated as 'high risk'.
2. Within 60 days of the Post Review Conference, follow up for each directive is received by the program supervisor/regional office and the Service Review and Compliance Unit.

Ministry program supervisors respond to a directive to review a file by indicating to the Service Review and Compliance Unit, in writing, that this has occurred along with any comments.

Following receipt by the Service Review and Compliance Unit of a society's response to all directives, a letter is sent to the program supervisor/regional office requesting sign off on the review.

The flowchart in Appendix A describes the Crown ward review process.
This summary report represents an analysis of the provincial findings obtained from reviews conducted at all 53 Ontario children's aid societies in 2009.

Current Context

The focus of the 2008 and 2009 Crown ward reviews was impacted by changes made to the *Child and Family Services Act* as well as the recommendations contained in the 2006 Auditor General's Report. In response to these changes and recommendations, the business practices for the 2007 Crown ward review were altered and strengthened to include a greater focus on remedying service deficiencies, and supervisory review and approval; this strengthened review process was also used for the 2008 and 2009 reviews.

Child and Family Services Act Amendments

Amendments to the *Child and Family Services Act* were proclaimed on November 30, 2006. These amendments strengthened the province's ability to protect and help vulnerable children, support a safer, more responsive and accountable system, and provide more options for children in need of protection to be placed in a permanent home. As a result, the Crown ward review tool used for the 2007, 2008 and 2009 reviews incorporates an augmented focus on planning services and documentation contained in children's files in relation to the:

- Initiation of and annual updates to the child's social history;
- Plan of Care addressing:
    - Consideration of all available information and the child's life domains as spelled out by Ontario Looking After Children requirements;
    - Identification of desired outcomes based on the child's specific strengths and needs;
    - Child-centred, measurable and achievable goals;
    - Reflection of the child's cultural and religious needs;
- Timely completion of society planning;
- Child's need for continuity and lasting family relationships;
- Efforts made by the society to encourage the participation of:
    - Aboriginal Crown wards in their cultural and spiritual practices; and
    - The Band/community in decisions or changes to a child's circumstances.

Directives were issued to address non-compliance with regulatory service requirements regarding a child's social history and plan of care.

Auditor General's Report

In December 2006, the Office of the Auditor General of Ontario released its report regarding the value-for-money audits of four child welfare agencies performed over the course of 2006. The ministry's management of the Child Welfare Program was also the subject of a separate report in which the Auditor General emphasized the need for better oversight of the Child Welfare program. The Auditor General made several recommendations regarding the need to strengthen ministry oversight of the Child Welfare Program, including the Crown ward review process to monitor compliance with legislated standards. Specifically, the report urged the ministry to strengthen the existing Crown ward reviews to reflect a greater focus on remedying service deficiencies identified in previous reviews, and supervisory review and approval.

Structure of the Report

The Child Welfare Review Summary Report provides the results of the 2008 and 2009 Crown ward reviews and adoption probation reviews.

The results of the 2008 and 2009 Crown ward review include:

- A description of the scope of the review conducted;
- A profile of the Crown wards reviewed;
- Information regarding legislative compliance; and
- Findings as they relate to outcomes of child safety, permanency and wellbeing.

The results of the 2008 and 2009 adoption probation reviews are also presented and include:

- A description of the scope of the review conducted;
- A profile of the reviewed Crown wards on adoption probation;
- Findings of the review;
- Legislative compliance.

PART II: Crown Ward Review

Scope of Review

The files of 5,218 children were eligible for review in 2009 – a decrease of almost 7% over the number reviewed in 2008 (5,594). Eight hundred and twenty-one (or 16%) of these cases were reviewed for the first time in 2009; 991 (or 18%) of these cases were first time reviews in 2008.

Context

It is important to note that the children reviewed through the Crown ward review represent a subset of Ontario's Crown wards. Not all children who are Crown wards at the time of the review are eligible for review. Children who are ineligible include children whose status review is before the courts and children who have not been Crown wards for the required 24 month period prior to review. On December 31st 2009, there were 8,962 Crown wards in the care of Ontario's children's aid societies, a decrease from the same date in 2008, when there were 9,416 Crown wards in care. In the context of these data, the children reviewed through the 2008 and 2009 reviews represent approximately 58%-59% of the Crown wards in the province during this time period.

Profile of Crown Wards

The Crown ward population reviewed in both 2008 and 2009 was 57% male and 43% female – a ratio consistent with data since 2000. In 2009, Crown wards had an average age of 8.2 years at the time of Crown wardship, only marginally younger than children reviewed in 2008 who were an average of 8.3 years. The average age at the time of the review was 14.1 years in 2009 and 13.9 years in 2008.

Children of Native Heritage

One thousand, one hundred and forty-three (1,143) of the children reviewed in 2009 were of Indian or native heritage. This number represents a decrease of just under 1% over the number of Native children reviewed in 2008 (n=1,153). As a group, Native children represent

22% of all Crown wards reviewed in 2009, a proportion that remains consistent with 2008 data, when 21% of all Crown wards reviewed were identified as having Native heritage.

Findings from the 2008 and 2009 Crown ward reviews specific to children of native heritage include the following:

- A slightly lower percentage of Crown wards of native heritage (60%) had status in 2009– i.e., were recognized by the federal government as members of an indigenous people having special rights and privileges, especially residence on a reservation - compared to the percentage of native Crown wards who had status (62%) in 2008;
- Thirty-six percent (*n*=419) of native children reviewed in 2009 were served by a designated Aboriginal children's aid society, a rate consistent with 2008 data (*n*=411);
- The percentage of native children placed in native homes (22%) in 2009 represents a decrease of 12% over 2008 data, which indicated that 25% of native children were placed in native homes.

Table 1: Native Children Profile and Standards: 2007-2009

Year	2007	2008	2009	% change 08-09
Total number of native children	1141	1153	1143	-1%
% Children aware of their native heritage	83%	88%	88%	0%
% First Nations representation in court proceedings	58%	52%	51%	-2%
% Children placed in home communities	8%	8%	8%	0%
% Children maintaining contact with home communities	23%	24%	22%	-6%
% First Nations representation in case planning	23%	16%	15%	-5%
% If no, efforts made by societies to involve First Nation representation in case planning	6%	10%	15%	46%
% Children involved in Aboriginal cultural practices	78%	82%	82%	0%
% Spiritual needs of children being addressed	74%	80%	80%	0%

As Table 1 above indicates, in 2009, the proportion of native children placed in their home communities remained consistent with 2008 data at 8%, while the percentage of children maintaining contact with their home communities decreased slightly. Table 1 also shows that

since 2008, First Nations representation in case planning has further decreased: from 16% of cases in 2008 to 15% in 2009. However, the 2009 data indicate that for those cases where First Nations representation did not occur, society efforts to secure representation in case planning increased in 2009 (15% of cases) compared to 2008 (10% of cases). Despite this increase, efforts to increase First Nations representation in cases involving native children remains an area requiring significant attention by the province's children's aid societies due to the low rate, overall, of First Nations representation in both court proceedings and case planning.

Reviewers determine whether a native child's spiritual needs are being addressed according to whether efforts have been made to encourage the child's connection to his or her traditions and home community or First Nations events and rituals. As indicated by Table 1, in 2009, reviewers assessed that the spiritual needs of 80% of native children reviewed were being addressed, consistent with the rate in 2008.

Identified Needs

Special Needs

The *Child and Family Services Act* defines a special need as "a need that is related to or caused by a behavioural, developmental, physical, mental or other handicap." Identified special needs include diagnoses such as Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD), as well as significant physical, emotional and developmental disabilities. A child is identified as having a special need if there has been a diagnosis made by a medical doctor, psychiatrist or psychologist.

The total number of children identified as having special needs decreased from 4,609 in 2008 to 4,355 in 2009; however, the proportion of Crown wards identified as having special needs increased marginally between the two years- from 82% of all children reviewed in 2008 to 83% in 2009. Table 2 (page 13) identifies the frequency and rate of the four most commonly

*Table 2: Top Four Identified Primary Special Needs, 2008/2009**

Identified Issue	2008 # Children Identified	2008 % Children w/ Primary Special Needs**	2008 % Children Reviewed***	2009 # Children Identified	2009 % Children w/ Primary Special Needs**	2009 % Children Reviewed***
ADD / ADHD	1395	30%	25%	1328	30%	25%
Psychiatric Diagnosis	888	19%	16%	802	18%	15%
Learning Disability	395	9%	7%	396	9%	8%
Developmental Disability	408	9%	7%	369	8%	7%
TOTAL	**3086**	**67%**	**55%**	**2895**	**66%**	**55%**

*Children have only one identified primary special need, therefore the total number of children identified represents unique children
**Calculated as a percentage of children with identified primary special needs in 2008 and 2009, *N = 4,609 and* 4,355 respectively
*** *Calculated as a percentage of all Crown wards reviewed in 2008 and 2009, *N* = 5,594 and 5,218 respectively

identified primary special needs, (ADD/ADHD; psychiatric diagnoses; learning disabilities; and developmental disabilities) which, combined, accounted for 66% of all children with an identified primary special need in 2009 (67% in 2008), and 55% of all children reviewed (both 2008 and 2009).

Behavioural Support Needs

Beginning in 2000, behavioural support needs were identified separately from clinical diagnoses. Behavioural issues refer only to behaviour that is of clinical significance. Generally, this will refer to behaviour that presents a risk to the child or others. Aggression includes all types of aggression towards others, such as physical assault, verbal attacks, fire setting, stealing, or other harm to others. From 2008 to 2009 the percentage of children reviewed who demonstrated behavioural support needs dropped from 45% to 43% (*n*=2,656 in 2008 and 2,606 in 2009) of all children reviewed. Table 3 (page 14) describes the four most frequently identified primary behavioural support needs for each year which, combined, were identified for 43% of all children reviewed in 2009 (44% in 2008), and represent 87% of all primary behavioural support needs identified in 2009 (93% in 2008).

Table 3: Top Four Identified Primary Behavioural Support Needs 2008/2009*

	2008			2009		
Identified Issue	# Children Identified	% Children w/ Behav. Support Needs**	% Children Reviewed***	# Children Identified	% Children w/ Behav. Support Needs**	% Children Reviewed***
Aggressive / Assaultive Behaviour	2001	75%	36%	1791	69%	34%
Other Behavioural Issue				189	7%	4%
Inappropriate Sexual Behaviour	182	7%	3%	144	6%	3%
Substance Abuse	172	6%	3%	140	5%	3%
Frequent AWOL	120	5%	2%			
TOTAL	2475	93%	44%	2264	87%	43%

*Children have only one identified primary behavioural issue, therefore the total number of children identified represents unique children
**Calculated as a percentage of all primary behavioural support needs identified in 2008 and 2009, *N* = 2,656 and 2,606 respectively
*** Calculated as a percentage of all Crown wards reviewed in 2008 and 2009, *N = 5,594 and* 5,218

For further information regarding all behavioural support needs identified, refer to Appendix B: Identified Needs 2008/2009.

Children and Youth at High Risk

As illustrated by Table 5 on page 17, the number of children identified as high risk decreased by 9% between 2008 (*n*=498) and 2009 (*n*=453); however, as a proportion of all children reviewed, the rate remained steady at 9%. Further discussion of Children and Youth at High Risk is found on page 17 in the section entitled "Service to High Risk Children".

Legislative Compliance

A file is in full compliance when all statutory requirements are met – i.e., no directives have been issued. Table 4 (page 15) indicates that of the total 5,218 cases reviewed in 2009, 66% of cases were in full compliance, an increase of almost 3% from 2008, where 64% of cases were in full compliance. The overall compliance rate in 2009, by society, ranged from a low of 12% (22% in 2008) to a high of 92% (94% in 2008).

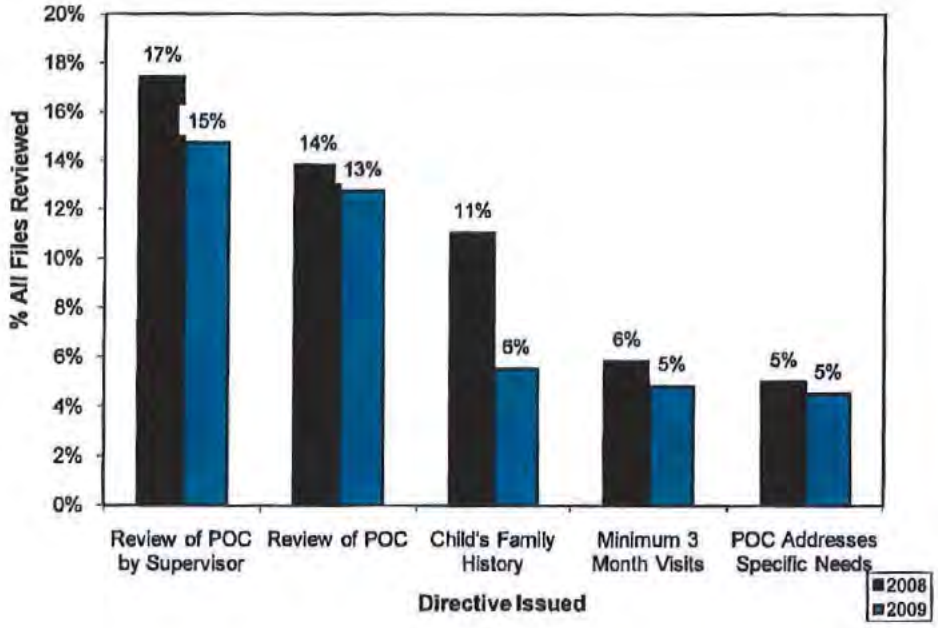
Table 4 also shows that as the rate of legislative compliance increased from 2008 to 2009, there was a corresponding decrease in the number of directives issued—from 3,886 in 2008 to 3,530 in 2009, a reduction of 9%.

Table 4: Overall Case Compliance and Directives Issued: 2007-2009

Year	2007	2008	2009	% change 08-09
# Cases Reviewed	5548	5594	5218	-7%
# Cases in Full Compliance	4325	3577	3432	-4%
% Cases in Full Compliance	78%	64%	66%	3%
# Cases not in Full Compliance	1223	2017	1,786	-11%
% Cases not in Full Compliance	22%	36%	34%	-5%
# Directives Issued	2009	3886	3530	-9%
Average # Directives Per Non-Compliant Case	1.64	1.93	1.98	21%

Chart 1 below illustrates the five legislated requirements with the most directives issued. These five legislated requirements account for 62% (or 2,213) of the 3,551 directives issued in 2009 and 77% (or 2,977) of the 3,866 directives issued in 2008.

Chart 1: Top Five Directives Issued 2008/2009



As illustrated by Chart 1, timely supervisory endorsement of plans of care drew the most directives and was issued on 17% of all files reviewed in 2008 and 15% in 2009. Refer to Appendix C: Directives Issued 2008/2009 for a complete overview of all directives issued in both reviews.

Safety, Permanency and Wellbeing

The remaining findings are described as they relate to outcomes for children regarding safety, permanency and wellbeing.

Safety

A primary objective of Ontario's child welfare system is to ensure that children in care are protected from further maltreatment or harm. Requirements or child information reviewed in relation to safety include:

- Provision of service to children designated as 'high risk';
- Youth criminal justice involvement;
- Abuse while in care.

Service to High Risk Children

When a child is designated as high risk and the reviewer believes that actions are required to address the risk, he or she will indicate that the case requires further action. For example, if a child who has substance abuse problems is going home for an access visit where he or she might have contact with drugs, the reviewer could ask the society to develop a plan to address this concern. As suggested by Table 5 below in 2009 87% of children considered to be high risk had services in place to address their high risk behaviours, while 13% (n=60) of high risk children identified in 2009 required further action by the society to address their needs. This finding represents an increase over 2008 data which indicate that of the 498 children identified as high risk, 11% required further society action.

Table 5: High Risk Cases: Further Action Required, 2007-2009

Year	2008	2009	% change 08-09
# High Risk Children/Youth	498	453	-9%
% of Children Reviewed*	9%	9%	0%
# Cases Requiring Further Action	54	60	11%
% Cases Requiring Further Action**	11%	13%	22%

*Calculated as a percentage of all Crown wards reviewed
**Calculated as a percentage of cases identified as High Risk

As Table 5 indicates, the percentage of children identified as high risk has remained steady since 2008.

Youth Criminal Justice Involvement

The percentage of Crown wards involved in illegal activities resulting in charges being laid under the *Youth Criminal Justice Act* (YCJA) during 2009 remained consistent with 2008 data

at 11%. In 2009, 8% of Crown wards had a history of *YCJA* involvement (a decrease from 9% in 2008) and 3.4% had a history of YCJA placements (a decrease from 4.5% in 2008).

Abuse While In Care

Table 6 below indicates that the percentage of children abused while in care since Crown wardship has remained steady at 4% since 2007. 'Abuse' refers to verified physical or sexual abuse by a caregiver. This finding relates to any caregiver that a child might have while in care also including, for example, his or her parents during an access visit, a child care provider or a babysitter. The percentage of children reviewed in 2009 with a history of abuse prior to admission remained consistent with 2008 data at 24%.

Table 6: Children Abused in Care* Since Crown Wardship: 2007-2009

Year	2007	2008	2009	% change 08-09
# Children Reviewed	5548	5594	5218	-7%
# Children Abused in care	222	224	223	0%
% Children Abused in care	4%	4%	4%	0%

*A child is counted as "abused in care" if s/he has a history of abuse in care at any time, including during a previous review period. As the annual incidence of abuse in care is low, this number remains relatively stable over time.

Permanency

Research has stressed that "stability and continuity of relationships promote children's growth and functioning".[2]

Requirements or child information reviewed in relation to permanency include:

- Permanency plans;
- Planning for independence;
- Placement type;

[2] Barber, J. G., & Delfabbro P.H. (2006). Psychosocial well-being and placement stability in foster care: Implications for policy and practice. In R.J. Flynn, P.M., Dudding & J.G. Barber (Eds.) *Promoting resilience in child welfare.* Ottawa, ON: University of Ottawa Press.

- Placement changes;
- Length of placement;
- Access

Permanency Plans

Table 7 below outlines the permanency plan for children reviewed in 2008 and 2009. This table demonstrates that the plan for the majority of Crown wards reviewed is to remain in long-term foster care. A significant minority of Crown wards reviewed are/were preparing for

Table 7: Permanency Plans, 2008/2009

	2008		2009		% change
Identifed Plan	**#**	**%**	**#**	**%**	**08-09**
Adoption	302	5%	279	5%	0%
Return Home	82	1%	55	1%	0%
Long Term Foster Care	3,098	55%	2,834	54%	-2%
Adult Services	258	5%	305	6%	20%
Long-term Residential Group Care	470	8%	415	8%	0%
Independence	1,097	20%	1,050	20%	0%
Not Clear	287	5%	280	5%	0%
TOTAL	5594	100%	5218	100%	0%

Independence. It is important to note that although the proportion of Crown wards for whom adoption was the identified plan is small (5% in both years), these data do not include all Crown wards where adoption is the permanency goal. As the data represent only those Crown wards whose length of wardship is greater than or equal to 24 months, a significant proportion of children for whom adoptive homes were being sought during the review years are not included in these data (those who had been Crown wards for under the required two years). See pages 29-30, "Context", for further discussion of adoptions.

Independence Planning

As the number of adolescent Crown wards continues to increase, focus on planning for independence will continue to require attention. This population of Crown wards requires services that focus on maintaining them in stable placements while adequately preparing them for independence or, in the cases of children with significant disabilities, a transition to adult services.

Chart 2 below indicates that all areas of independence planning for youth aged 15 years or more require some improvement. A reviewer indicates that there is a need for improvement when no plan exists to address:

- Social development for youth who are unable to successfully participate in social activities;
- Vocational training for youth who are unsure of their future career;
- Employment training for youth who require an orientation to the expectations of the work environment;
- Life skills for youth who need to learn the basics for functioning independently like budgeting, banking, cooking, laundry, etc.;
- Extended care and maintenance for youth who wish to receive ongoing financial support from a society past their 18th birthday; and
- Adult support for youth with significant physical and/or developmental challenges who will be unable to live independently as adults.

Chart 2: Independence Planning for Youth 15+ Years, 2008/2009

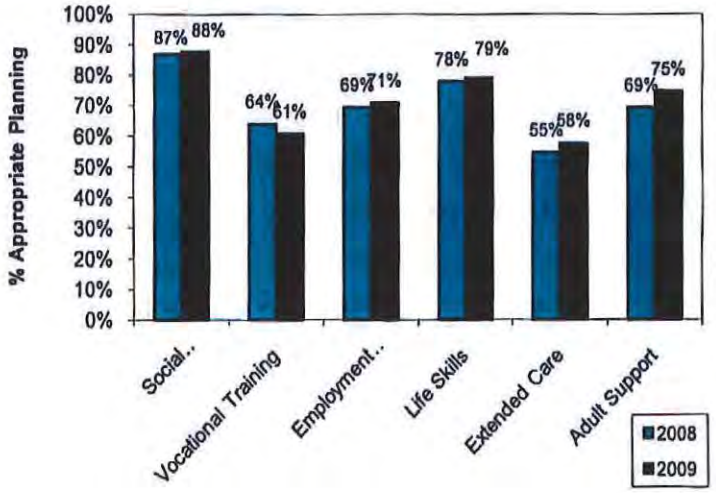


Chart 2 (above) presents the percentage of files where reviewers assessed planning to be appropriate across the domains noted above. For example, 87% of files in 2008 and 88% in 2009 were assessed as having appropriate planning regarding the young person's social development. As Chart 2 demonstrates, societies must focus, in particular, on developing an appropriate plan for those children requiring vocational and employment training, and extended care and maintenance plans, as reviewers noted that the most improvement was required in these areas.

Placement Type

The majority of Crown wards reviewed (57%) resided in society-operated foster care in 2009, consistent with 2008 data. A sizeable minority (10%) of these resided in kinship care placements, a rate just slightly higher than in 2008 (9%). During both 2008 and 2009, the use of Outside Paid Resource (OPR) parent model and staffed group homes accounted for 18% of placements, while just over 16% of children were placed in OPR foster homes. In 2009, the percentage of children requiring the added support provided by specialized and treatment foster care increased slightly from 2008 data—from 22% in 2008 to 24% in 2009. Refer to Appendix D: Current Placement Type for more detail.

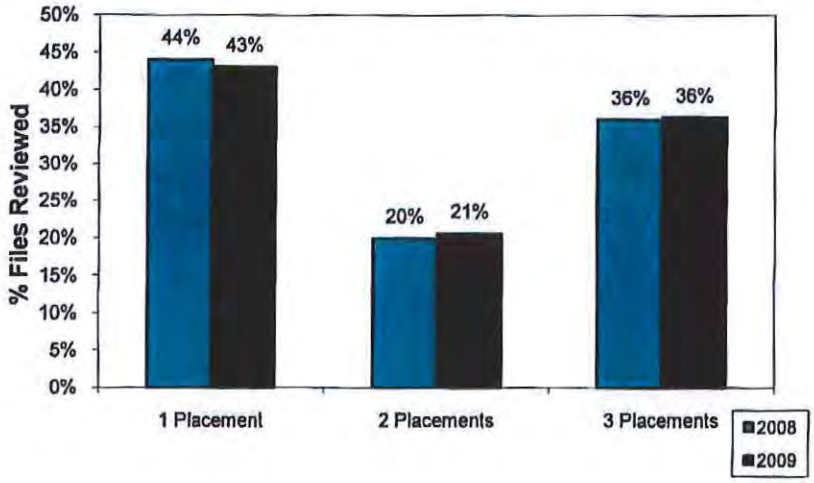
Placement Changes

Placement stability remains a key factor in the provision of continuity of care for children and for their on-going security and optimum development. Research suggests that a significant number of placement breakdowns, particularly during the teenage years, and the impact of frequent moves affect a child's ability to function as an adult.[3]

As Chart 3 (page 22) indicates, in 2009 57% of the children reviewed have had two or more placements since Crown wardship, a rate that has remained consistent with 2008 data (56%).

[3] Report of the Task Force on Safeguards for Children and Youth in Foster or Group Home Care; Barth, Berry and Courteney 1994.

Chart 3: Number of Placements Since Crown Wardship, 2008/2009



Length of Placement

In 2007, placement length for children averaged 23 months. In 2008, this average rose to 25.5 months, and in 2009 there was a further increase to 27 months. In 2009, the average length of placement, by society, ranged from a low of 5.4 months (14.3 in 2008) to a high of 49.1 months (45.1 in 2008).

Access

The existence of an access order governing an individual's right to contact with a Crown ward may be instrumental in preserving family connections. Seventy-six percent of Crown wards reviewed in 2008 had access orders to at least one family member. This percentage has remained steady since 2006. Eighty-eight per cent of those children with access orders experienced access to their immediate or extended family, a slight increase from 2007 during which time 85% of children with access orders experienced access. When access with siblings is also considered, data from 2008 indicate that 91.4% of all children had some form of access with family members. This represents a decrease since 2007 when 95% of all children had some form of access with family and/or extended family.

Unduplicated case level data on access are not available for 2009. However, 2009 data indicate that 67% of children reviewed had access orders in place for mothers, 46% for fathers, and 20% for extended family. Access was exercised by mothers in 71% of eligible

cases[4], by fathers in 39% of eligible cases and by extended family in 53% of eligible cases. Children exercised access with siblings in 80% of cases.

Child Wellbeing

To achieve positive outcomes regarding Child Wellbeing, children must receive appropriate and adequate services to meet their many needs. Requirements and child information reviewed specifically in relation to Child Wellbeing include:

- Worker contact with the child;
- Worker continuity;
- Plans of Care;
- Education; and
- Psychotropic medication and therapy.

Caseworker Continuity and Contacts

The number of caseworker contacts with children and the length of caseworker assignment have an important impact on the continuity of relationships for children and youth. A consistent, reliable presence in children's lives provides continuity for the child. These relationships are important to assist children in understanding the complex issues that are associated with being in care. Children require support and guidance from their caseworkers, particularly in times when there are difficult changes occurring and decisions to make.

Caseworker Continuity

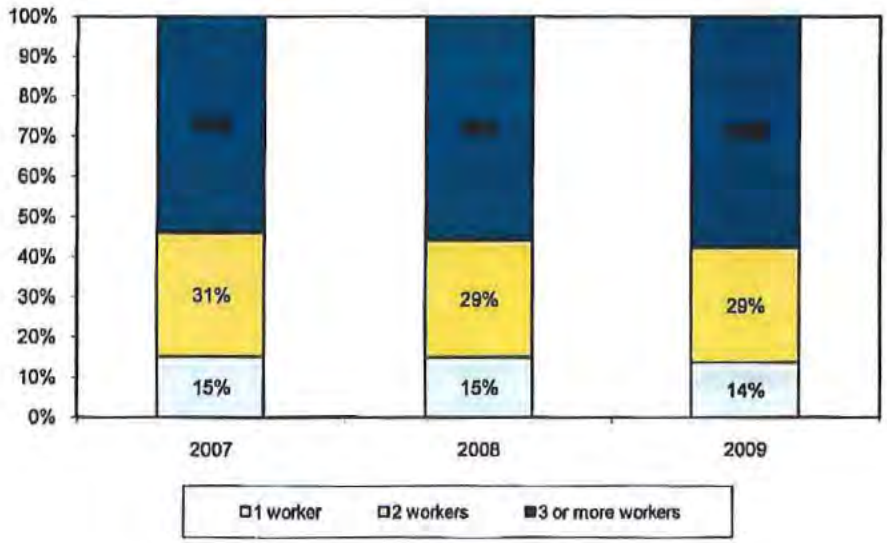
Raychaba (1988) cites the high number of worker changes, coupled with infrequency of contact between the children and youth in care and their social workers, as one of the primary reasons for the "unwillingness or conditioned inability of children and youth to trust and commit in strong long term relationships with others."

Chart 4 below indicates that in 2009, a higher percentage of Crown wards had experienced three or more caseworkers since Crown wardship compared to previous years. On average,

[4] "Eligible cases were considered those where the court had ordered access or remained "silent" on access to a particular party. Cases where the court had ordered no access were not considered eligible cases.

caseworker assignments changed every 21.1 months in 2009, a duration that is consistent with 2008 data. In 2009, caseworker duration, in months, ranged from a society average low of 10.1 (8.9 in 2008) months to a high of 32.2 (39.9 in 2008) months.

Chart 4: Number of Workers Since Crown Wardship, 2007-2009



Caseworker Contacts

Contacts between caseworkers and children occurred, on average, once per month for an overall average across societies of 11.9 contacts in 2009 (12.1 in 2008). The society average number of caseworker contacts in 2009 ranged from a low of 7.8 (7.4 in 2008) to a high of 15.5 (15.8 in 2008) contacts within the previous twelve months.

Table 8: Compliance Rates, Contact with Children/Youth: 2007-2009

Requirement	2007	2008	2009	% Change 08-09
7 Day Visit	99%	99%	99%	0%
30 Day Visit	99%	99%	99%	0%
3 Month Visit	96%	94%	95%	1%
Private Visit	98%	98%	98%	0%

Statutory requirements include personal face-to-face visits made by caseworkers with children and youth. At a minimum, visits are required within seven, and 30 days after a placement occurs and every three months thereafter. Children must also be provided with an opportunity to meet their caseworker in private. Table 7 above outlines compliance rates regarding contact with children and youth.

Table 8 (above) shows that the rates of compliance in all areas of statutory contact have remained consistently high over the past several years; however, requirements represent minimal contact with the child so that a high rate of compliance is desired. The 5% of children in 2009 who did not experience the required minimum three month visit(s) translates into 253 children; in 2008, 6% (or 324 children) did not have the minimum three month visit(s). As a result, continued attention to contact with children is required.

Plans of Care

A child's plan of care must be developed and finalized within 30 days of placement. That plan of care must then be reviewed three months after the placement, six months after the placement and at least every six months thereafter — or earlier if there is a material change in circumstances which necessitates a review of the plan, or when there is a change in the child's placement. Reviews of plans of care must be endorsed in a timely fashion by supervisors. As Table 9 (page 26) indicates, the compliance rate for review of plans by Supervisors increased by 3% between 2008 and 2009. Compliance with the requirement that plans of care address the child's specific needs remained constant between 2008 and 2009 at 95%. Although the compliance rate is high for this requirement, the 5% non-compliance rate in 2009 translates into 236 children whose plan of care was identified as needing improvement (279 in 2008).

Table 9: Percentage of Files in Compliance with Plan of Care (POC) Standards: 2007-2009

Standard	2007	2008	2009	% change 08-09
Review of POC	95%	86%	87%	1%
Review of POC within 30 Days of Move	99%	97%	97%	0%
POC Addresses Specific Needs	95%	95%	95%	0%
Review of POC by Supervisor	91%	83%	85%	3%

Table 10 below describes 2008/2009 provincial findings as well as the range of society findings regarding compliance for Plans of Care. Society compliance ranged from 78% to 100% for the requirement that the plan of care addresses the child's specific needs in 2008; in 2009 the range was from 71% to 100%.

Table 10: Range of Society Compliance with Plan of Care (POC) Standards, 2008/2009

	2008			2009		
Standard	% Compliant	Low	High	% Compliant	Low	High
Review of POC	86%	34%	100%	87%	47%	100%
Review of POC within 30 Days of Move	97%	88%	100%	97%	86%	100%
POC Addresses Specific Needs	95%	78%	100%	95%	71%	100%
Review of POC by Supervisor	83%	29%	100%	85%	40%	100%

Education

Research consistently shows that children receiving child welfare services are behind their peers in all aspects of cognitive development and school performance. School performance is the simplest indicator of cognitive functioning for school-aged children.

Educational Profile

Of the 5,218 children reviewed in 2009, 97% (*n*=5,045) were enrolled in an educational program; in 2008, 5,265 children were enrolled in school, 94% of all children reviewed. Table 11 below indicates that 50% of children enrolled in school had been reviewed by an Identification Placement Review Committee (IPRC) in 2008 (52% in 2009). Ninety-five percent of children, who had received an IPRC review, were placed in the recommended placement in both years.

Table 11: Independent Placement Review Committee Placements for Children Enrolled in School Programs In 2008/2009

	2008		2009	
Educational Status	**# Children**	**%**	**# Children**	**%**
# Children Enrolled in an Educational Program	5,265	100%	5,045	100%
Subject of an IPRC*	2,649	50%	2,616	52%
Placed in Recommended Placement**	2,520	95%	2,492	95%

* Percentage calculated as a % of all children enrolled in educational program, *N*=5,265 in 2008 and 5,045 in 2009

** Percentage calculated as a % of all children who were the subject of an IPRC, *N*=2,649 in 2008 and 2,616 in 2009

Table 12 (page 28) describes provincial findings for 2008 and 2009 as well as the range of society findings regarding the educational profile of Crown wards.

*Table 12: Individual Educational Plans & Suspensions, 2008/2009**

	2008				2009			
	# Children	Prov. Avg.	Low (CAS)	High (CAS)	# Children	Prov. Avg.	Low (CAS)	High (CAS)
Individual Educational Plan	3131	59%	35%	89%	3,116	62%	39%	83%
Suspended in the Previous 12 Months	950	18%	8%	50%	837	17%	4%	46%

*All percentages calculated as a percent of children enrolled in school, *N*=5,265 in 2008 and 5,045 in 2009

Educational Progress

Table 13 below shows that in 2009, 91% (92% in 2008) of the children enrolled in a school program were progressing towards promotion as indicated on the report card of children in elementary school or by the number of credits achieved by youth in high school. The promotion of 7% (6% in 2008) of Crown wards enrolled in a school program was at risk.

*Table 13: Educational Progress of Crown Wards 2008/2009**

	2008				2009			
Progress Status	# Children	Prov. Avg.	Low (CAS)	High (CAS)	# Children	Prov. Avg.	Low (CAS)	High (CAS)
Promotion Likely	4841	92%	59%	100%	4607	91%	73%	100%
Promotion at Risk	336	6%	0%	17%	358	7%	0%	23%
Promotion Cannot be Determined	88	2%	0%	27%	69	1%	0%	6%

* Percentages may not add to 100% due to rounding

Children not attending school were either not required to attend school because they were too young (e.g., toddlers), beyond the age of compulsory school attendance, expelled from a school program, or elected not to attend despite the requirement to do so. Data is not available regarding the reason for non-attendance for school-aged children.

Psychotropic Medication and Therapy

Psychotropic medication may be prescribed as part of a treatment plan to address children's special needs, such as Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder. The

proportion of Crown wards taking psychotropic medication in 2009 increased slightly to 49% from 47% in 2008.

The percentage of Crown wards receiving therapy to address their special needs remained consistent at 41% for both 2008 and 2009. Therapy can include speech, occupational and physical therapy as well as counselling services.

PART III: Adoption Probation Review

Introduction

The goal of the adoption probation review is to determine that an adequate plan of care is developed for Crown wards placed on adoption probation. The review is also intended to stimulate improvement in the overall service delivery to children.

The objectives of the adoption probation review are to:

- Monitor compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward placed on adoption probation;
- Determine whether there has been an adequate assessment of the child's needs, a suitable placement, supporting services, and realistic planning for and with the child, as appropriate;
- Issue directives regarding non-compliance and to make and encourage and monitor implementation of recommendations about particular cases and general policy and practices; and
- Provide information to the society under review about best practices employed in other societies and jurisdictions.

Context

It is important to note that children reviewed through the Adoption Probation review represent only those children who have been Crown wards for the required timeframe (at least 24 consecutive months) at the time of review. As a result, the children placed

on Adoption Probation represent only a subset of Crown wards who are actively involved in the adoption process in any given year. As children are most likely to be adopted within their first two to three years of Crown wardship, the vast majority of children placed on Adoption Probation in any given year are not reviewed through this process. For example, in 2008/09, the societies completed 824 adoptions; in 2009/10, this number increased to 993. Although these data represent fiscal year data, and the number of completed adoptions as opposed to adoptions-in-process, they support the notion that children reviewed through the Adoption Probation review (N=131 in 2008 and 153 in 2009) represent a minority of children involved in the adoption process in any given year.

Scope of the Review

In 2009, 153 children on adoption probation were reviewed, representing an increase of 17% from 2008 (*N*=131).

Profile of Crown Wards on Adoption Probation

Fifty-two percent of the Crown wards on adoption probation reviewed in 2009 were male; in 2008, male children comprised 56% of the children on adoption probation reviewed. The average age at the time of the 2009 review remained consistent with 2008 data at 8.2 years.

Findings of the Review

Adoption Plan

Table 14 (page 31) describes society plans for adoption finalization. The number of adoptions finalized after six months has decreased by 19% between 2008 and 2009.

Table 14: Adoption Probation Time to Finalization: 2007-2009

Year	2007		2008		2009		% change 08-09
# Finalized Within 6 Months*	48	(40%)	49	(37%)	78	(51%)	38%
# Finalized After 6 Months*	72	(60%)	82	(62%)	75	(50%)	-19%

*The number finalized within 6 months plus the number finalizedafter 6 months may not add to 100% due to rounding

Length of Time on Adoption Probation

The average length of time that a child was on adoption probation in 2009 was 11.1 months. This represents an increase over 2008 data, where the average length of adoption probation in was 10 months.

Legislative Compliance

A directive is issued when a statutory requirement has not been met. As with the Crown ward review, the overall compliance rate is calculated by determining the number of cases in full compliance. As Table 15 below indicates, the rate of compliance decreased significantly between 2008 and 2009 — from 95% to 76%, a decrease of 19%.

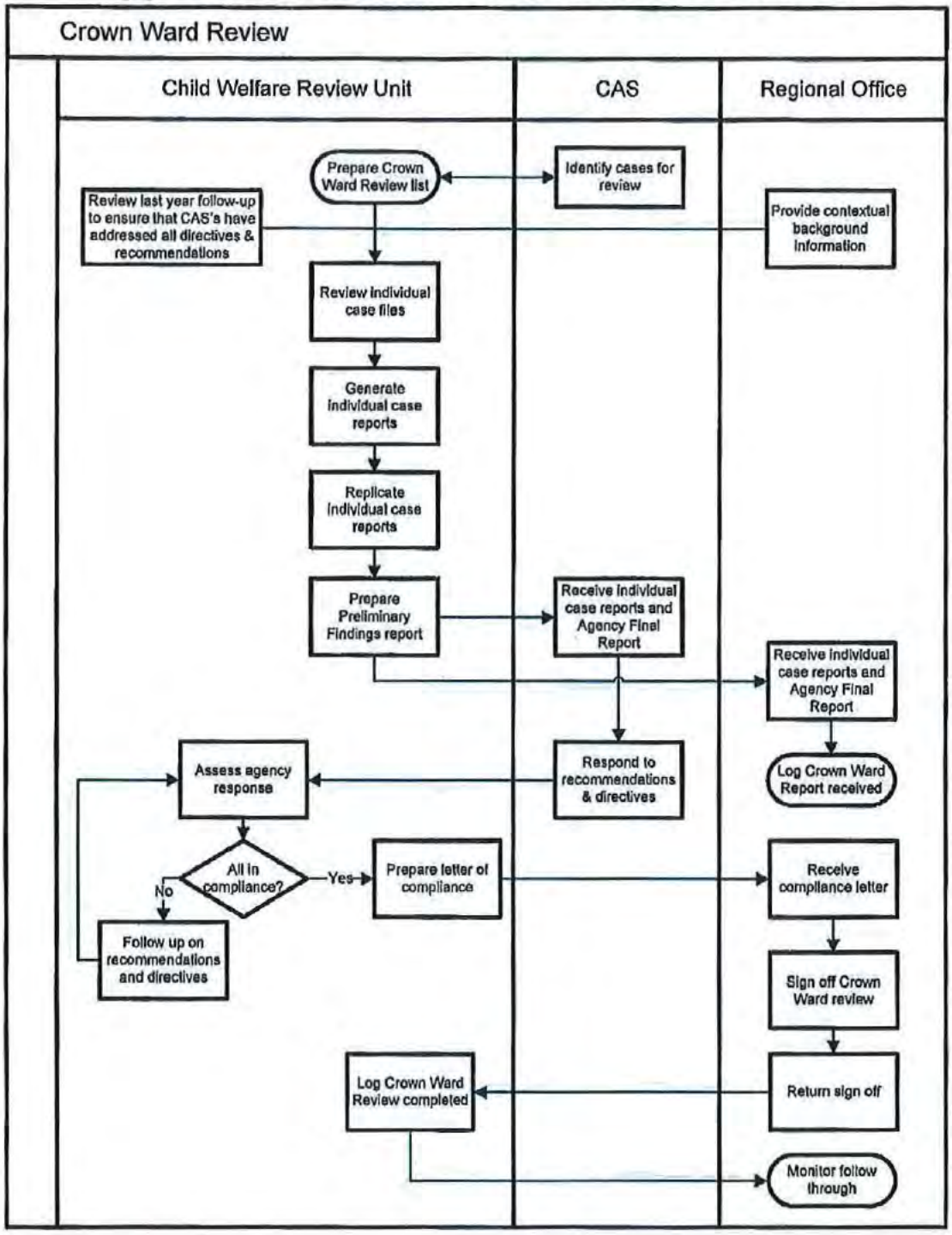
Table 15: Adoption Probabtion Compliance Levels: 2007-2009

Year	2007	2008	2009	% change 08-09
# Cases Reviewed	120	131	153	17%
# Cases in Full Compliance	112	124	117	-6%
% Cases in Full Compliance	93%	95%	76%	-19%
# Cases not in Full Compliance	8	7	36	414%
% Cases not in Full Compliance	7%	5%	24%	340%
# Directives Issued	9	16	43	169%
Average # of Directives per Non-Compliant Case	1.07	2.29	1.19	-48%

As the rate of compliance decreased, there was a corresponding increase in the number of directives issued; however, the average number of directives issued per non-compliant case dropped (from 2.29 in 2008 to 1.19 in 2009), suggesting that were fewer non-compliant cases with multiple directives in 2009 compared to 2008. The increase between 2008 and 2009 is attributable to a large number of directives (30, or 70% of all directives) given that fall in the category of "other". The "other" category consists mainly of directives given to address requirements stemming from the 2006 revisions to the *CFSA* not covered by the current Adoption Probation tool.

Appendices

Appendix A: Crown Ward Review Process



Appendix B: Identified Needs 2008/2009

Appendix B: Identified Primary Needs, 2008/2009

	2008		2009	
Special Need	**# Children Identified**	**%***	**# Children Identified**	**%****
ADD/ADHD	1395	30%	1328	30%
FAE/FAS	242	5%	241	6%
Eating Disorder	2	0%	1	0%
Psychiatric Diagnosis	888	19%	802	18%
Developmental delay	408	9%	369	8%
Neurological Disorder	197	4%	208	5%
Multiple Disabilities	138	3%	142	3%
Dual Diagnosis	44	1%	33	1%
Depression/anxiety	102	2%	85	2%
Intellectual Disability	296	6%	283	6%
Physical Disability	31	1%	28	1%
Medical Condition	182	4%	199	5%
Medically Fragile	20	0%	13	0%
Learning Disability	395	9%	396	9%
Emotional Difficulty	266	6%	225	5%
Other Disability	3	0%	2	0%
TOTAL	4609	100%	4355	100%
Behavioural Support Needs	**2008**		**2009**	
Frequent AWOL	120	5%	114	4%
Inappropriate Sexual Behaviour	182	7%	144	6%
Involvement in Prostitution	0	0%	5	0%
Self-harming Behaviours	70	3%	67	3%
Suicidal Ideation/Gesturing -Current	62	2%	46	2%
Suicidal Ideation/Gesturing -Historical	45	2%	110	4%
Aggressive/Assaultive Behaviour	2001	75%	1791	69%
Substance Abuse	172	6%	140	5%
Other	4	0%	189	7%
TOTAL	2656	100%	2606	100%

* Percentage is calculated as a proportion of total children with an identified special need or behavioural support need in 2008, *N*=4,609 and 2,656 respectively

** Percentage is calculated as a proportion of total children with an identified special need or behavioural support need in 2009, *N*= 4,355 and 2,606 respectively

Appendix C: Directives Issued 2008/2009

Appendix C: Summary of Directives Issued, 2008/2009

	2008		2009	
Directive	**# Issued**	**%* **	**# Issued**	**%****
Review of Plan by Society Supervisor	976	25%	769	22%
Plan Addresses Specific Needs	281	7%	236	7%
Review of Plan	774	20%	666	19%
Minimum 3 Month Visit	327	8%	253	7%
Annual Medical Exam	195	5%	170	5%
Private Visits	120	3%	81	2%
Annual Dental Exam	104	3%	107	3%
7 Day Visit	60	2%	51	1%
Discussion of Rights	49	1%	46	1%
30 Day Visit	50	1%	50	1%
Review Within 30 days of Move	183	5%	179	5%
Family History	619	16%	289	8%
File to Reviewed by Senior Management	46	1%	57	2%
Serious Occurrence Report	51	1%	35	1%
Annual School Report on File	10	0%	11	0.3%
Plan from Other Residential Resources	26	1%	36	1%
File to be Reviewed by Program Supervisor	13	0%	7	0.2%
Other	2	0%	508	14%
TOTAL	**3886**	**100%**	3551	100%

* Percentage is calculated as a proportion of total Directives Issued, *N*=3,886

** Percentage is calculated as a proportion of total Directives Issued, *N*=3,551

Appendix D: Current Placement Type

Appendix D: Current Placement Type, 2007-2009*

Placement Type	2007	2008	2009
Regular Foster Care	25%	25%	23%
Specialized and Treatment Foster Care	22%	22%	24%
Children's Aid Society Group/Parent Model Home	2%	2%	2%
Emergency Receiving Home	<1%	<1%	<1%
Outside Paid Resource Foster Home	17%	16%	16%
Outside Paid Resource Parent Model	4%	4%	3%
Outside Paid Resource Group Home	15%	15%	15%
Young Offender Facility	1%	1%	1%
Children's Mental Health Centre	<1%	<1%	<1%
Independent Living	5%	5%	4%
Kinship Care	9%	9%	10%
Community Caregiver/Parents	1%	<1%	<1%

*Percentages may not add to 100% due to rounding

The following placement types are categorized as society-operated foster care:

- Regular Foster Care;
- Specialized and Treatment Foster Care;
- Kinship Care.

This is **Exhibit "27"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Ontario

Child Welfare Review

Ontario's Crown Wards

Summary Report
2010

Ministry of Children and Youth Services

Client Services Branch, Service Delivery Division

November 2015

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Executive Summary

The Crown Ward Review is an annual process undertaken by the Ministry of Children and Youth Services (hereafter referred to as "the ministry") to determine if the placement, services, educational and social needs of Crown wards in Ontario are being identified and appropriately addressed. The Crown Ward Review is an accountability mechanism used by the ministry to determine if children's aid societies (CASs) are undertaking appropriate planning and services for each child reviewed. The review monitors compliance with legislation and regulations related to the care of children, and identifies areas that need improvement. The review also collects a rich set of information about children's strengths, needs and experiences in care that can be used to assess outcomes related to well-being, safety, and permanency.

A Crown ward is a child who has been made a ward of the Crown pursuant to a court order under the *Child and Family Services Act,* R.S.O. 1990, c. 11. The file of each Crown ward is reviewed in the year following 24 months of successive Crown wardship and every year thereafter. Reviews continue until the child is discharged from the care of the society or reaches 18 years of age, or the case is before the court on a status review.

In 2010, the files of 5,194 children were reviewed, less than a 1% decrease from the number reviewed in 2009 (N=5,218). Of these files, 979 (19%) were reviewed for the first time. The review population was comprised of 2,279 boys (57%) and 2,215 girls (43%). Of the children reviewed, 1,130 (or 22%) were of Aboriginal heritage.

The analytic strategy used to prepare the 2010 Summary Report represents a departure from previous years. Data were stratified, wherever appropriate, by child sex and age at the time of review to allow for a better understanding of the different constellation of issues and service events presenting for boys and girls and younger versus older Crown wards.

In the review population as a whole, 82% of children were identified as having at least one "special need" (e.g. ADD/ADHD, developmental delay) and 42% of children had at least one "behavioural support need" (e.g. aggressive behaviour, self-harm). Clear differences emerged between boys and girls and across age groups in terms of both the prevalence and relative frequency of identified needs.

Legislative Compliance

A file is in full compliance when all statutory/legislative requirements are met – i.e., no directives have been issued for failing to meet requirements. In 2010, of the 5,194 files reviewed, 3,835 (or 74%) were in full compliance. This is an improvement over the full compliance rate for the past several years (66% in 2009 and 64% in 2008).

A total of 2,467 directives were issued to CASs in 2010, which represents a decrease of 1084 directives when compared to 2009. The majority of directives required CASs to come into compliance with the following legislative requirements: Review of Plan of Care by Supervisor; 3 Month Review of the Plan of Care; and "Other" requirements introduced through child welfare transformation related to the implementation of Ontario Looking After Children (OnLAC) plan of care requirements and not captured in the standardized instrument used to assess Crown ward files in 2010.

The files of 143 Crown wards on adoption probation were reviewed in 2010. The overall rate of compliance increased from 76% in 2009 to 80% in 2010. For further details about the adoption probation review, please see Part 3: Results from the Adoption Probation Review.

1. The Crown Ward Review

1.1 Purpose and Process of the Review

The *Child and Family Services Act (CFSA)* is intended to promote the protection, best interests and well-being of children in Ontario. The Crown ward review is an annual process legislated under Section 66 of the Act to review the status of every child:

- who is a Crown ward; and
- who was a Crown ward throughout the immediately preceding twenty-four months; and
- whose status has not been reviewed under section 66 or under section 65.2 during that time.

The review process ensures that the circumstances of each Crown ward, including those on adoption probation, are re-examined regularly by the ministry.

The review is conducted annually in all Children's Aid Societies (CASs) in the province. The ministry's review team conducts an on-site file review of eligible files using a standardized instrument designed to capture demographic information, a range of child characteristics and special / behavioural / educational support needs, significant case events, and to assess compliance with the legislation, regulations, ministry standards, directives and policies. The objectives of the Crown ward review are to:

- Monitor agency compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward;
- Determine whether there has been an adequate assessment of the Crown ward's needs, a suitable placement, supporting services, and realistic planning for and with the child as appropriate;
- Issue directives regarding non-compliance and to monitor implementation of recommendations about particular cases and general policy and practices;
- Provide Crown wards with the opportunity, through questionnaires and interviews, to comment on: the care they are receiving; contacts with their biological families; their case plans; and their current circumstances; and
- Provide information to the society under review about best practices employed in other societies and jurisdictions.

Unless the child's case is before the court for a status review, reviews continue annually until the child is discharged from the care of the society or reaches 18 years of age; the files of youth who were over 18 years of age and continued to receive services from a CAS under an Extended Care and Maintenance agreement (now known as Continued Care and Supports for Youth agreement) are not eligible for review.

A society's Crown ward review findings are based on a review of the Crown ward files, questionnaires completed by Crown wards and client interviews. In complex and/or high-risk cases, society caseworkers and managers may also be consulted. Individual case reports are prepared for each Crown ward reviewed. These reports provide feedback to caseworkers, society managers, and ministry program supervisors on key areas of service delivery, case management and planning.

Feedback regarding the file reviewed can be in the form of a 'directive'. Directives are issued when a statutory/legislative requirement is not met. Directives regarding non-compliance are issued, for example when: children do not meet face-to-face with their caseworkers every three months; if children have not

received annual medical or dental examinations; or if planning is not completed within statutory or timelines or has not adequately addressed a child's needs.

Recommendations are made if file documentation does not support comprehensive case planning on behalf of a Crown ward. For example, a recommendation may be made to review the child's access with his or her family if it appears that the access experience is not meeting the child's needs. Recommendations are made for the society's consideration to which the society must respond.

Through the review process, children may be identified as 'high risk'. This will occur when children exhibit behaviours that present harm to themselves or others. A child will be identified as high risk if there is evidence of two or more of the behaviours listed below. Depending upon the severity of the behaviour, a designation may also be made if a child exhibits only one of these behaviours:

- Aggressive/assaultive behaviour
- Suicidal gestures or ideation
- Alcohol/substance abuse
- Two or more placements in previous 12 months
- School suspension/expulsion
- Serious emotional problems
- Serious oppositional/defiant behaviours
- Sexual "acting out"
- Serious psychiatric disorders
- Involvement in criminal activity
- Frequent running from their placements.

Societies are required to address all directives, recommendations and any direction to provide follow up for cases designated as 'high risk' as follows:

1. Within 30 days of the Post Review Conference (Exit Meeting) to the Child Welfare Review Unit for cases designated as 'high risk'.
2. Within 60 days of the Post Review Conference to the program supervisor/regional office and the Child Welfare Review Unit to address directives and recommendations.

If a directive is issued for a review of a file by the ministry program supervisor, the program supervisor is required to provide a written response to the Child Welfare Review Unit confirming that the review has occurred along with any comments.

When the Child Welfare Review Unit receives a society's response to all directives and recommendations, a letter is sent to the program supervisor/regional office to sign off on the review.

The flowchart in Appendix A illustrates the Crown ward review process.

1.2 Current Context

2010 marks the final full calendar year of reviews conducted using the Crown Ward Review instrument developed in the early 1990s. A new Crown ward review tool and process was implemented in August 2011. Future reports will represent data based on the new Crown ward review tool and, as a result, for some variables data will not be directly comparable with the 2010 or earlier reports. From an accountability perspective, the new tool is designed to provide data regarding compliance-by-requirement rather than compliance-by-file, making 2010 the final year for which an overall compliance rate based on the percentage of files in full compliance is available. The redesigned processes for the review will include a focus on continuous quality improvement.

1.3 Structure of the Report

The 2010 Child Welfare Review Summary Report provides the results of the 2010 Crown ward review in Section 2. The results of the 2010 Crown ward review include:

- Demographic and background information about the Crown wards reviewed;
- Findings as they relate to outcomes of well-being, safety, and permanence; and
- Information regarding overall legislative compliance and directives issued.

The results of the 2010 adoption probation review are presented in Section 3 and include:

- A description of the scope of the review;
- A profile of the reviewed Crown wards on adoption probation; and
- Information regarding overall legislative compliance.

1.4 Scope of the Review and Limitations of the Data

The children reviewed through the Crown ward review represent a subset of Ontario's Crown wards. Not all children who are Crown wards at the time of the review are eligible for review. Children who are ineligible include children whose status review is before the courts and children who have not been Crown wards for the required 24 month period prior to review. As Crown wards reviewed represent a cross-sectional (point in time) sample, those children who were served during the year and met the 24 month criteria. Children who were discharged from care before the scheduled review are not accounted for.

Crown ward review data include a disproportionate number of children who have long term in-care experiences as they are both eligible for review (i.e. have been Crown wards for at least two years) and still in care at the time of review (i.e. have not been discharged). Children who are never accounted for by the review data are those who become Crown wards and exit care quickly (i.e. before reaching 24 months of Crown wardship) to either permanent or non-permanent (i.e. aging out) arrangements. **The findings presented in this report are relevant to those children who have longer-term Crown ward experiences rather than representative of all children who become Crown wards.**

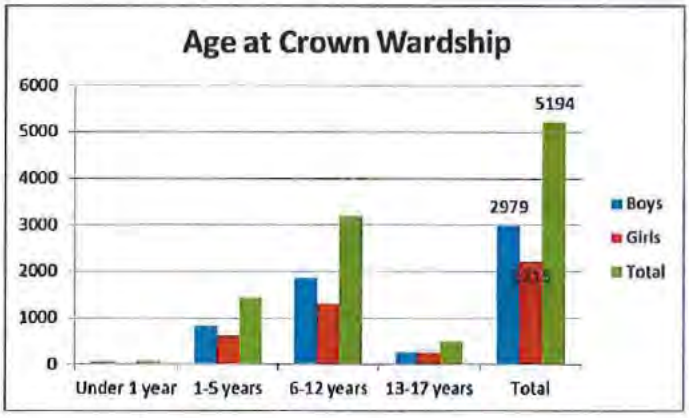
3. Findings of the 2010 Crown Ward Review

2.1 Demographic and Other Background Information

2.1.1 Age at Crown Wardship

The graph below shows the age at Crown warship by child sex and highlights the similarities and differences between age groups for boys and girls. The chart highlights that the majority of children became Crown wards in their middle years.

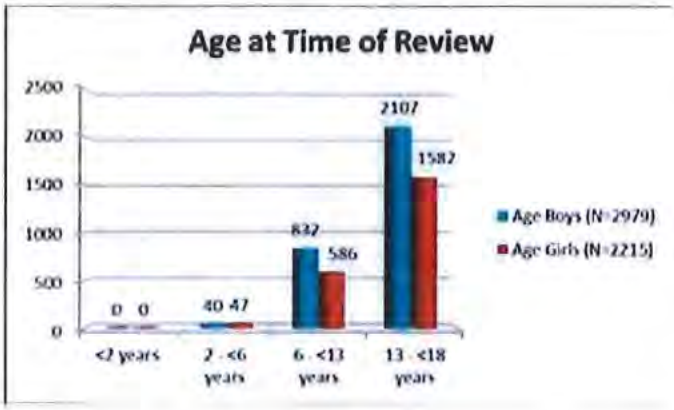
Research is unequivocal about the increased likelihood of adoption for young children and the difficulties inherent in placing children for adoption the longer they remain and age in care. Some research estimates that the likelihood of children remaining in long term foster care until they age out of the system increases substantially by the age of 8 or 9 years. This emphasizes the importance of CASs maintaining a focus on continuously assessing and reassessing permanency options for children from the point of admission and throughout the life of a child's involvement with the agency.



- *61% of children became Crown wards in CASs between the ages of 6 and 12.9.*
- *29% of all children became Crown wards before their sixth birthday.*
- *When the data (not shown) was analyzed for children of Aboriginal heritage, 40% of Aboriginal children became Crown wards before the age of six, versus 25% of non-Aboriginal children.*

2.1.2 Age at the Time of Review

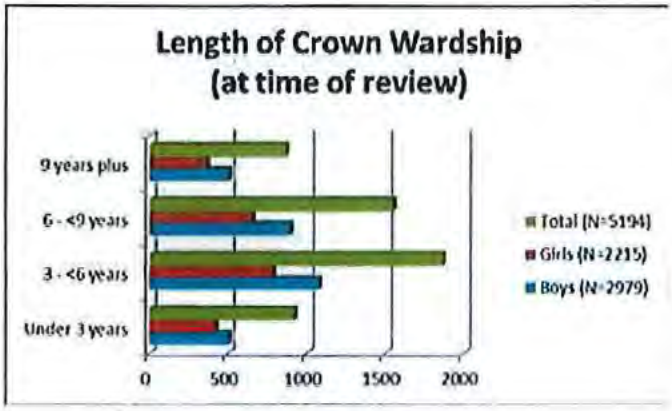
The graph below shows child age at the time of review by child sex (boys versus girls). Children who were not Crown wards for 24 months and those children who exit care quickly after becoming Crown wards are not included in these statistics.



- *Consistent with the 2009 Crown ward review findings, the average age at review for all children was 14.2.*
- *71% of children reviewed were adolescents aged 13 to 17.9.*
- *2% of children were under the age of 6.*

2.1.2 *Length of Crown Wardship*

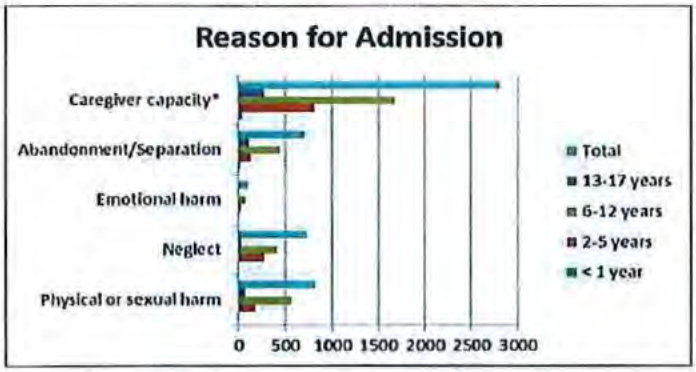
The graph below illustrates that the majority of children reviewed (83%) were Crown wards between three to over nine years, highlighting that the Crown wards eligible for review are those children and youth with longer-term Crown ward experiences.



- *The average length of Crown wardship for all children reviewed was 6.1 years with an age range between 2 and 16.8 years.*
- *36% of children were Crown wards between 3 and 5.9 years.*
- *30% were Crown wards between 6 and 8.9 years.*
- *18% were Crown wards for less than 3years.*
- *17% of children were Crown wards for 9 or more years.*

2.1.3 *Reason for Admission to Care*

The graph below provides the primary reason for admission to care that led to CASs seeking Crown wardship orders. The graph highlights that caregiver capacity was the primary reason for admission to care for the vast majority of Crown wards. *2.14* Other Demographic Information captures the number children and youth who had previous admissions to care before Crown wardship was sought by CASs.

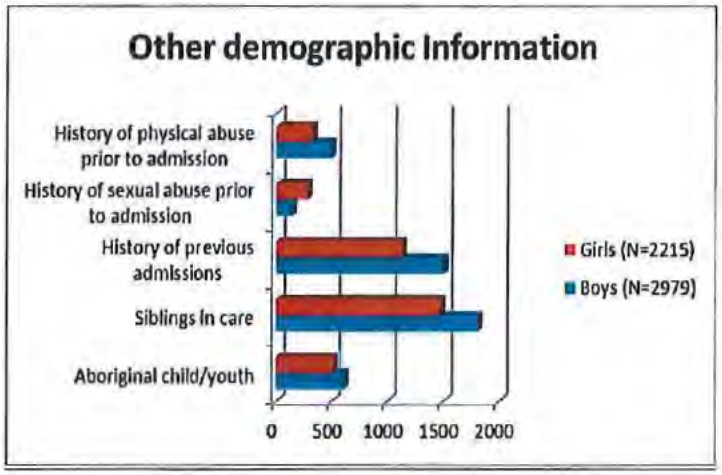


*includes caregiver mental health and substance abuse issues

- *Caregiver capacity was the primary reason for admission to care for both, boys (55%) and girls (53%).*
- *For girls, the 2nd most common reason for admission to care was physical or sexual harm (17%) followed by neglect (16%).*
- *For boys, the 2nd most common reasons for admission to care were physical or sexual harm (15%) and abandonment/separation (15%).*

2.1.4 *Other Demographic/Background Information*

The graph below shows additional background information about the children reviewed in 2010. Of the 5,194 children reviewed, boys were over-represented at 57% of the review population which is consistent with the Crown ward review findings since 2000. Further, the proportion of Aboriginal children and youth (22%) is consistent with the 2008 and 2009 Crown ward review findings.



- Approximately half of all Crown wards experienced previous admissions to care before a Crown wardship order was sought by a CAS.
- 63% of children had at least one sibling in care with girls (67%) more likely than boys (61%) to have a sibling in care.
- 13% of girls versus 5% of boys reviewed had a history of sexual abuse prior to admission to care.
- 17% of boys versus 15% of girls reviewed had a history of physical abuse before admission to care.

2.1 Child Well-Being

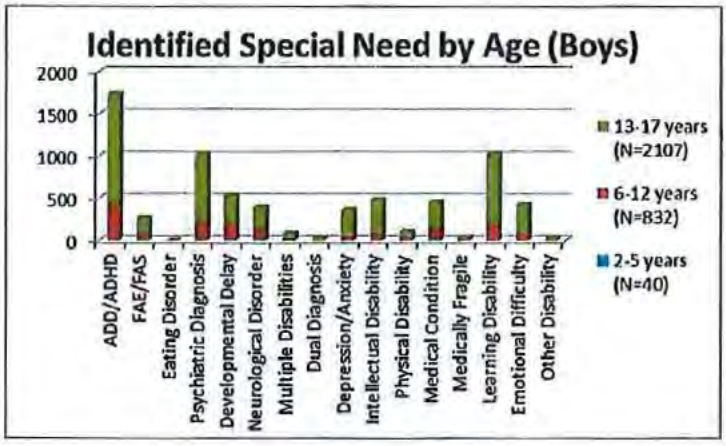
The following section provides information about various aspects of child well-being for Crown wards reviewed, including identified "special needs" and "behavioural support needs", educational progress, involvement in criminal activity, along with a subsection related to continuity of relationships, spiritual and cultural identity for Aboriginal Crown wards.

2.2.1 *Identified Special Needs*

The *Child and Family Services Act (CFSA)* defines a special need as " a need that is related to or caused by a behavioural, emotional, physical, mental, or other disability". A child is identified as having a special need if there has been a diagnosis made by a health or mental health professional. For reviews conducted using the 2010 and prior instrument, diagnoses of autism or Tourette's syndrome are subsumed under the catergory "neurological disorder". Conduct disorder, oppositional defiant disorder and obsessive-compulsive disorder are classified as "psychiatric disorders" and are separated out from diagnoses of "depression/anxiety". The category "medical condition" is comprised of chronic medical issues that interfere significantly with a child's daily functioning, e.g. asthma, enuerisis. "Other" refers to any diagnosis that does not fit into one of the categories listed in the graphs below.

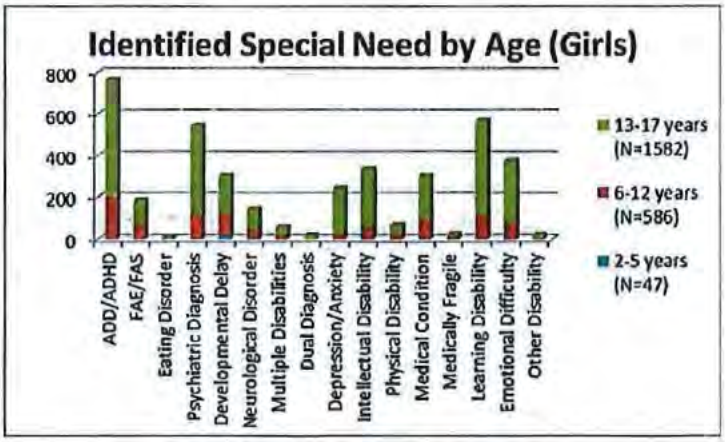
The graphs below illustrate the prevalence of all special or behavioural needs for Crown wards reviewed in 2010, whether primary or secondary, by child age and sex. Previous Crown ward review summary reports have reported the frequency of primary special and behavioural support needs only, for the review population as a whole. Whether "primary" or "secondary", understanding the prevalence in the Crown ward population provides a more accurate profile of the needs of Ontario's Crown wards.

The graphs below illustrate the prevalence of all special needs for Crown wards reviewed in 2010 broken down by age at the time of the review. Consistent with the 2008 and 2009 findings, **82%** of all Crown wards reviewed had at least one special need identified (N=4280).



- A higher percentage of younger boys between 2 and 6 years were diagnosed with developmental delay (43%), neurological disorder (35%) and medical condition (33%).
- 54% of boys between 6 and 12 years versus 61% of adolescent boys had a diagnosis of ADD/ADHD.

- A higher percentage of younger girls between 2 and 6 years were diagnosed with developmental delay (38%), neurological disorder (19%) and medical condition (15%).
- 35% of girls between 6 and 12 years versus 36% of adolescent girls had a diagnosis of ADD/ADHD.



Important Fact about Crown wards with Special Needs

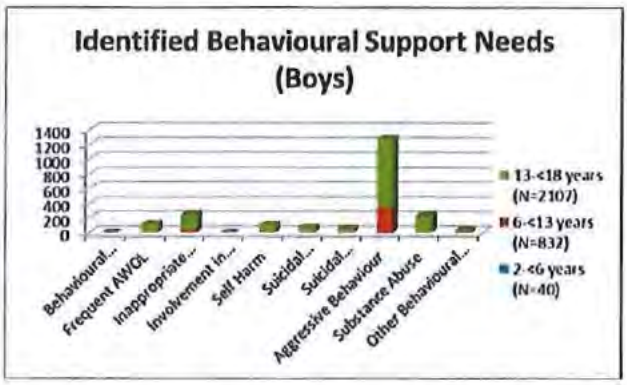
Compared to their elementary school-aged counterparts, adolescent Crown ward boys and girls presented with more frequent diagnoses of special needs as evidenced by the higher proportion of children with psychiatric diagnosis, depression/anxiety, emotional difficulties and identified learning and intellectual disabilities.

2.2.1.2 Behavioural Support Needs

Behavioural support needs refer to behaviour that presents a risk to the child or others. For example, "aggressive behaviour" includes all types of aggression towards others, such as physical assault, verbal attacks, fire setting, stealing, or other harm to others.

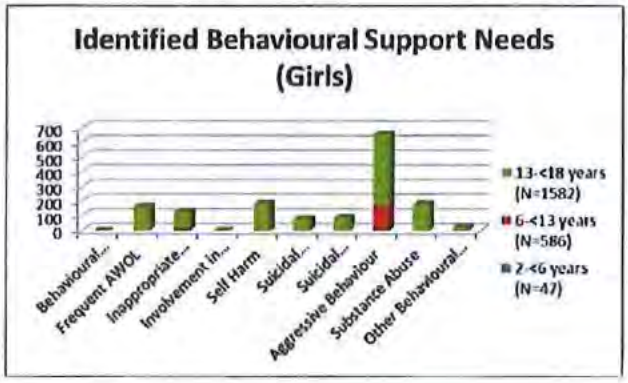
The graphs below present the data stratified by child sex and age at the time of review. Controlling for age is particularly important as many of the behavioural support needs documented by the review apply predominantly to older children, e.g. a very young child is extremely unlikely to display suicidal behaviour or substance abuse issues.

Overall, **42%** (N=2196) of Crown wards reviewed had at least one identified behavioural support need. When compared to 2008 and 2009, the percentage of Crown wards with one identified behaviour support has continued to decrease slightly from **45%** in 2008 to **43%** in 2009.



- Aggressive behaviour was the predominant concern across all age groups - 10% of boys between 2 and 6 years, 42% of boys between 6 and 13 years and 44% of adolescent males between 13 and 18 years.
- 10% of adolescent boys engaged in frequently running from placements.
- 11% of adolescent males engaged in self-harm and 5% of adolescent boys presented with suicide ideation or gestures, both current and historical).

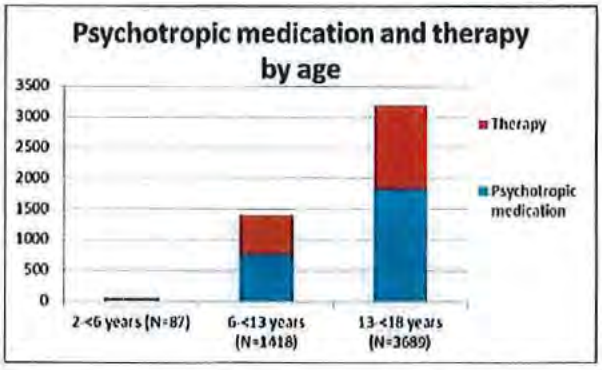
- Aggressive behaviour was also the predominant concern across all age groups – 15% of girls between 2 and 6 years, 29% of girls between 6and 13 years and 30% of adolescent females between 13 and 18 years.
- 6% of girls engaged in frequently running from placements.
- 5% of adolescent females engaged in self-harm and 3% of adolescent girls presented with suicide ideation or gestures, both current and historical.



2.2.1 Psychotropic Medication and Therapy

As part of the review, Crown ward reviewers document whether or not a child is currently taking any kind of prescribed psychotropic medication such as Ritalin, anti-psychotics, anti-depressants, etc. Reviewers also document whether or not the child is actively engaged in any kind of therapy. Therapy may include any specialized services that address the child's special needs such as art and music therapy, occupational and physical therapy and specialized treatments such as Applied Behavioural Analysis / Intensive Behavioural

Intervention. The graph below shows that number of children who were taking psychotropic medication and receiving therapy by age.

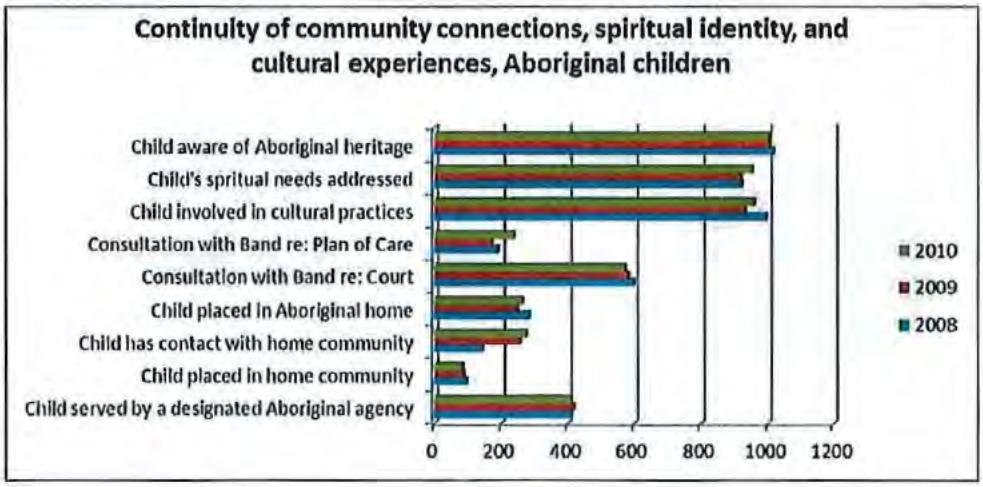


- 50% of all children (58% of boys and 39% of girls were taking psychotropic medication, with a greater proportion of older children compared to younger children of both sexes using medication.
- 40% of all children (41% of boys and 38% of girls) were engaged in therapy.
- Boys were more likely than girls to be engaged in therapy across all age categories.

2.2.2 *Connection to Community, Culture and Spiritual Identity: Aboriginal Children and Youth*

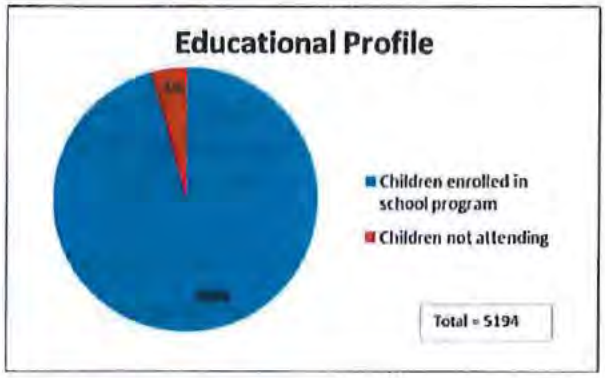
The graph below highlights standards and practices designed to promote cultural, linguistic and spiritual continuity for Aboriginal Crown wards, with data provided from 2008 to 2010. The placement of Aboriginal children within Aboriginal homes, and/or their home communities supports ties with important people in their lives and with their cultural, linguistic and spiritual identity, and has been recognized as a best practice for some time. As noted in the chart below, placing children in Aboriginal homes or in their home communities requires further attention as does ensuring that Aboriginal children maintain contact with their home communities.

Although there is relatively high compliance with standards regarding exposure to cultural and spiritual practices, the data collected does not speak to the quality or frequency of these experiences. Overall, while the rate of adherence to most standards and practices has either remained materially unchanged or, improved in the case of certain standards/practices (i.e. contact with home community; consultation with Band regarding the plan of care), data clearly shows that there is still work to be done to better support the provision of culturally-based care and services for Aboriginal Crown wards.

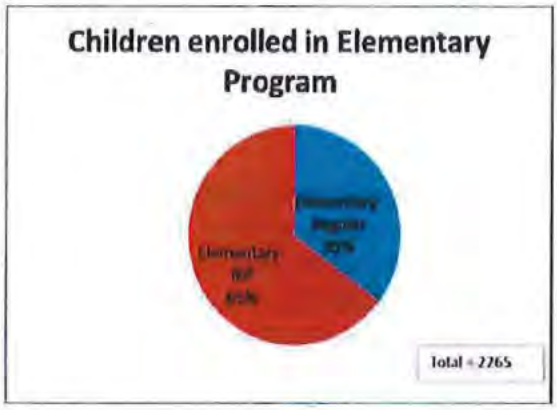


2.2.3 *Educational Profile*

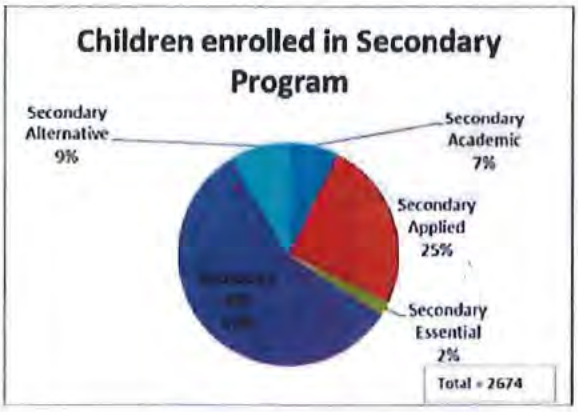
The table below outlines the educational profile of Crown wards. The majority were enrolled in and attending a school program (96% of all Crown wards). The high number of children requiring an Individual Education Plan (IEP) indicate that Crown wards experience academic difficulties and require additional supports to manage in the school system.



- Children not enrolled in school were either too young (i.e. toddlers and pre-schoolers), or not attending school despite the legal requirement to do so.



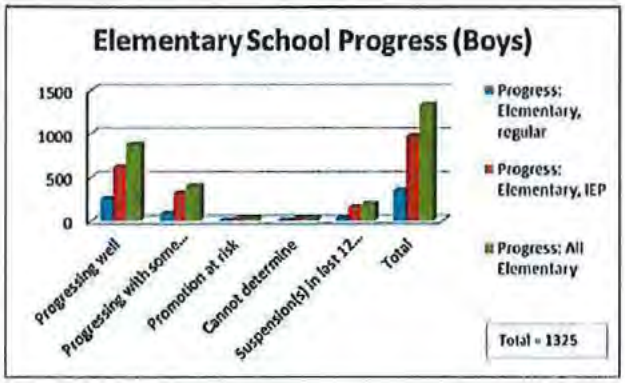
- Overall, 49% of children enrolled in a school program were the subject of an Independent Placement Review Committee (IPRC).
- The majority of children and youth at both the elementary (65%) and secondary level (57%) required an Individual Education Plan (IEP) to assist them to succeed in the school system.

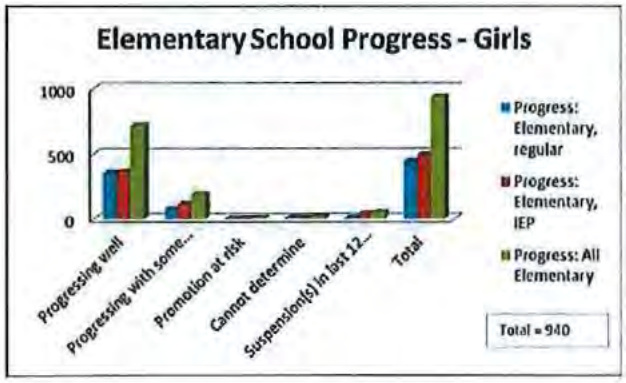


- The lower percentage of youth enrolled in a regular elementary program (35%) or the secondary academic (7%) or applied streams (25%) – those streams which allow youth to proceed to university or college – likely limit options for Crown wards to obtain a post-secondary education.

2.2.3.1 Elementary School Progress

The graphs below outline progress of children enrolled in an elementary school program, stratified by child sex and the nature of the program that they were following. Overall, 70% of all children enrolled in an elementary school program were "progressing well" academically with a higher proportion of children enrolled in the regular program (76%) identified in this way compared to those following an IEP (67%).

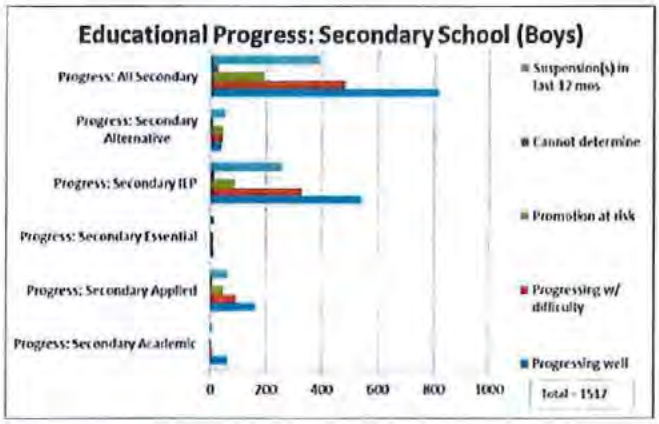




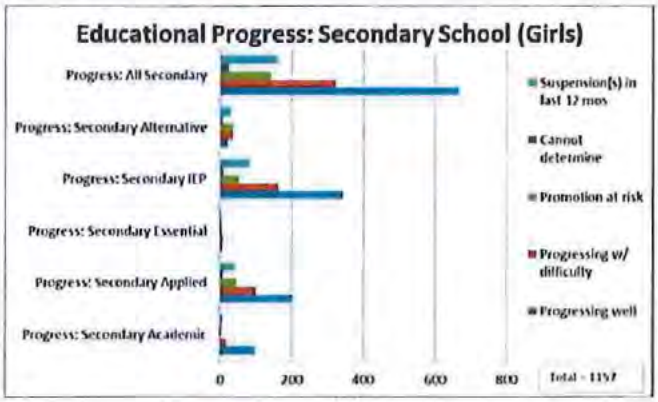
- Overall, 28% of children enrolled in an elementary school were progressing with difficulty or their promotion was at risk.
- 32% of boys experienced some or significant difficulties with academic progress ("progressing with some difficulty" or "promotion at risk") compared to 21% of girls.
- 34% of boys following an IEP were experiencing some or significant difficulties and were also the group most likely to have been suspended at least once in the 12 months prior to the review (16%).
- In general, boys were more likely than girls to be struggling academically and to have been suspended.

2.2.3.2 Educational Progress, Secondary School

The graphs below present data regarding the progress of children enrolled in secondary school, stratified by the type of program and by child sex. Overall, 55% of children enrolled in secondary school were "progressing well" academically, a notably lower rate than their elementary school counterparts (70%). The group with the highest proportion of children progressing well towards promotion (81%) was youth enrolled in the "academic" program, with only minor differences between the progress of girls and boys.



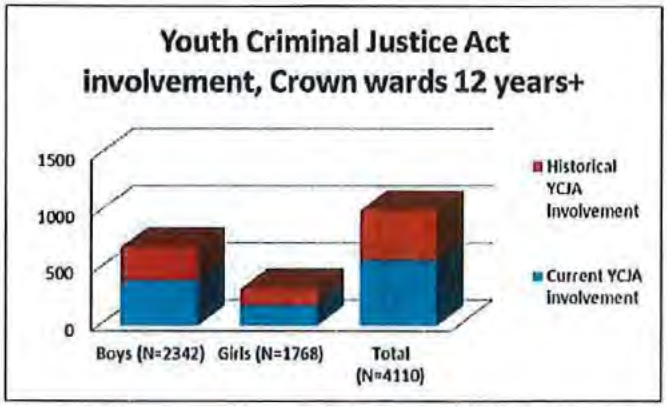
- 43% of youth enrolled in a secondary school program were either progressing with difficulty or their promotion was at risk compared to 28% of elementary school-aged children.
- The data illustrates Crown wards experience increased academic difficulties at the secondary school level, which aligns with the higher proportion of adolescent Crown wards diagnosed with learning and intellectual disabilities.
- These difficulties likely present barriers to graduating from high school for these Crown wards.



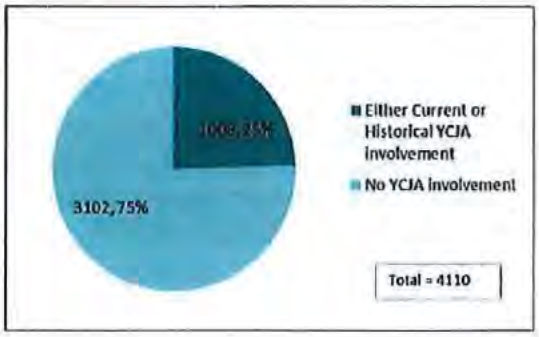
- Boys (35%) enrolled in the "essential" program appeared to be the most vulnerable group whereby their promotion was at risk. 45% of boys in this program had also been suspended from school.
- Crown wards enrolled in the "alternative" program were also experiencing a high rate of academic difficulties (promotion at risk for 32% of boys and 36% of girls) and of school suspensions (39% of boys and 28% of girls), the highest rate for girls across any of the school programs.

2.2.4 *Involvement in Criminal Activity*

Involvement in criminal activity provides information about youth behavioural well-being. The Crown ward review collected information about involvement under the *Youth Criminal Justice Act* (YCJA), including criminal charges, custody, community service or probation orders, both historical (prior to the review period) and current (during the review period). Data are collected using these as mutually exclusive categories (i.e. if a child has both current and historical involvement, s/he is counted as "currently" involved only).



- A higher proportion of boys compared to girls have either current (17% of boys versus 10% respectively) or historical (12% versus 8%) YCJA involvement.
- Overall, 25% of the Crown wards reviewed have been involved in the youth justice

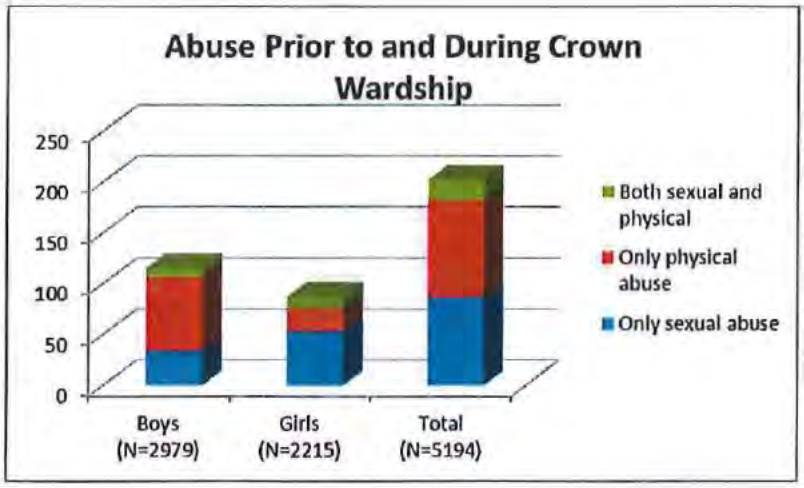


2.3 Safety

Child safety is a critical outcome of the child welfare system. The Crown ward review provides information about maltreatment experienced by Crown wards in care both prior to and during Crown wardship as well as children assessed as "high risk", both indicators of safety for children in care. Further, the review documented the number of children for whom a "serious occurrence" report has been filed in the 12 months prior to the review. Serious occurrences are often (although not always) related to events that compromise children's safety such as injuries, reports of maltreatment by caregivers, and risky behaviours such as running from placement.

2.3.1 Maltreatment while in care prior to and during Crown wardship

It is important to note two things about the data presented. First, they are <u>not</u> incidence data (i.e. data do not indicate the number of *new* instances of abuse during the period under review). Rather, data show the number of children who have *ever* been abused since their admission to care and during their time as Crown wards. Second, the perpetrator of the abuse is not necessarily the child's caregiver in the resource (e.g. foster parent / group home staff). Children are counted as abused during Crown wardship if the abuser is a family or community member and whether or not the abuse takes place in the placement, in the community (e.g. in a daycare or other service setting), or while home on an access visit. The common feature across all perpetrators is that they must have been in a caregiving capacity.

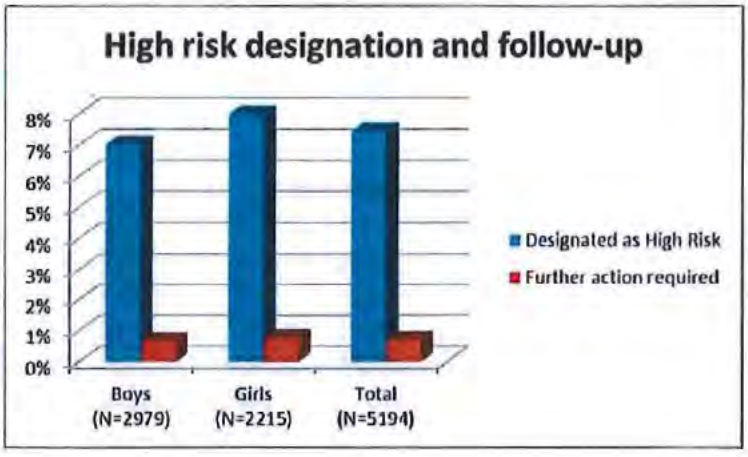


- The prevalence of any abuse since admission to care is ~4%.
- The data also illustrates a higher rate of sexual abuse for girls (2.4%) compared to boys (1.1%) and an increased incidence of physical abuse for boys (2.4%) compared to girls (1.0%).

As the population of children reviewed includes many of the same children from year to year, and the annual incidence of abuse (the number of Crown wards newly abused during any given year) is low, the proportion of Crown wards reviewed who have experienced abuse since admission to care has remained stable over time.

2.3.2 *High Risk Designation*

Children are designated "high risk" when there are significant concerns about harm to themselves or others. For a full description of the high risk designation, see page 6. The Table below shows the proportion of children identified as high risk through the 2010 review, broken out by child sex. In previous years' reports, only the total for all children was reported (9% in 2009 and 8% in 2008); the corresponding statistic in 2010 is 7% of all children reviewed.



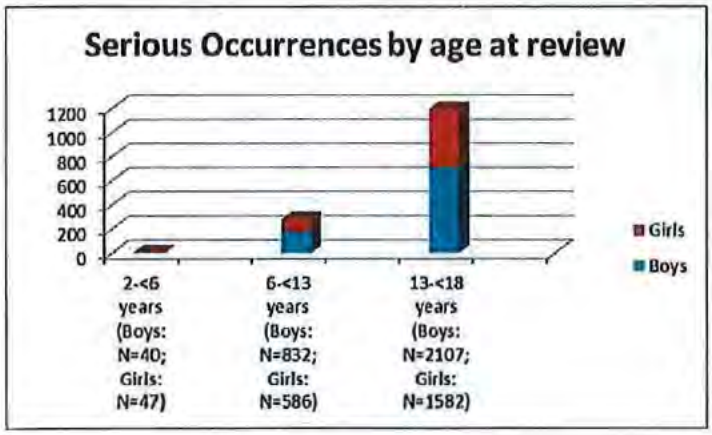
- The proportion of girls identified as "high risk" (8%) is similar to that of boys (7%).
- Based on analysis (not shown) on adolescents, the results indicated that 11% of adolescent girls (aged 13 to 17.9) and 9% of teenaged boys were identified as "high risk".
- Consistent with previous years' findings, 10% of children identified as high risk (37 of the 386 "high risk" Crown wards) were assessed as requiring further planning and safeguarding by the CAS.

2.3.3 Serious Occurrences

Service providers who deliver any direct service to children and youth under the *Child and Family Services Act* must inform the ministry when there is an incident involving a child in care that is deemed by the provider to be serious. Serious occurrences are comprised of the following eight categories of events:

1. Any death of a client which occurs while participating in a service. For CASs, this applies only to children in care at the time of death and children who received service in the prior year.
2. Any serious injury to a client.
3. Any alleged abuse or mistreatment of a client by staff, volunteers or others associated with providing the service which occurs while participating in a service.
4. Any situation where a client is missing in accordance with ministry requirements and any applicable legislative requirements.
5. Any disaster on the premises where a service is provided, that interferes with daily routines (e.g., fire, flood, etc.)
6. Any complaint about the operational, physical or safety standards of the service that is considered serious by the service provider.
7. Any complaint made by or about a client, or any other serious occurrence involving a client that is considered by the service provider to be of a serious nature.
8. Any use of a physical restraint of a client in a residence licensed as a children's residence under the *Child and Family Services Act* or that results in a) no injury, b) injury, c) allegation of abuse.

Table 18 below outlines the number of children on whose behalf a serious occurrence report was filed in the 12 months prior to the review. Some children may have had more than one serious occurrence report in this time period. The review does not document the nature of the serious occurrence.



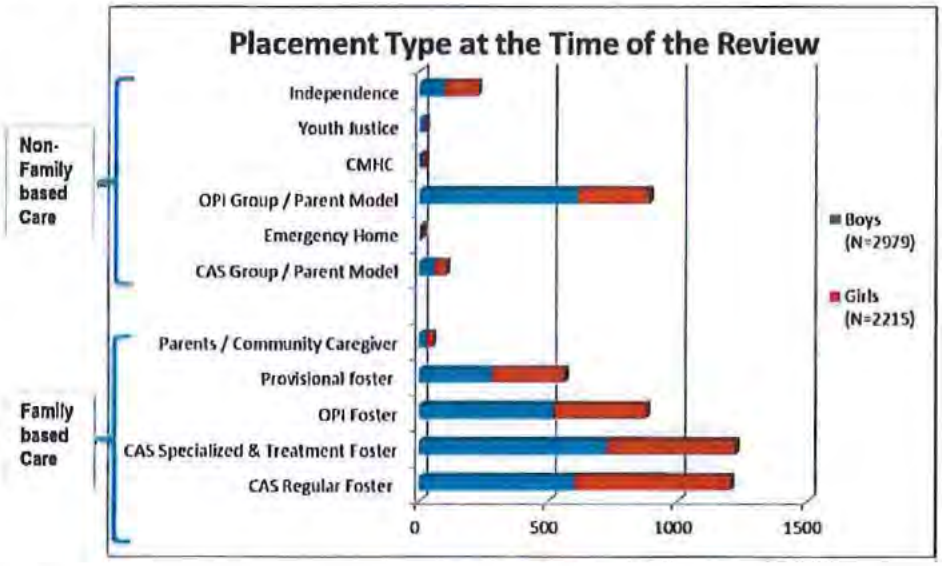
- Overall, 29% of children reviewed were the subject of at least one serious occurrence report in the review period.
- Overall, boys were more likely than girls to have at least one serious occurrence (30% compared to 20% respectively).
- Adolescents were considerably more likely than younger children to be subject of a serious occurrence.

2.4 Permanency

Permanency planning in child welfare has been a focus of the field for the last several decades. The following section explores the findings of the 2010 Crown ward review with respect to multiple measures of permanency, including the nature of permanency plans, placement stability, and continuity of relationships with birth families and child welfare workers. This section also includes the current placement type for the Crown wards reviewed.

2.4.1 Current Placement Type

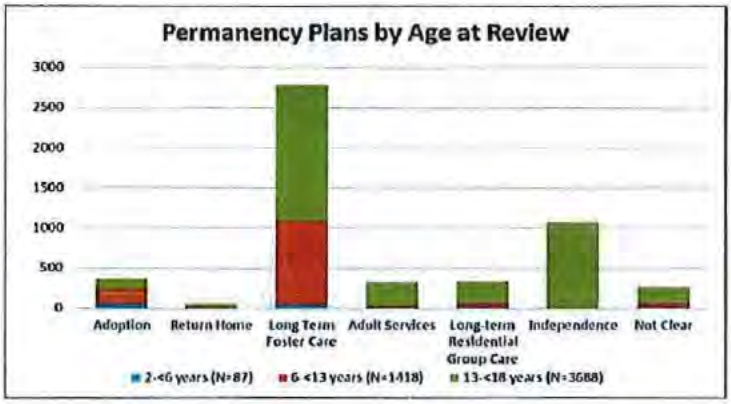
Family based care is generally accepted as the most appropriate placement type for the majority of children in care. Placement in family-based settings and the critical role that families and consistent caregivers play in children's development is particularly important for Crown wards – many of whom will spend several years in care.



- As illustrated in the chart above, when the various forms of family based care are bundled together (i.e. all forms of foster care plus children living with their parents, relatives or community members), 75% of all Crown wards reviewed were placed in a form of family based care at the time of review.
- Further analysis (not shown) revealed that the rate of family based care for children 12 and under at the time of review was 94% for girls and 87% for boys, indicating a higher use of family based care for younger Crown wards.
- Girls (79%) were more likely to be placed in family-based care than boys (73%).
- Placement in group home settings (both CAS and outside purchased combined) was less likely for girls (14%) compared to boys (23%).
- Girls were more likely to be living in a provisional foster (e.g. kinship) home at the time of review (13%) compared to boys (9%) and twice as likely to be living independently (6% compared to 3% of boys).

2.4.2 Permanency Plans

The Crown ward review collects data regarding the permanency plan in place for all children reviewed. The permanency plan reflects the CAS's aspiration for the child with respect to the most appropriate living arrangement over the longer-term. The chart below provides data about children's permanency plans at the time of review by age category. This method provides an understanding of the differences across developmental stages as some plans are more typically sought and completed for younger versus older children and vice versa. Overall, 54% of children have long term foster care as their permanency plan. This percentage is consistent with the findings from the 2008 and 2009 Crown ward reviews. The plan for children to remain in long term residential group care decreased from 8% in 2008 and 2009 to 6% in 2010.



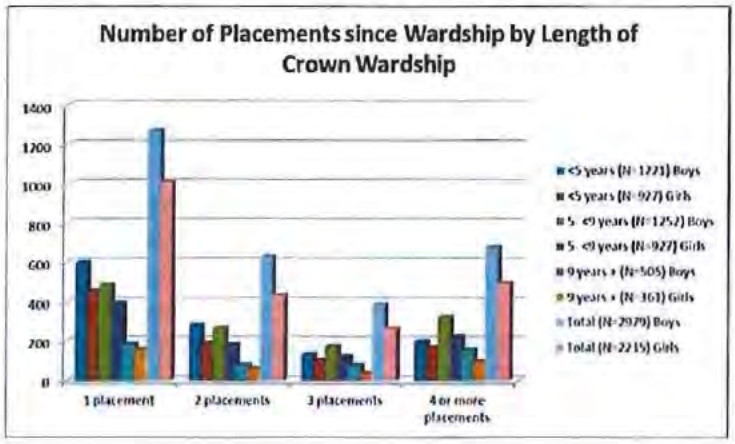
It is important to note that this data is not representative of permanency plans for all children who become Crown wards, as it does not include children who are recent Crown wards, or those children who were discharged to a permanent placement within the review period.

- The permanency plan for children under the age of six (53%) was adoption; the plan for a further 41% was long term foster care.
- For children aged 6 to 12.9 years, the majority of permanency plans were for long term foster care (74%), with an adoptive home being sought for 14% of children, and long term group care for 5% of these children.
- The plan for the majority of adolescents was to remain in long term foster care (46%) or proceed to independence (29%).
- Adult services was the permanency plan for 8% of teenagers and long term residential group care was the long term plan for 7% of teens.

2.4.3 Placement Stability

Research indicates that placement stability is important for children to develop and maintain healthy, secure relationships with family, peers and the community. The importance of minimizing placement changes as part of permanency planning is well documented in research studies. A stable placement experience promotes attachment to a single primary caregiver, which is a critical outcome of early child development. While some placement changes may be beneficial, research indicates that multiple and unplanned placements are associated with negative outcomes for children, including increased behaviour problems, poor academic performance and mental health difficulties.

The graph below show the number of placements since Crown wardship by categories (one placement, two placements, three placements and four or more placements) and stratifies the data by length of Crown wardship and sex of the child.

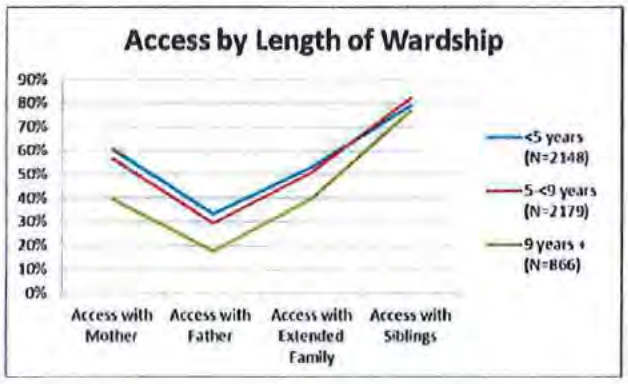


- Overall, 43% of boys and 46% of girls had one placement since Crown wardship.
- Girls were more likely than boys to have had only one placement across all lengths of Crown wardship.
- As length of Crown wardship increases, the likelihood of having only one placement decreases.

Data (not shown) indicate that the younger the child at Crown wardship, the greater the likelihood of placement stability even after controlling for length of Crown wardship. For example, for children who had been Crown wards for the longest (9 years or more, N=345), of those children who became Crown wards under the age of one, 53% were still in their initial placement. This proportion declines to 45% for those who became Crown wards between the ages of 1 and 5 years, and to 28% when the age at wardship was between 6 and 8.9 years.

2.4.4 Access to Parents, Extended Family and Siblings

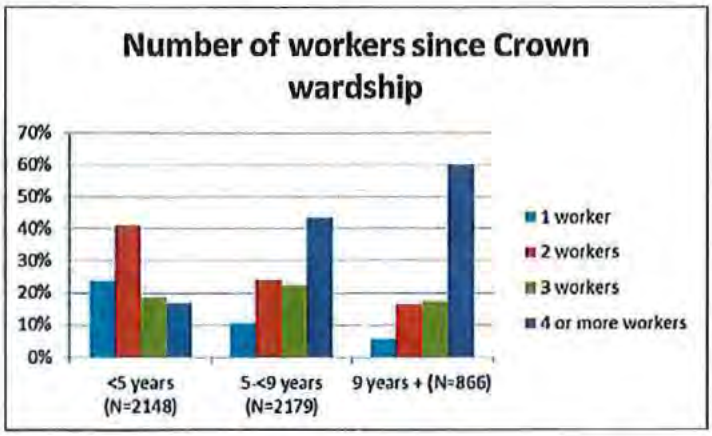
The graph below shows the proportion of children who exercised access with mothers, fathers, siblings and extended family, stratified by length of wardship. Overall, 91% of children exercised some form of access with their families, with a small minority of children (11%) maintaining access with each of mothers, fathers, siblings and extended family.



- Overall, 91% of children exercised some form of access with their families, with a small minority of children (11%) maintaining access with each of mothers, fathers, siblings and extended family.
- Children who were Crown wards for 9 years or more had the lowest rates of access with mothers (39%) and fathers (18%).
- Overall, access is significantly more likely to be exercised with mothers (55%) compared to fathers (18%).
- 80% of all children reviewed, regardless of length of wardship, maintained access/ contact with their siblings.
- Children who were Crown wards for 9 years or more also had less access with extended family (40%) compared to children who were Crown wards for 5 years or less (53%).

2.4.5 *Worker Continuity and Contacts*

The graph below shows the number of workers since Crown wardship for children reviewed, by length of wardship duration.



- The average worker duration was 2.4 years.
- The likelihood of having had the same caseworker since Crown wardship diminishes with time, with 23% of children who were Crown wards for less than five years having one caseworker compared to 6% of children who were Crown wards for 9 years or more.
- 60% of children who were Crown wards for more than 9 years had four or more caseworkers compared to 17% of children who were Crown wards for less than 5 years.

The average number of caseworker visits per child was 12 with a minimum of 1 and a maximum of 53 visits on a case-by-case basis.

2.4.6 *Independence Planning*

Adolescent Crown wards require services that specifically focus on preparing them for independence, or the cases of children with significant disabilities, a transition to adult services. The Crown ward review collects data with respect to independence planning for youth 15 years or older across a number of domains. A reviewer indicates that there is a need for improvement when no plan exists to assist young people with the following:

- Social development;
- Vocational training;
- Employment training;
- Life skills;
- Extended care and maintenance plans for youth who wish to receive ongoing financial support from a society past their 18th birthday; and
- Adult support for youth with significant physical and/or developmental challenges who will be unable to live independently as adults.

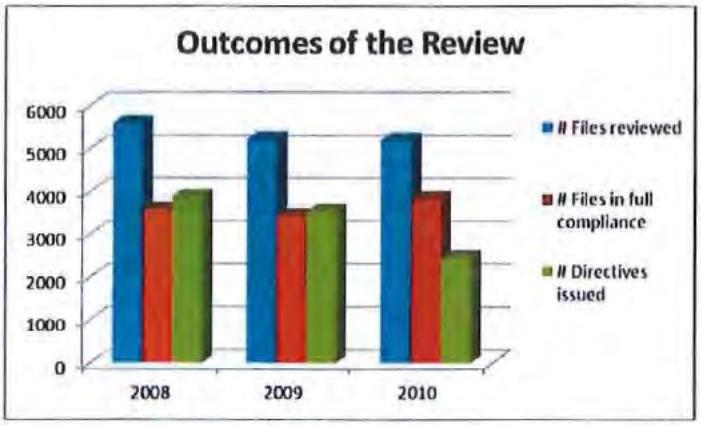
The graph below provides data on the number of children for whom the type of planning was applicable.

- The data indicates that some areas of independence planning of youth aged 15 years or more (N=2,546) require some improvement, particularly in the areas of vocational and employment training, and planning around extended care and maintenance, now known as Continued Care and Supports for Youth.

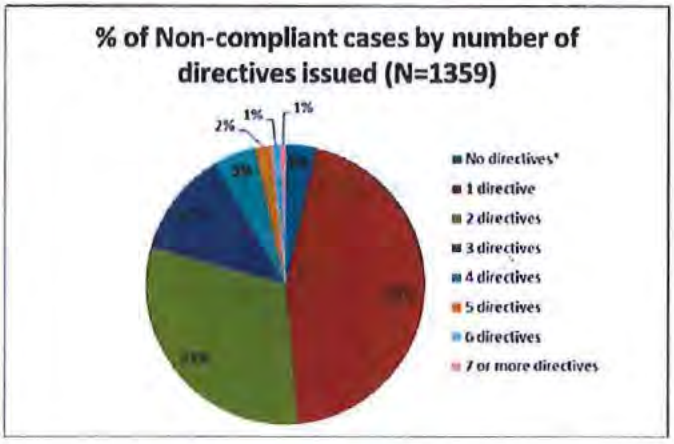
2.5 Legislative Compliance Results

2.5.1 Overall Compliance Rates

A file is in full compliance when all statutory requirements are met – i.e., no directives have been issued. Another way of contextualizing "full compliance" with statutory requirements is to examine the distribution of cases by the number of directives issued.



- Of the 5,194 cases reviewed in 2010, 74% of cases were in full compliance, an increase of 10% since 2008, where 64% of cases were in full compliance.
- The number of directives issued decreased by 37% between 2008 and 2010, from 3886 in 2008 to 2467 in 2010.

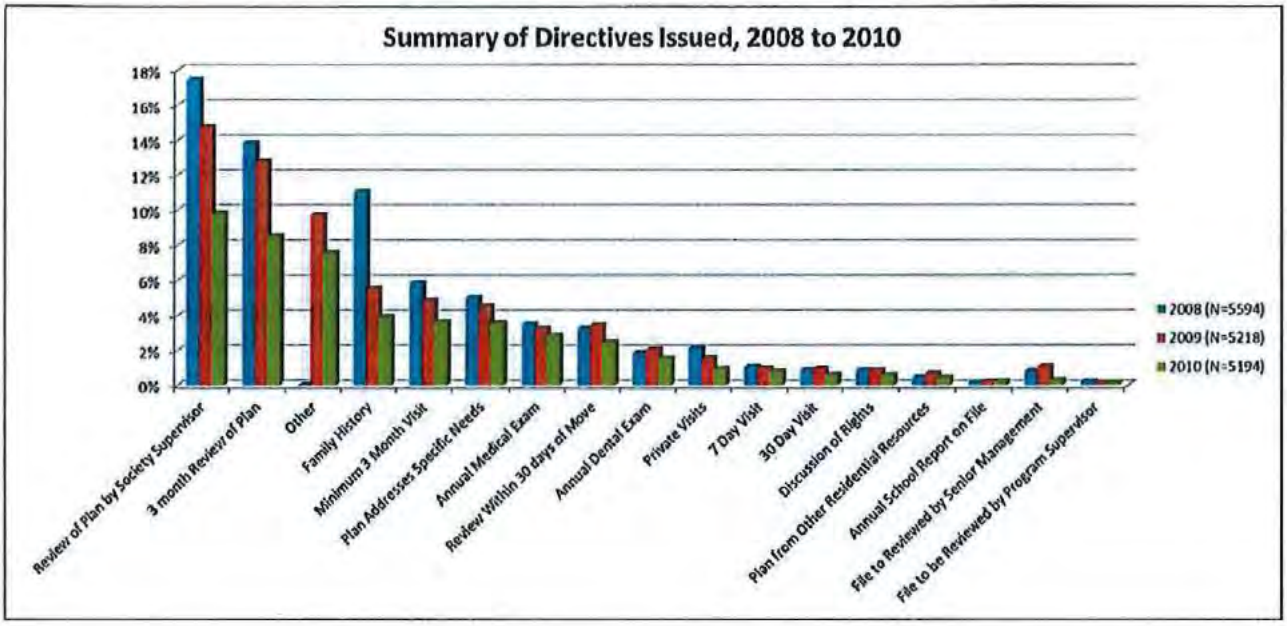


- Almost half (49%) of cases reviewed had either no directives* or one directive issued.
- 21% of cases reviewed had three directives or more issued.

*Cases that are non-compliant and no directives are issued occurs when circumstances are beyond the control of a CAS, i.e. a youth refuses to attend a medical or dental appointment.

2.5.2 Directives Issued

Understanding the types of directives that were issued allows a society to target service areas for improvement. Certain directives have a trend of being more frequently issued than others over the course of several years. The graph below provides data on non-compliance by directive from 2008 to 2010, organised from highest frequency to lowest frequency in 2010.



- With the exception of the category "other" directives, the relative frequency of directives issued in 2008, 2009 and 2010 has not changed, with Review of the Plan by Supervisor, 3 Month Review of Plan of Care, and Child's Family History remaining the most frequently issued directives.
- The percentage of files in compliance with statutory requirements regarding visits with children, including 7 day visits, 30 day visits and minimum 3 month visits has been consistently high over the last several years. However, as noted in previous reports, these are minimum requirements for visiting with children and youth in care, therefore compliance is expected to be high.
- The number of files referred for review by senior management significantly decreased from previous years (from 46 in 2008, 57 in 2009, to 16 in 2010. Cases are referred to senior management when Crown ward reviewers have significant concerns respecting case planning for children.
- Compliance rates by agency are provided for each requirement in Appendix B.

2.6 Summary of Findings

The data collected through the Crown ward review represent a rich set of information that can be used to understand better a population to whom the sector and the ministry have the highest obligation: to act as a parent would and provide Crown wards with every opportunity to reach their full potential. This report has provided an overview of the characteristics, needs and experiences of Ontario's Crown wards reviewed, including information about their well-being, safety and permanence while receiving care. The report has also highlighted the extent to which service to these children and youth is provided in accordance with the standards and requirements set out by legislation and regulations.

The current analysis has demonstrated the importance of applying a developmental lens in identifying the needs of the Crown ward population. Findings suggest that different events and constellations of needs are experienced by Crown wards at different developmental stages, with developmental and neurological issues particularly prevalent for the youngest children, and diagnoses of AD(H)D, psychiatric and other emotional issues, school and learning difficulties, and aggressive behaviour emerging as important issues requiring attention for older Crown wards. Separating out the analyses by child sex has also highlighted the specific struggles of boys compared to girls in the review population. In particular, adolescent boys emerge as a high needs population, struggling with high rates of AD(H)D, academic and school-related behavioural problems, and issues with aggression. Consideration needs to be given to how best to support all children and improve their trajectories as they transition to adulthood.

Other findings of the review have implications for practice. For example, data regarding permanency planning for Crown wards highlight the need to understand better why the permanency plan for so many children reviewed is long-term foster care despite a policy direction that emphasizes a wider range of permanency options. Although adoption may not be appropriate for some or many of these children, ensuring that all other options are explored (e.g. placement with kin, customary care for Aboriginal children and youth, legal custody) should be a focus of permanency planning.

Data from the 2010 review also demonstrate important improvements with respect to compliance with child-in-care standards. Not only has overall compliance improved, but compliance with respect to historically hard-to-meet standards has also increased. New analyses presented in the current report identify that while just over a quarter of cases are not in full compliance, almost half of those cases have either no or only one directive, emphasizing that the relative breadth of non-compliance for many cases is quite minor.

Despite this, further attention is required to some standards and practices, most importantly to those having to do with the care of Aboriginal children. For practices that are designed to promote cultural and spiritual identity and continuity, the findings indicate that further attention is required in the following areas: placing First Nations children in Aboriginal homes and in their home communities; and when this is not possible, ensuring that Aboriginal children and youth maintain contact with their First Nations (home) communities.

3. Results from the 2010 Adoption Probation Review

3.1 Introduction

The goal of the adoption probation review is to determine that an adequate plan of care is developed for Crown wards placed on adoption probation. The review is also intended to stimulate improvement in the overall service delivery to children.

The objectives of the adoption probation review are to:

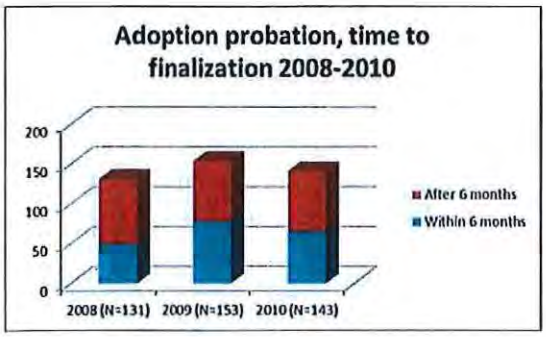
- Monitor compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward placed on adoption probation;
- Determine whether there has been an adequate assessment of the child's needs, a suitable placement, supporting services, and realistic planning for and with the child, as appropriate;
- Issue directives regarding non-compliance and to make and encourage and monitor implementation of recommendations about particular cases and general policy and practices; and
- Provide information to the society under review about best practices employed in other societies and jurisdictions.

3.2 Scope of the Review and Profile of Children Reviewed

In 2010, 143 children on adoption probation were reviewed, representing a decrease of almost 7% compared to 2009 data. Of the 143 children reviewed, 66 were boys and 75 were girls; data regarding child sex was missing for two children. The average age of children at the time of review was 8.7 years, an increase from 2009 where the average age was 8.2 years. The average age at Crown wardship for children reviewed was 5.2 years.

3.3 Adoption Finalization Findings

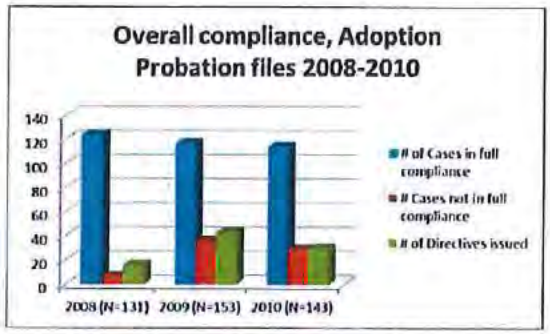
The graph below describes CAS plans for adoption finalization. An adoption probation period of at least six months is typically required before an adoption proceeds to finalization.



- In over half the files reviewed in 2010, adoptions were finalized after six months.
- The average length of time that a child was on adoption probation in 2010 was 11.1 months. This average is consistent with the findings of the 2009 adoption

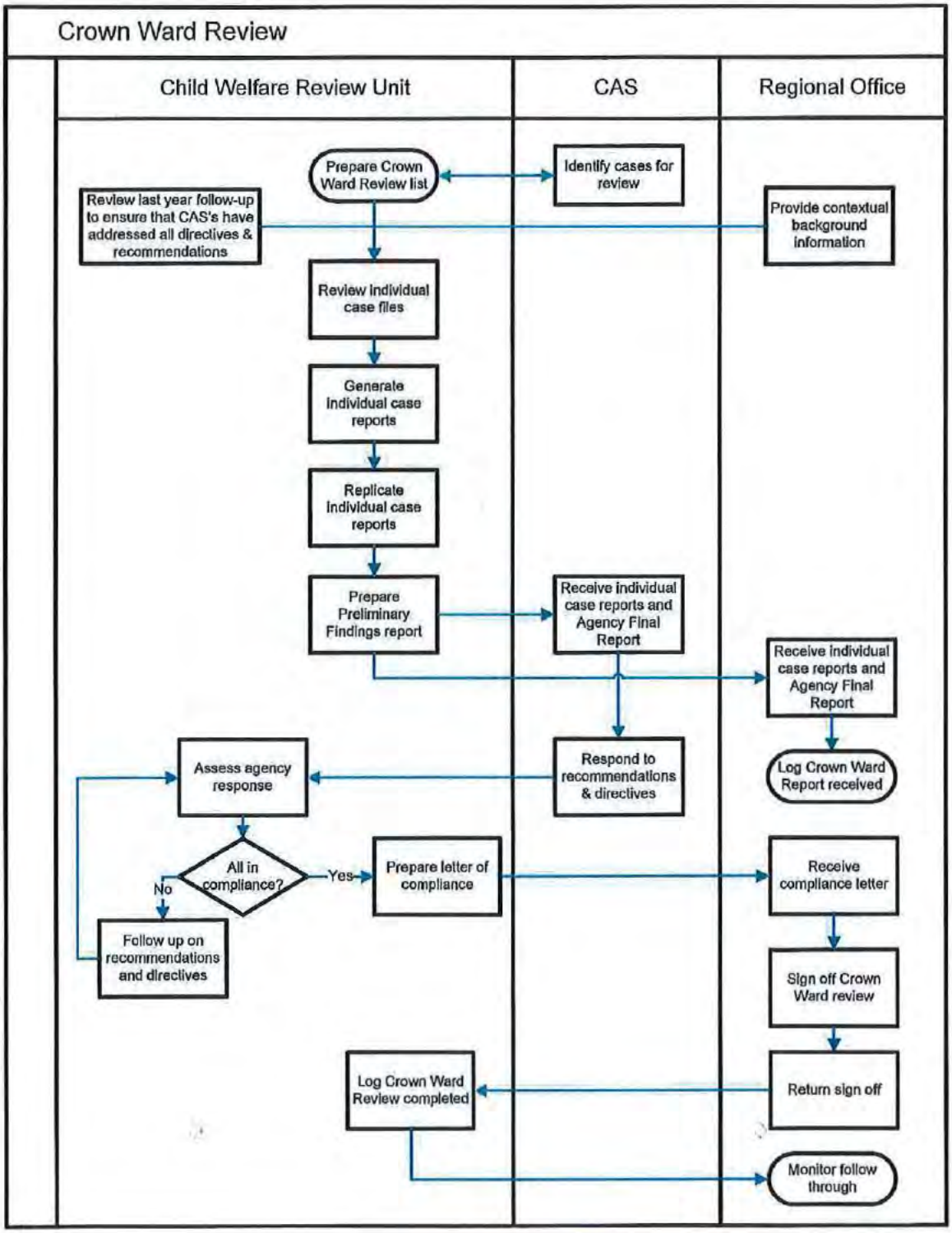
3.4 Overall Legislative Compliance

A directive is issued when a statutory requirement has not been met. As with the Crown Ward Review, the overall compliance rate is calculated by determining the number of cases in full compliance.



- The rate of compliance decreased significantly between 2008 and 2010 – from 95% to 76%, and then increased to 80% in 2010.
- Overall, 30 directives were issued in 2010 with an average of one directive per non-compliant file.

Appendix A: Crown Ward Review Process



Appendix B: Agency-by Agency Compliance, by Directive, 2010*

Region	CAS	Review POC-Sup.	Review POC-3 Month	Other	Child's Family History	POC Address Needs	Annual Medical	Review POC-30 Days Move	Annual Dental	Private Visits	7 Day Visit	Min. 3 Month Visit	30 Day Visit	Discuss Rights	POC-Other Res. Resource	Annual School Report
Central East	DURHAM	93.2%	94.2%	97.1%	94.5%	95.5%	99.0%	97.1%	99.7%	99.7%	98.1%	98.1%	98.4%	99.7%	100.0%	99.7%
	KAWARTHA-HALIBURTON	100.0%	100.0%	98.7%	96.2%	98.7%	100.0%	98.7%	98.7%	100.0%	98.7%	98.7%	100.0%	100.0%	100.0%	100.0%
	NORTHUMBERLAND	73.3%	73.3%	86.7%	96.7%	86.7%	96.7%	90.0%	100.0%	93.3%	96.7%	90.0%	96.7%	100.0%	96.7%	100.0%
	SIMCOE	79.1%	88.4%	91.5%	98.4%	99.2%	93.0%	96.1%	98.4%	99.2%	99.2%	97.7%	100.0%	99.2%	100.0%	98.4%
	YORK	92.6%	92.6%	92.6%	95.9%	98.6%	97.3%	98.6%	100.0%	99.3%	99.3%	96.6%	99.3%	100.0%	98.6%	100.0%
Central West	DUFFERIN	95.0%	95.0%	100.0%	60.0%	95.0%	95.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	HALTON	94.6%	94.6%	100.0%	100.0%	94.6%	98.2%	98.2%	100.0%	100.0%	100.0%	94.6%	100.0%	100.0%	98.2%	100.0%
	PEEL	92.0%	92.0%	99.1%	99.1%	96.5%	94.7%	100.0%	95.6%	100.0%	99.1%	100.0%	100.0%	97.3%	100.0%	100.0%
	WATERLOO	95.5%	95.5%	95.5%	98.9%	100.0%	100.0%	98.9%	100.0%	100.0%	98.9%	97.7%	98.9%	98.9%	100.0%	100.0%
	WELLINGTON	86.8%	86.8%	90.6%	100.0%	100.0%	96.2%	92.5%	98.1%	100.0%	98.1%	96.2%	98.1%	100.0%	100.0%	100.0%
Eastern	OTTAWA	93.4%	94.7%	76.3%	95.4%	96.7%	96.7%	96.1%	98.7%	100.0%	100.0%	95.4%	100.0%	99.3%	96.7%	99.3%
	PRESCOTT-RUSSELL	98.5%	98.5%	95.4%	96.9%	100.0%	98.5%	100.0%	100.0%	100.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%
	RENFREW	97.1%	98.0%	80.4%	83.3%	93.1%	94.1%	100.0%	97.1%	98.0%	100.0%	94.1%	99.0%	100.0%	100.0%	100.0%
	STORMONT	93.5%	93.5%	93.5%	92.9%	98.7%	96.8%	99.4%	98.7%	98.7%	100.0%	94.8%	100.0%	97.4%	100.0%	100.0%
Hamilton Niagara	BRANT	91.9%	94.1%	90.4%	98.5%	92.6%	95.6%	97.1%	99.3%	100.0%	99.3%	95.6%	98.5%	100.0%	100.0%	100.0%
	HALDIMAND-NORFOLK	87.0%	87.0%	96.3%	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	HAMILTON-WENTWORTH	99.6%	99.6%	98.8%	99.6%	98.8%	100.0%	100.0%	100.0%	99.6%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%
	HAMILTON-WENTWORTH CCAS	80.0%	80.0%	85.6%	94.4%	98.9%	92.2%	97.8%	98.9%	100.0%	98.9%	97.8%	100.0%	100.0%	98.9%	100.0%
	NIAGARA	81.5%	83.1%	96.6%	100.0%	96.6%	98.3%	98.9%	100.0%	100.0%	99.4%	98.9%	100.0%	100.0%	100.0%	100.0%
North East	PAYUKOTAYNO	60.0%	60.0%	100.0%	80.0%	96.0%	96.0%	96.0%	100.0%	92.0%	100.0%	92.0%	100.0%	100.0%	100.0%	100.0%
	JEANNE SAUVE	58.3%	58.3%	83.3%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	MUSKOKA	72.7%	81.8%	100.0%	100.0%	90.9%	90.9%	81.8%	90.9%	100.0%	90.9%	90.9%	90.9%	81.8%	100.0%	100.0%
	NIPISSING	98.6%	100.0%	93.0%	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%
	PORCUPINE	42.9%	50.0%	92.9%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	92.9%	100.0%
	TIMISKAMING	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Northern	ALGOMA	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	ANISHNAABE	89.0%	93.2%	87.7%	97.3%	91.8%	98.6%	95.9%	95.9%	95.9%	97.3%	95.9%	98.6%	95.9%	100.0%	100.0%
	DILICO	66.3%	68.7%	95.1%	99.4%	98.2%	100.0%	95.1%	100.0%	100.0%	98.8%	96.3%	98.8%	100.0%	100.0%	100.0%

* The provincial average in this Table is calculated as an average of each Society's performance, i.e. the sum of all Society's percentages divided by 53. As a result, the provincial average in this table does not match the percentages given in Table 27 (page 35), where the calculation is based on the percentage of all files reviewed, i.e. the number of directives issued, divided by the total files reviewed. The rationale for the different calculations in that in this Table, each *agency* should have a weight of "1" when calculating the provincial average for performance on each directive; in Table 27, each *file* should have a weight of "1" when calculating the percentage of files in compliance with each standard/requirement.

Appendix B: Agency-by Agency Compliance, by Directive, 2010*

Region	CAS	Review POC-Sup.	Review POC-3 Month	Other	Child's Family History	POC Address Needs	Annual Medical	Review POC-30 Days Move	Annual Dental	Private Visits	7 Day Visit	Min. 3 Month Visit	30 Day Visit	Discuss Rights	POC-Other Res. Resource	Annual School Report
	KENORA	86.4%	86.4%	72.7%	100.0%	95.5%	86.4%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	RAINY RIVER	100.0%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%
	SUDBURY	79.4%	83.0%	92.9%	97.9%	95.7%	95.7%	92.9%	99.3%	99.3%	100.0%	95.0%	97.9%	99.3%	100.0%	100.0%
	THUNDER BAY	89.9%	90.9%	97.0%	85.9%	97.0%	100.0%	99.0%	98.0%	100.0%	97.0%	93.9%	98.0%	100.0%	100.0%	100.0%
	TIKINAGAN	74.6%	80.3%	71.8%	90.1%	87.3%	95.8%	97.2%	97.2%	93.0%	97.2%	85.9%	98.6%	97.2%	98.6%	91.5%
	WEECHI-IT-TE-WIN FS	100.0%	100.0%	100.0%	92.9%	85.7%	85.7%	92.9%	100.0%	92.9%	100.0%	78.6%	100.0%	100.0%	100.0%	100.0%
South East	FRONTENAC	83.3%	85.6%	82.2%	94.4%	98.9%	86.7%	97.8%	96.7%	90.0%	100.0%	80.0%	100.0%	98.9%	98.9%	100.0%
	HASTINGS	92.1%	92.6%	93.7%	94.2%	86.3%	96.8%	97.9%	99.5%	100.0%	100.0%	98.4%	99.5%	100.0%	99.5%	99.5%
	LANARK	97.6%	100.0%	87.8%	100.0%	100.0%	97.6%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	LEEDS-GRENVILLE	94.1%	98.0%	98.0%	100.0%	96.1%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%
	LENNOX	85.7%	85.7%	95.2%	100.0%	100.0%	100.0%	95.2%	100.0%	97.6%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%
	PRINCE EDWARD	89.7%	89.7%	93.1%	93.1%	100.0%	100.0%	100.0%	96.6%	100.0%	100.0%	93.1%	100.0%	100.0%	100.0%	100.0%
South West	BRUCE	94.1%	94.1%	55.9%	82.4%	88.2%	94.1%	94.1%	91.2%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%
	CHATHAM-KENT	75.4%	76.9%	95.4%	100.0%	98.5%	93.8%	95.4%	95.4%	100.0%	100.0%	95.4%	100.0%	100.0%	100.0%	100.0%
	ELGIN	97.1%	97.1%	100.0%	100.0%	91.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	GREY	61.2%	63.3%	83.7%	89.8%	100.0%	91.8%	91.8%	89.8%	98.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%
	HURON-PERTH	98.0%	98.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	SARNIA LAMBTON	100.0%	100.0%	92.9%	100.0%	97.6%	100.0%	100.0%	97.6%	97.6%	95.2%	97.6%	100.0%	97.6%	100.0%	100.0%
	LONDON & MIDDLESEX	85.9%	88.0%	87.3%	95.8%	97.5%	96.5%	96.8%	95.4%	99.3%	98.6%	95.1%	98.9%	99.6%	98.2%	99.3%
	OXFORD	98.6%	100.0%	90.4%	98.6%	100.0%	93.2%	98.6%	100.0%	98.6%	97.3%	98.6%	98.6%	100.0%	100.0%	100.0%
	WINDSOR	93.0%	95.0%	93.0%	97.0%	95.5%	95.5%	97.0%	95.5%	100.0%	99.5%	98.5%	99.5%	99.5%	99.5%	100.0%
Toronto	JF&CS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	NATIVE CHILD & FAMILY SRVS.	91.5%	94.9%	93.2%	100.0%	100.0%	98.3%	94.9%	100.0%	98.3%	98.3%	96.6%	98.3%	100.0%	100.0%	100.0%
	TORONTO	97.1%	97.5%	96.9%	98.4%	97.7%	98.0%	98.4%	98.2%	98.6%	99.6%	97.3%	99.8%	99.8%	100.0%	100.0%
	TORONTO CATHOLIC	97.0%	97.4%	91.4%	91.7%	93.7%	98.7%	99.0%	98.7%	99.3%	99.3%	96.7%	99.7%	98.0%	99.3%	100.0%
PROVINCE		88.2%	89.6%	92.0%	95.6%	96.6%	96.7%	96.8%	98.5%	98.8%	99.1%	95.8%	99.4%	99.2%	99.5%	99.8%

* The provincial average in this Table is calculated as an average of each Society's performance, i.e. the sum of all Society's percentages divided by 53. As a result, the provincial average in this table does not match the percentages given in Table 27 (page 35), where the calculation is based on the percentage of all files reviewed, i.e. the number of directives issued, divided by the total files reviewed. The rationale for the different calculations in that in this Table, each *agency* should have a weight of "1" when calculating the provincial average for performance on each directive; in Table 27, each *file* should have a weight of "1" when calculating the percentage of files in compliance with each standard/requirement.

This is **Exhibit "28"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Ontario

Child Welfare Review

Summary Report – 2012

Ministry of Children and Youth Services
Client Services Branch, Service Delivery Division
January 2016

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Executive Summary

The Crown Ward Review is an annual process undertaken by the Ministry of Children and Youth Services (MCYS) to determine if the placement, services, educational and social needs of Crown wards in Ontario are being identified and appropriately addressed. The Crown Ward Review is an accountability mechanism used by the ministry to determine if children's aid societies (CASs) are undertaking appropriate planning and services for each child reviewed. The review monitors compliance with legislation and regulations related to the care of children, and identifies areas of strength as well as areas for improvement. The review collects a rich set of information about children's strengths, needs and experiences in care that can be used to assess outcomes related to well-being, safety, and permanency.

A Crown ward is a child who has been made a ward of the Crown pursuant to a court order under the *Child and Family Services Act,* R.S.O. 1990, c. 11. The file of each Crown ward is reviewed in the year following 24 months of successive Crown wardship and every year thereafter. Reviews continue until the child is discharged from the care of the CAS, reaches 18 years of age, or the case is before the court on a status review.

In 2012, the files of 4,582 children were reviewed, an 11.7% decrease from the number reviewed in 2010 (N=5,194). The review population was comprised of 2,664 boys (58%) and 1,918 girls (42%). Of the children reviewed, 710 (or 15%) were of Aboriginal heritage.

Data for this review was categorized, where appropriate, by child sex and age at the time of review to allow for a better understanding of the different patterns of issues and service events presenting for boys and girls and younger versus older Crown wards.

In the review population as a whole, 79% of children were identified as having at least one "special need" (e.g. ADD/ADHD, developmental delay) and 58% of children had at least one "behavioural support need" (e.g. aggressive behaviour, self-harm). Clear differences emerged between boys and girls and across age groups in terms of both the prevalence and relative frequency of identified needs.

Legislative Compliance

In 2011, the Crown Ward Review (CWR) process was revised to include, among other enhancements, a new method for measuring compliance. Rather than determine compliance by how many requirements were satisfied within each individual child file, CAS-compliance is now measured by legislative and regulatory requirement. At the conclusion of a review, CASs are provided with compliance scores related to each requirement and grouped by the outcomes of safety, permanency and well-being. Compliance is grouped into the following categories: "Full" (requirements that were 100% compliant), "High" (requirements that were compliant between 75 – 99%), "Moderate" (requirements that were compliant between 50 – 74%) and "Low" (below 50%). In 2012, CASs achieved full or high compliance in over 85% of legislative and regulatory requirements.

The files of 135 Crown wards on adoption probation were reviewed in 2012. Overall, 27% of adoptions were finalized within six months of children being placed on adoption probation, with 64% being finalized after six months. For further details about the adoption probation review, please see Part 5.0: Results from the 2012 Crown Ward Review – Adoption Probation Review.

1.0 The Crown Ward Review

1.1 Purpose and Process of the Review

The Crown Ward Review (CWR) is an annual accountability process completed by a team of Ministry of Children and Youth (MCYS) staff to determine if the placement, educational and social needs of Crown wards in care for longer than two year are being appropriately addressed. It is legislated under the *Child and Family Services Act* (CFSA) under Section 66. The review process seeks to ensure that the circumstances of each Crown ward, including those on adoption probation, are re-examined regularly by the ministry.

The reviews are conducted in all Children's Aid Societies (CASs) in the province. The ministry's team of Crown Ward Reviewers conduct an on-site file review of eligible files using a standardized tool designed to capture demographic information, a range of child characteristics and special / behavioural / educational support needs, significant case events, and to assess compliance with the legislation, regulations, ministry standards, directives and policies. The objectives of the Crown ward review are to:

- Monitor agency compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward;
- Determine whether there has been an adequate assessment of the Crown ward's needs, a suitable placement, supporting services, and realistic planning for and with the child as appropriate;
- Issue directives regarding non-compliance and to monitor implementation of recommendations about particular cases and general policy and practices;
- Provide Crown wards with the opportunity, through questionnaires and interviews, to comment on: the care they are receiving; contacts with their biological families; their case plans; and their current circumstances; and
- Provide information to the society under review about best practices employed in other societies and jurisdictions.
- Using a strengths-based approach, identify and convey to societies the strengths of service delivery.

Unless the child's case is before the court for a status review, reviews continue annually until the child is discharged from the care of the society or reaches 18 years of age; the files of youth who were over 18 years of age and continued to receive services from a CAS under an Extended Care and Maintenance agreement (now known as Continued Care and Supports for Youth agreement) are not eligible for review.

A society's Crown ward review findings are based on a review of the Crown ward files, questionnaires completed by Crown wards and client interviews. In complex and/or high-risk cases, society caseworkers and managers may also be consulted.

Crown Ward Reviewers issue directives when the documentation in a child/youth's file does not support full compliance with ministry requirements. Directives regarding non-compliance are issued, for example when: children do not meet face-to-face with their caseworkers every three months; if children have not received annual medical or dental examinations; or if planning is not completed within statutory timelines or has not adequately addressed a child's needs. Societies are required to report back to the ministry regarding all directives within 60 days of the review.
Recommendations can also be issued as a signal to a CAS that, while directives are not indicated, file documentation does not fully support requirements and improvements are required. Societies are not required to report back to the ministry regarding directives.

1.2 "High Risk" Children/Youth

Societies are required to report to the ministry within 30 days when a case is designated as "high risk" and requires further action to address the identified risks to a child/youth. Children/youth can be designated as "high risk" if they exhibit behaviours that present harm to themselves or others and exhibit at least one of the characteristics listed below. High-risk characteristics include:

- Aggressive/assaultive behaviour
- Suicidal gestures or ideation
- Self-harm
- Substance abuse (drugs/alcohol)
- Two or more placements in previous 12 months
- School suspension/expulsion
- Persistent serious behavioural problems
- Serious occurrence
- Medically fragile
- Serious psychological/emotional problems
- Inappropriate sexual behaviour
- Serious psychiatric disorders
- Frequent AWOL – 2 or more runs in the past 12 months

1.3 Reports

Individual case reports are prepared for each Crown ward reviewed. These reports provide feedback to caseworkers, society managers, and ministry program supervisors on key areas of service delivery, case management and planning. An agency report is also provided to CASs at the conclusion of the review that outlines the society's strengths and opportunities for improvement in key outcome areas like permanency, safety and well-being.

1.4 Revised Crown Ward Review Process, 2011

In August 2011, the CWR process was revised in order to:

- Introduce new software technology for completing reviews.
- Create more efficiency and transparency by incorporating amendments to the *CFSA*, and clearly conveying all legislative/regulatory requirements to CASs;
- Promote consistent interpretation of legislative/regulatory requirements;
- Determine society compliance by legislative requirement rather than by individual file;
- Incorporate operational policies and procedures for quality management;
- Provide agencies with raw data to support continuous quality improvement;
- Share the *Crown Ward Review Tools and Business Practices* manual with CASs to further increase transparency and accountability regarding ministry expectations

As part of this, the method of measuring CAS compliance to legislative and regulatory compliance was enhanced. Societies' compliance is now based on each legislative requirement rather than individual file. At the end of a CW review, rather than receiving a score on how many Crown ward files were compliant, societies receive feedback or scores related to their compliance with each legislative requirement. This shift in focus is meant to reflect a truer measure of CASs' compliance to legislative and regulatory requirements and CASs have applauded this change.

The new process was introduced mid-year in 2011. As a result, CWR data for 2011 is in two distinct parts that were not compatible with each other. For this reason, a 2011 CWR annual report was not prepared.

1.5 Continuous Quality Improvement

As part of the revised CWR process, CASs are required to undertake a continuous quality improvement (CQI) process that aims to continually build on society's strengths and address areas of improvement. This process is supported by the ministry through the release of CWR raw data to CASs at the conclusion of each review. Together with their MCYS program supervisor, societies will analyze the data from the review and develop a Quality Improvement Plan (QIP) following their review. The QIP will identify areas of improvement and strategies for the CAS to implement to address those areas. The Ministry monitors QIPs as well as CASs' progress in implementing the proposed strategies.

1.6 Current Context

This report contains analysis of the CWR data collected during the 2012 calendar year. This is the first CWR Annual Report to use data collected after the CWR process was revised in 2011. As noted above, compliance is now measured "by requirement" rather than by individual file. As a result, some variables included in the analysis will be new while others previously used in the 2010 (and previous) report are discontinued with the introduction of the revised process.

The revised CWR process focused on those areas that were strictly related to legislative and regulatory requirements. As a result, the review no longer tracks *Youth Criminal Justice Act* information and Serious Occurrence Reports unless the file has a high risk designation.

The number of Crown wards eligible for review has been in decline for several years. In 2009, there were 5,218 Crown wards reviewed. In 2010, the total number reviewed was 5,194. For the report in 2012, 4,582 Crown wards were reviewed, a 12% decline since 2009.

1.7 Scope of the Review and Limitations of the Data

The children reviewed through the Crown ward review represent a subset of Ontario's Crown ward population. *Not all children who are Crown wards at the time of the review are eligible for review.* Only files of children/youth who have been Crown wards for at least 24 consecutive months prior to review are eligible to be reviewed. As well, those Crown wards who were discharged from care prior to the scheduled CWR are also not eligible.

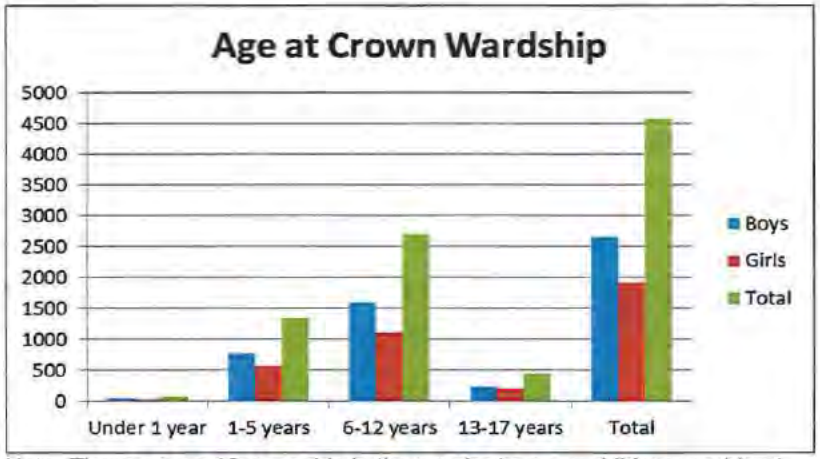
It is also important to note that this data contains a disproportionate number of children who have long term in-care experiences as they are both eligible for review (i.e. have been Crown wards for at least two years) and are still in care at the time of review (i.e. have not been discharged). Children who are never accounted for by the review data are those who become Crown wards and exit care quickly (i.e. before reaching 24 months of Crown wardship) to either permanent or non-permanent (i.e. aging out) arrangements. **The findings presented in this report are relevant to those children who have longer-term Crown ward experiences rather than representative of all children who become Crown wards.**

2.0 Findings of the 2012 Crown Ward Review

2.1 Demographic and Other Background Information

2.1.1 Age at Crown Wardship

The graph below shows the age at Crown wardship by child sex and highlights the similarities and differences between age groups for boys and girls. The chart highlights that the majority of children became Crown wards in their middle years.

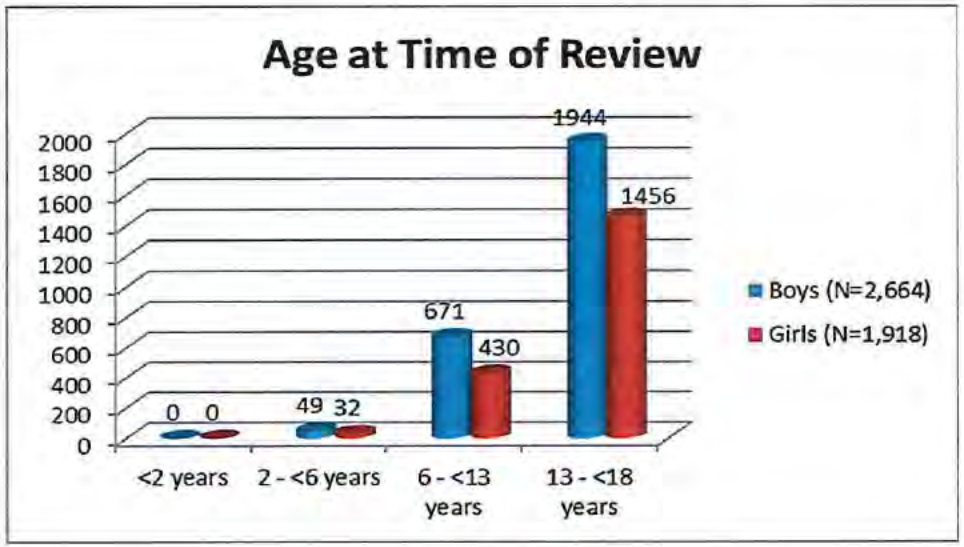


Note: There are no 18 year olds in the graph above as children would not become Crown wards at that age.

- *59% of children became Crown wards in CASs between the ages of 6 and 12.9.*
- *31% of all children became Crown wards before their sixth birthday.*
- *Only 10% of children became Crown wards after their 13th birthday.*
- *When the data was analyzed for children of Aboriginal heritage (not shown), 55% of Aboriginal children became Crown wards before the age of six, versus 27% of non-Aboriginal children.*

2.1.2 Age at the Time of Review

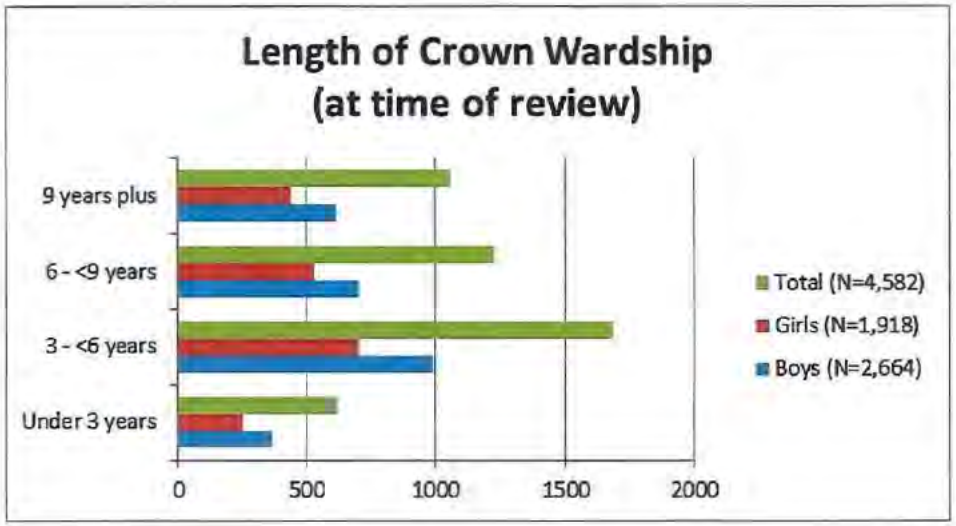
The graph below shows child age at the time of review by child sex. It is important to remember that children who were not Crown wards for 24 months and those children who exit care quickly after becoming Crown wards are not included in these statistics.



- *The average age at review for all children was 13.9. This represents a slight decrease over the past three years (14.9 in 2009).*
- *72% of children reviewed were adolescents aged 13 to 18.*
- *2% of children were under the age of 6.*

2.1.3 Length of Crown Wardship

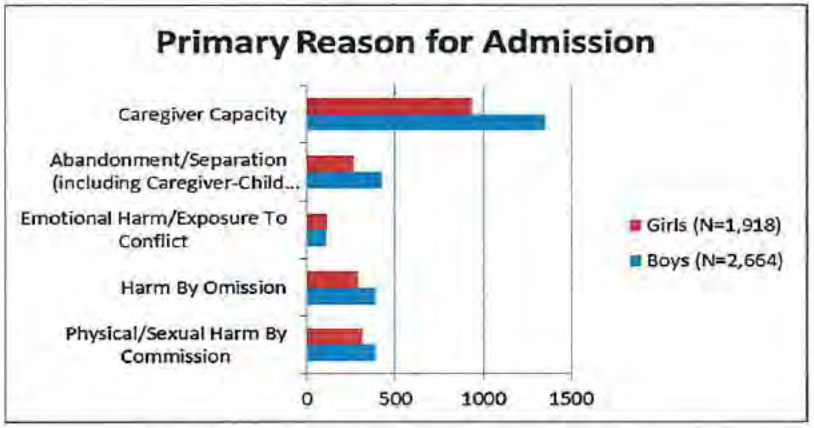
The graph below illustrates that the majority of children reviewed (87%) have been Crown wards for between three to over nine years.



- *The average length of Crown wardship for all children reviewed was 5.9 years with an age range between 2 and 18 years.*
- *37% of children had been Crown wards for between 3 and 5.9 years.*
- *27% were Crown wards between 6 and 8.9 years.*
- *13% were Crown wards for less than 3years.*
- *23% of children were Crown wards for 9 or more years.*

2.1.4 Reason for Admission to Care

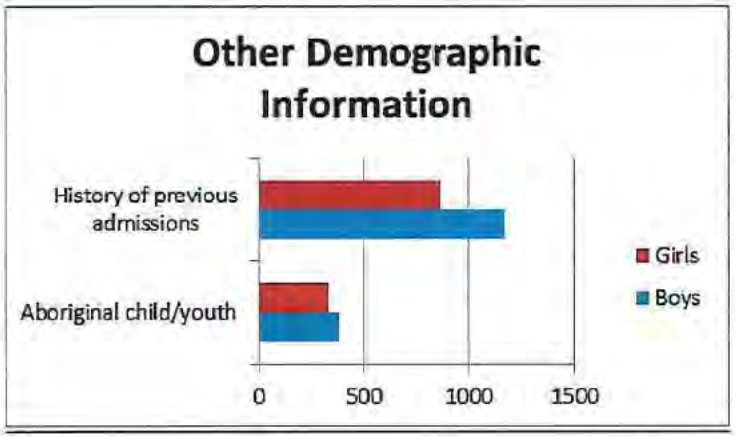
The graph below provides the primary reason for admission to care that led to CASs seeking Crown wardship orders. The graph highlights that caregiver capacity was the primary reason for admission to care for the vast majority of Crown wards. Section *2.1.5 Other Demographic/Background Information* captures the number children and youth who had previous admissions to care before Crown wardship was sought by CASs.



- *Caregiver capacity was the primary reason for admission to care for both, boys (51%) and girls (49%).*
- *For girls, the 2nd most common reason for admission to care was physical or sexual harm (16%) followed by harm by omission (15%).*
- *For boys, the 2nd most common reasons for admission to care were abandonment/separation (16%).*

2.1.5 Other Demographic/Background Information

The graph below shows additional background information about the children reviewed in 2012. Of the 4,582 children reviewed, boys were over-represented at 58% of the review population which is consistent with the Crown ward review findings since 2000. Further, the proportion of Aboriginal children and youth (15%) is lower than in previous review years.



- *Of all Crown wards reviewed, 44% experienced previous admissions to care before a Crown wardship order was sought by a CAS.*
- *There were 710 Aboriginal children reviewed through the Crown ward review in 2012.*

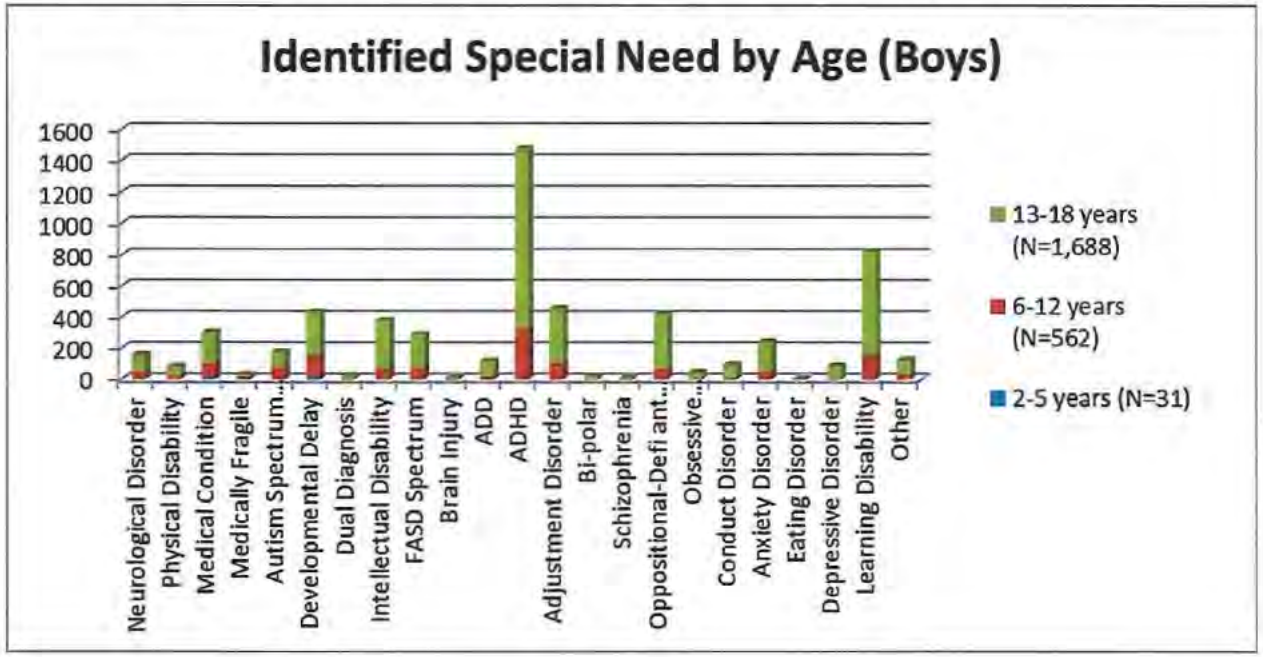
2.2 *Child Well-Being*

The following section provides information about various aspects of child well-being for Crown wards reviewed, including identified "special needs" and "behavioural support needs", educational progress, along with a subsection related to continuity of relationships, spiritual and cultural identity for Aboriginal Crown wards.

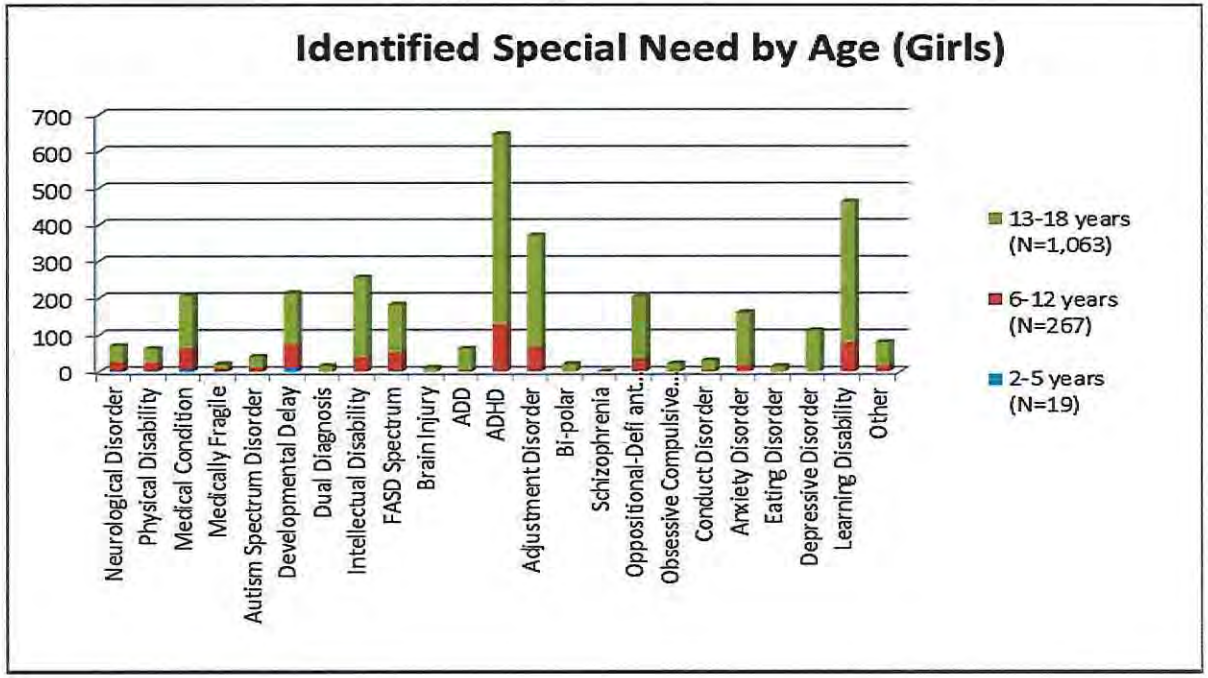
2.2.1 Identified Special Needs

The *Child and Family Services Act (CFSA)* defines a special need as "a need that is related to or caused by a behavioural, emotional, physical, mental, or other disability." A child is identified as having a special need if there has been a diagnosis made by a health or mental health professional.

The graphs below illustrate the prevalence of all special or behavioural needs for Crown wards reviewed in 2012, whether primary or secondary, by child age at time of review and sex. Whether they be "primary" or "secondary", understanding the prevalence in the Crown ward population provides a more accurate profile of the needs of Ontario's Crown wards. Consistent with the 2009 and 2010 findings, **79%** of all Crown wards reviewed had at least one special need identified (N=3,630).



- The most prevalent special needs among boys in the youngest category were developmental delay (55%) and medical condition (52%).
- 61% of boys between 6 and 12 years versus 74% of adolescent boys with special needs had a diagnosis of ADD/ADHD, the most common special need among the two age groups.
- The second most common special need among boys aged 6 to 18 years was learning disability (37%).



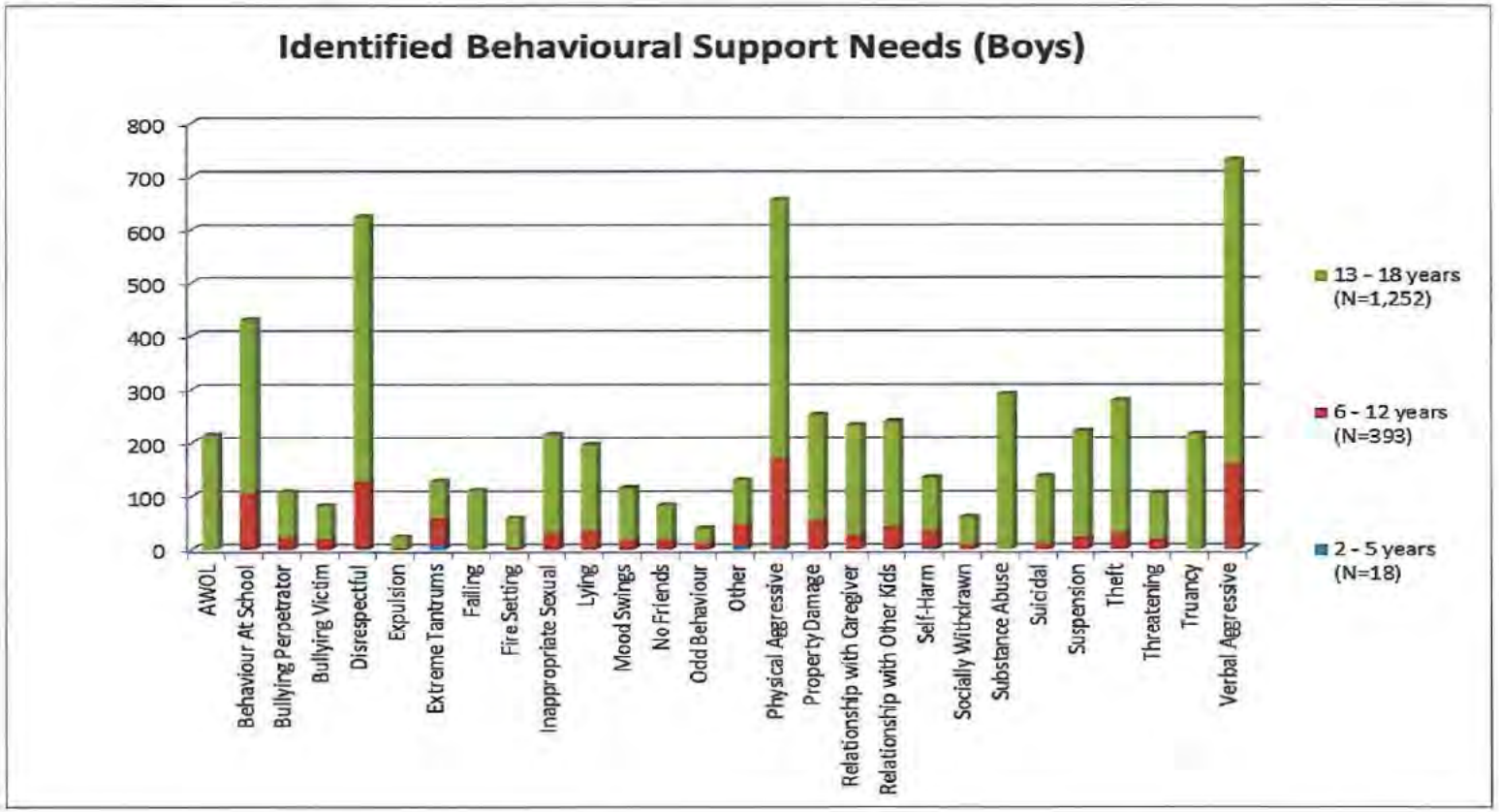
- The most prevalent diagnosis for girls age 2-6, like boys of the same age, was developmental delay (58%).
- 50% of girls between 6 and 12 years versus 54% of adolescent girls had a diagnosis of ADD/ADHD, the most common among these age groups.
- The second most common special need among girls aged 6 to 18 is the same as boys of the same age – learning disability (35%).

2.2.2 Behavioural Support Needs

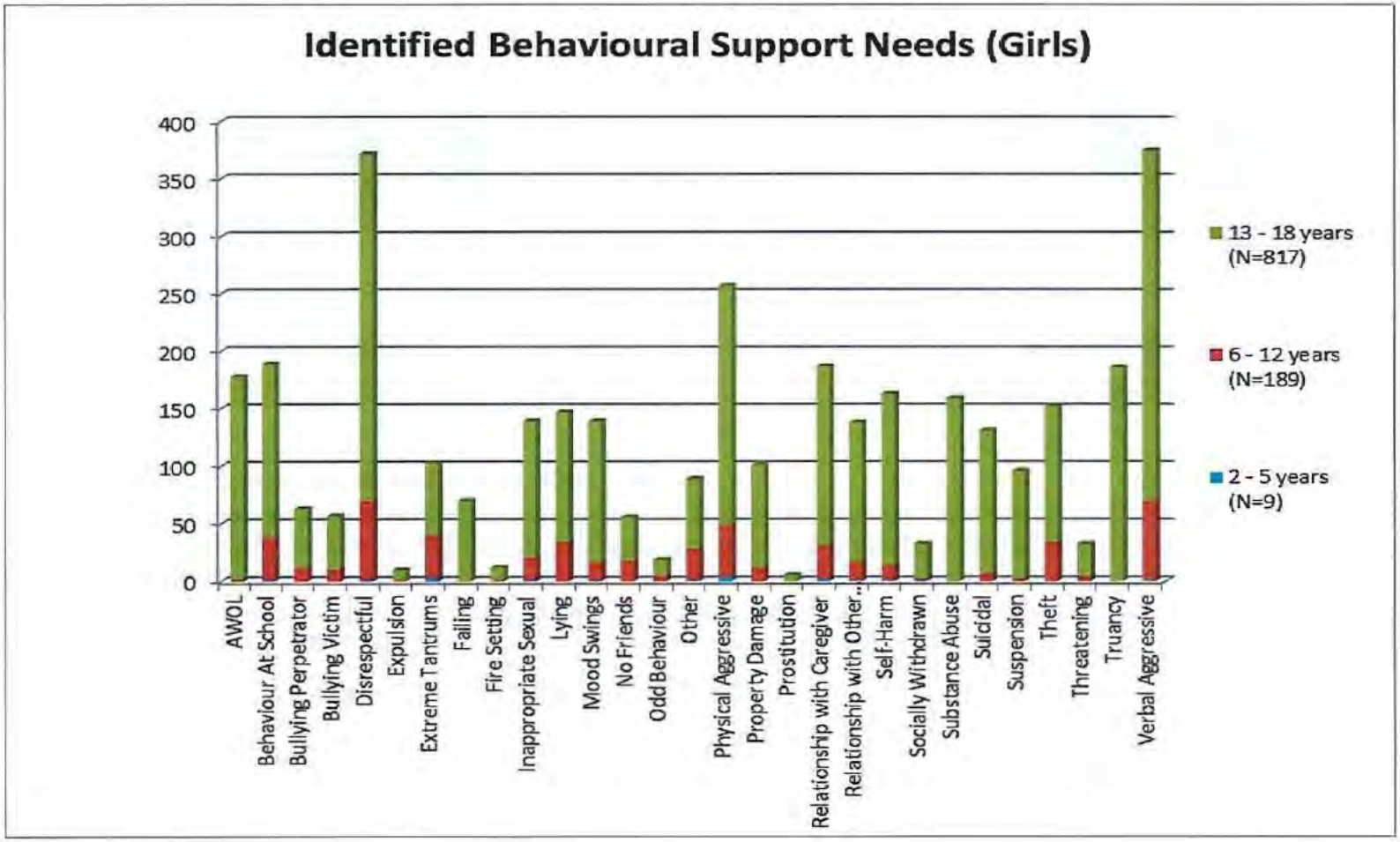
Behavioural support needs refer to behaviour that presents a risk to the child or others. For example, "aggressive behaviour" includes all types of aggression towards others such as physical/verbal attacks, fire setting, stealing, or other harm to others.

The graphs below present the data by child sex and age at the time of review. Controlling for age is particularly important as many of the behavioural support needs documented by the review apply predominantly to older children, e.g. a very young child is extremely unlikely to display suicidal behaviour or substance abuse issues.

Overall, **58%** (N=2,678) of Crown wards reviewed had at least one identified behavioural support need. When compared to 2009 and 2010, the percentage of Crown wards with one identified behaviour support has increased from 43% in 2009 and 42% in 2010.



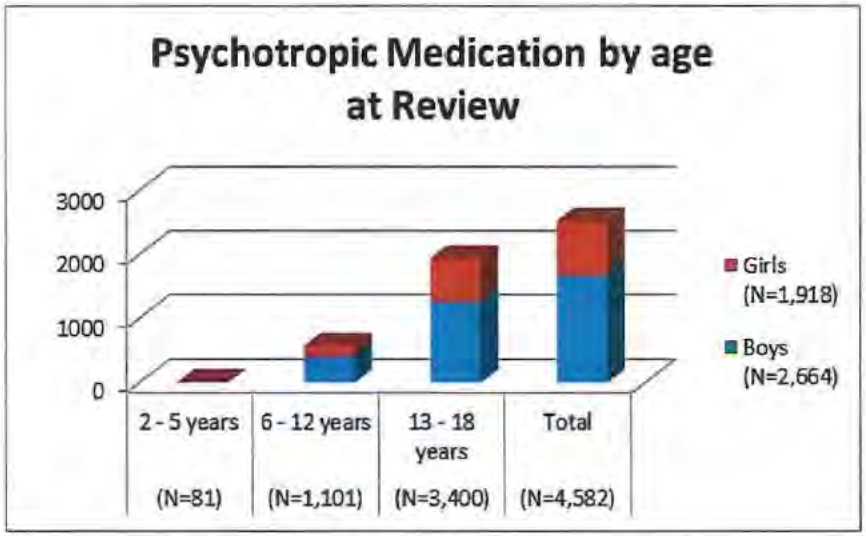
- Aggressive behaviour (verbal and physical) had the highest incidence rate for boys among the older age groups - 49% of boys between 6 and 12 years and 54% of adolescent males between 13 and 18 years. Extreme tantrums was the most prevalent need among the 2 to 6 year old category.
- 17% of adolescent boys engaged in frequently running from placements.
- 8% of adolescent males engaged in self-harm (a 3% decrease from 2010) and 10% of adolescent boys presented with suicide ideation or gestures (a 5% increase from 2010).
- 23% of adolescent boys with a behavioural need were identified as having substance abuse needs.
- 38% of all boys reviewed presented no behavioural needs.



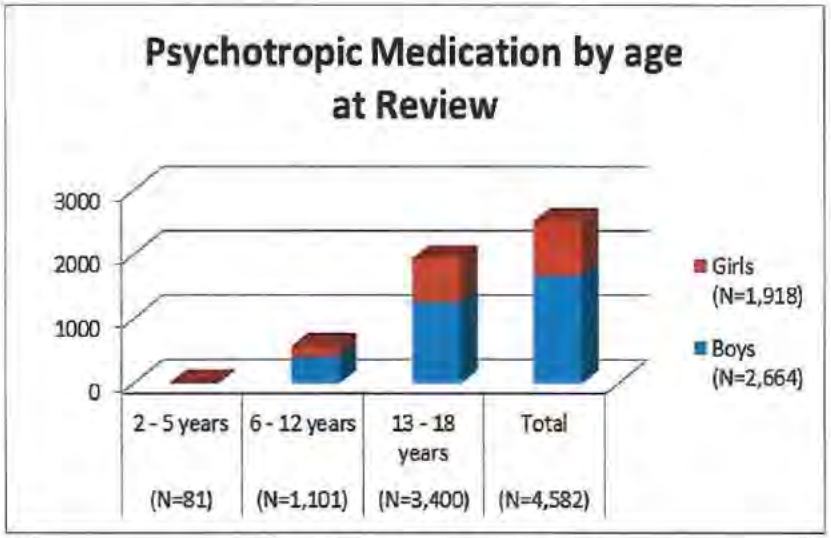
- Aggressive behaviour was also the predominant concern across all age groups – 16% of girls between 2 and 6 years, 27% of girls between 6 and 12 years and 35% of adolescent females between 13 and 18 years.
- 9% of girls engaged in frequently running from placements.
- 10% of females reviewed aged13 to 18 engaged in self-harm and 9% presented with suicide ideation or gestures.

2.2.3 Psychotropic Medication and Therapy

As part of the review, Crown ward reviewers document whether or not a child is currently taking any kind of prescribed psychotropic medication such as Ritalin, anti-psychotics, anti-depressants, etc. Reviewers also document whether or not the child is actively engaged in any kind of therapy. Therapy may include any specialized services that address the child's special needs such as art and music therapy, occupational and physical therapy and specialized treatments such as Applied Behavioural Analysis / Intensive Behavioural Intervention. The graph below shows the number of children who were taking psychotropic medication and receiving therapy by age.



- Over half of all children reviewed (55%) were taking psychotropic medication, with a greater proportion of older children compared to younger children of both sexes using medication.
- 63% of boys reviewed were prescribed psychotropic medication, with 44% of girls.

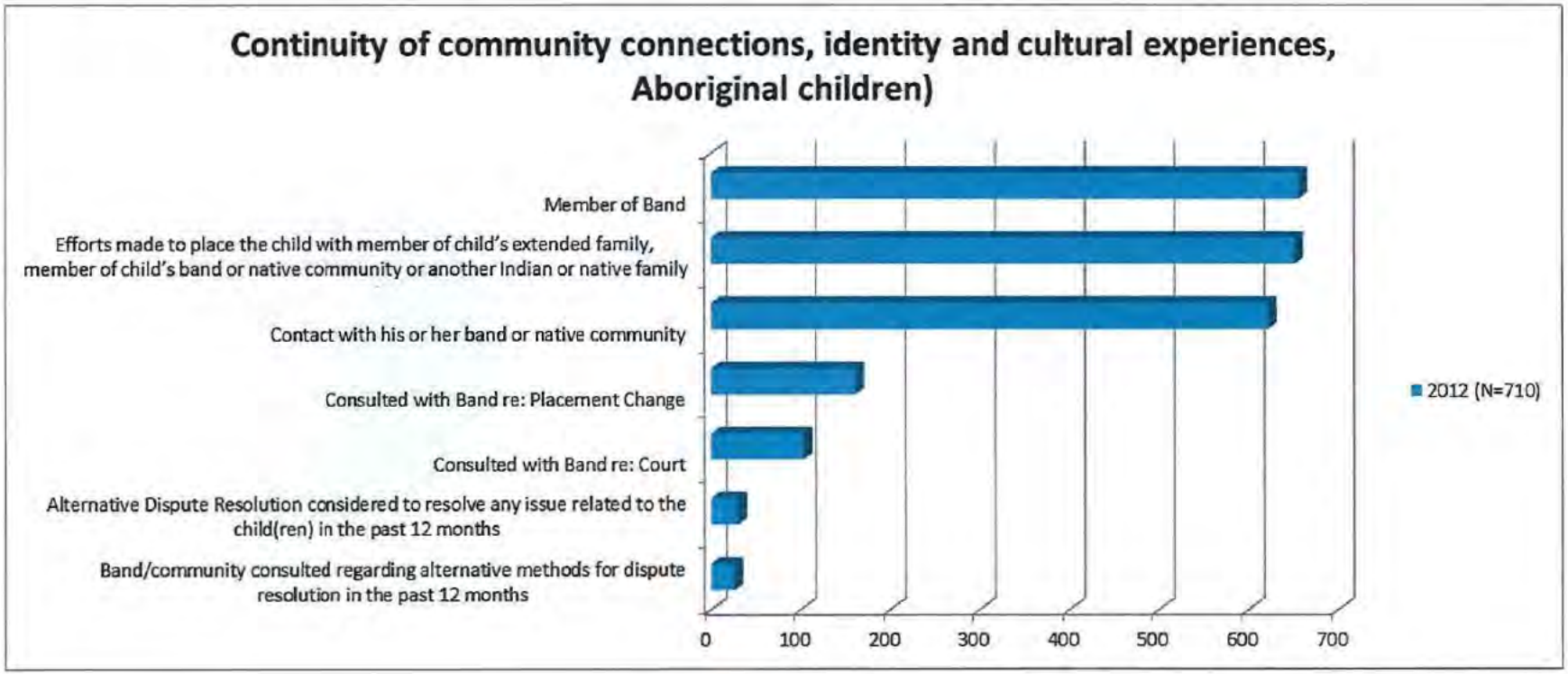


- Approximately 62% (N=2,840) of all children reviewed were receiving some form of specialized therapy.
- Boys (63%) were more likely to be receiving therapy than girls (60%).

2.2.4 Connection to Community, Culture and Spiritual Identity: Aboriginal Children and Youth

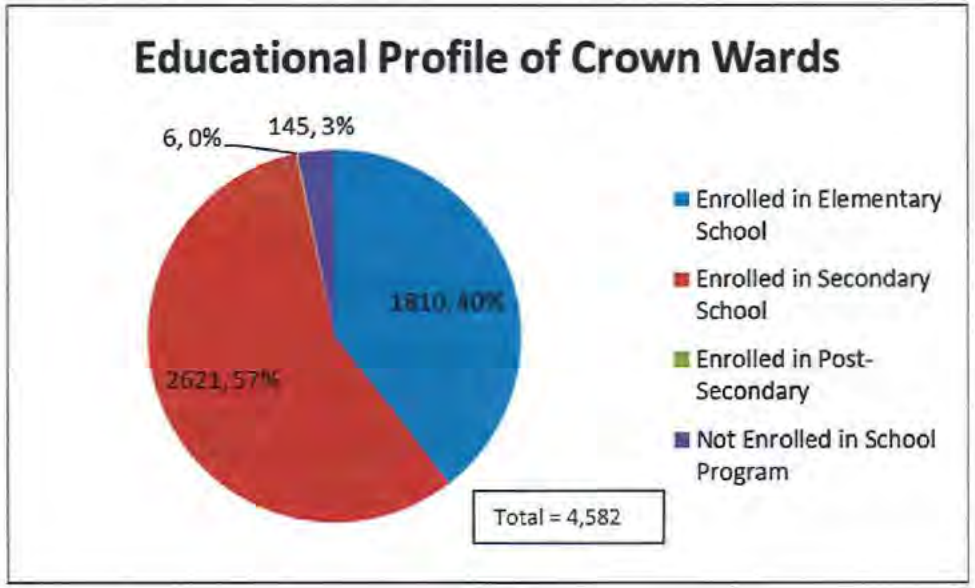
The graph below highlights standards and practices designed to promote cultural, linguistic and spiritual continuity for Aboriginal Crown wards. The placement of Aboriginal children within Aboriginal homes, and/or their home communities supports ties with important people in their lives and with their cultural, linguistic and spiritual identity, and has been recognized as a best practice. Placing children in Aboriginal homes or in their home communities requires further attention as does ensuring that Aboriginal children maintain contact with their home communities. The graph below shows CASs' success at working toward placing Aboriginal Crown wards with their extended family or within their native community.

Although there is relatively high compliance with standards regarding exposure to cultural and spiritual practices, the data collected does not speak to the quality or frequency of these experiences.



2.2.5 Educational Profile

The table below outlines the educational profile of Crown wards reviewed in 2012. As would be expected, the vast majority of children reviewed were enrolled in and attending a school program (97% of all Crown wards).

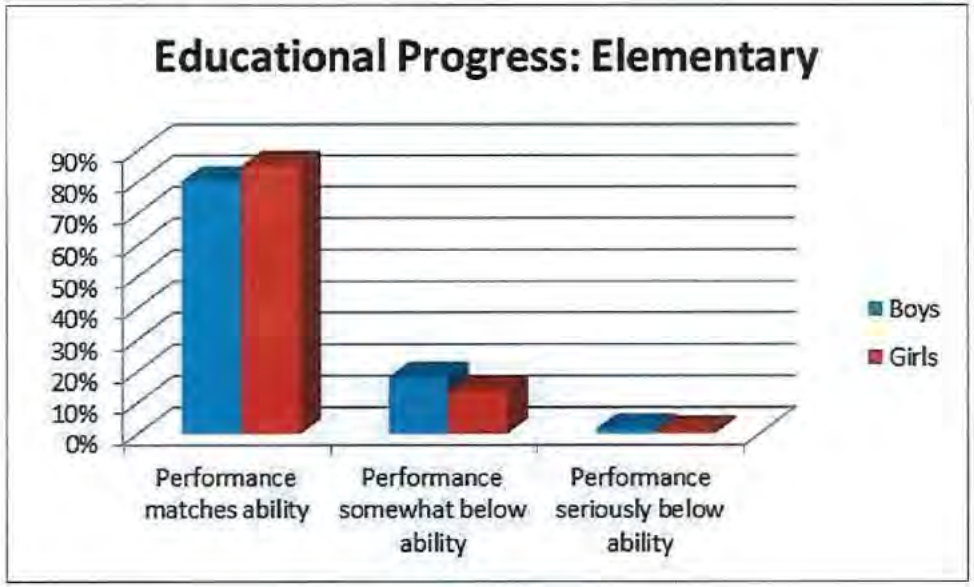


- Children not enrolled in school were either too young (i.e. toddlers and pre-schoolers), or not attending school despite the legal requirement to do so.

Overall, 49% of children enrolled in a school program were the subject of an Independent Placement Review Committee (IPRC). The majority of children and youth at both the elementary (52%) and secondary level (53%) required an Individual Education Plan (IEP) to assist them to succeed in the school system.

2.2.6 Elementary School Progress

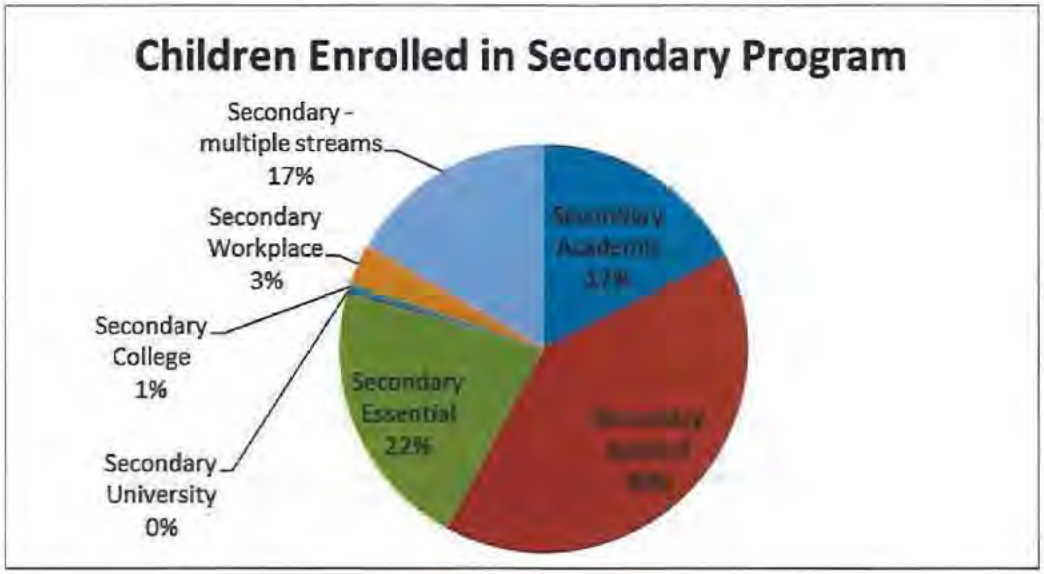
The graphs below outline the progress of children enrolled in an elementary school program by child sex. Overall, the academic performance of 82% of all children enrolled in an elementary school program "matched their ability", with 16% performing below their abilities and only 1% performing "seriously below ability."



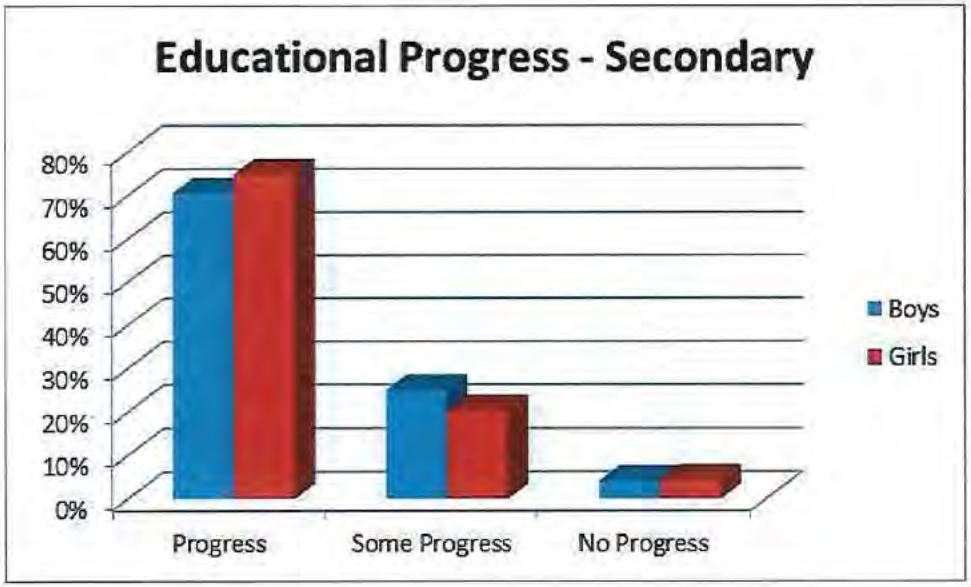
- Overall, girls enrolled in an elementary school program performed to their abilities slightly more (85%) than boys reviewed (80%) in 2012.
- A greater number of boys (196) were performing below their abilities than girls (105).
- In general, boys were more likely than girls to be struggling academically and to have been suspended in the 12 months prior to review.

2.2.7 Educational Enrollment and Progress, Secondary School

The graphs below present data regarding the progress of children enrolled in secondary school, stratified by the type of program and by child sex. Overall, 73% of children enrolled in secondary school showed "progress" academically during the 12 months prior to review. The group with the highest proportion of children showing progress (80%) was youth enrolled in the "academic" program, with girls performing slightly better (83%) than boys (78%) in this stream.



- The majority of youth in a secondary school program were enrolled in an applied or essential program.
- 18% of secondary students were enrolled in a post-secondary stream (Secondary Academic and Secondary College), while 17% were enrolled in multiple streams.



- The data illustrates Crown wards experience increased academic difficulties at the secondary school level, compared to the elementary level (fewer Crown wards demonstrating progress), which aligns with the higher proportion of adolescent Crown wards diagnosed with learning and intellectual disabilities

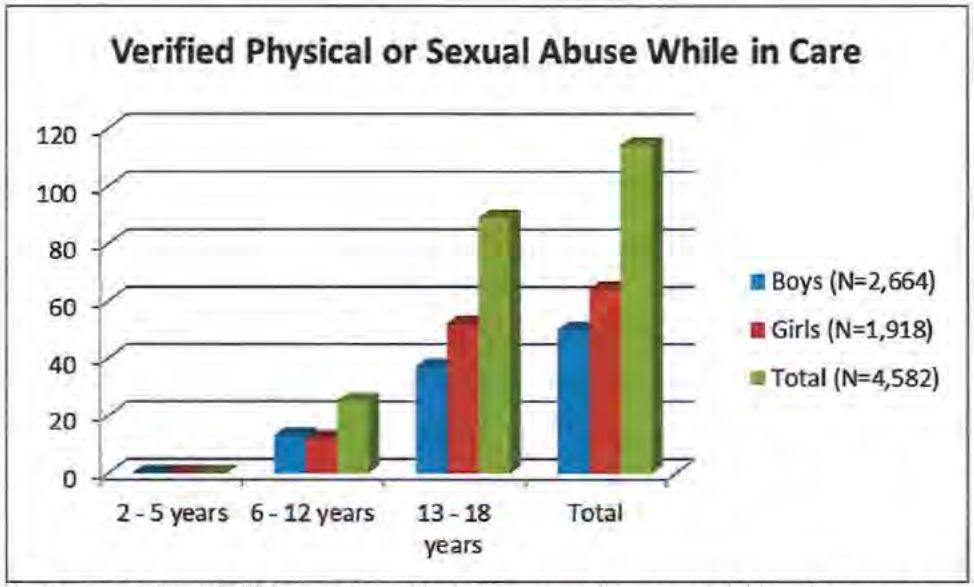
- Youth enrolled in "essential" or "applied" program streams were more likely to demonstrate some or no progress academically, with boys showing less success than girls.
- 15% of boys in these streams had also been suspended from school.

2.3 *Safety*

Child safety is a critical outcome of the child welfare system. The Crown ward review provides information about maltreatment experienced by Crown wards in care both prior to and during Crown wardship as well as children assessed as "high risk", both indicators of safety for children in care.

2.3.1 Maltreatment while in care during Crown wardship

It is important to note two things about the data presented. First, these are <u>not</u> incidence rates, i.e. the data does not indicate the number of *new* instances of abuse during the period under review. Rather, data shows the number of children who have *ever* been abused since their admission to care and during their time as Crown wards. Second, the perpetrator of the abuse is not necessarily the child's caregiver (e.g. foster parent / group home staff). Children are counted as abused during Crown wardship if the abuser is a family or community member and whether or not the abuse takes place in their placement, in the community (e.g. in a daycare or other service setting), or while home on an access visit. The common feature across all perpetrators is that they must have been in a caregiving capacity.

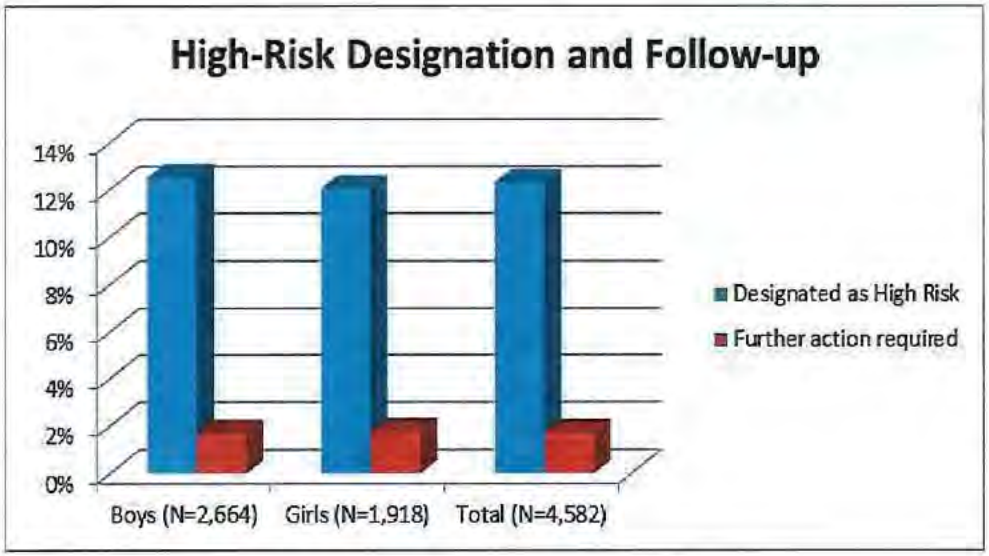


As the population of children reviewed includes many of the same children from year to year, and the annual incidence of abuse (the number of Crown wards newly abused during any given year) is low, the proportion of Crown wards reviewed who have experienced abuse since admission to care has remained stable over time.

- The prevalence of any abuse since admission to care is 2%.
- The data also revealed (not shown) a slightly higher incidence rate of physical or sexual abuse with girls (3.3%) compared to boys (1.9%).
- There was no instances of abuse reported for children in the youngest category.

2.3.2 High Risk Designation

Children are designated "high risk" when there are significant concerns about harm to themselves or others. For a full description of the high risk designation, see page 7. The graph below shows the proportion of children identified as high risk through the 2012 review, broken out by child sex. In previous years' reports, only the total for all children was reported (9% in 2009 and 8% in 2008); the corresponding statistic in 2010 is 7% of all children reviewed.



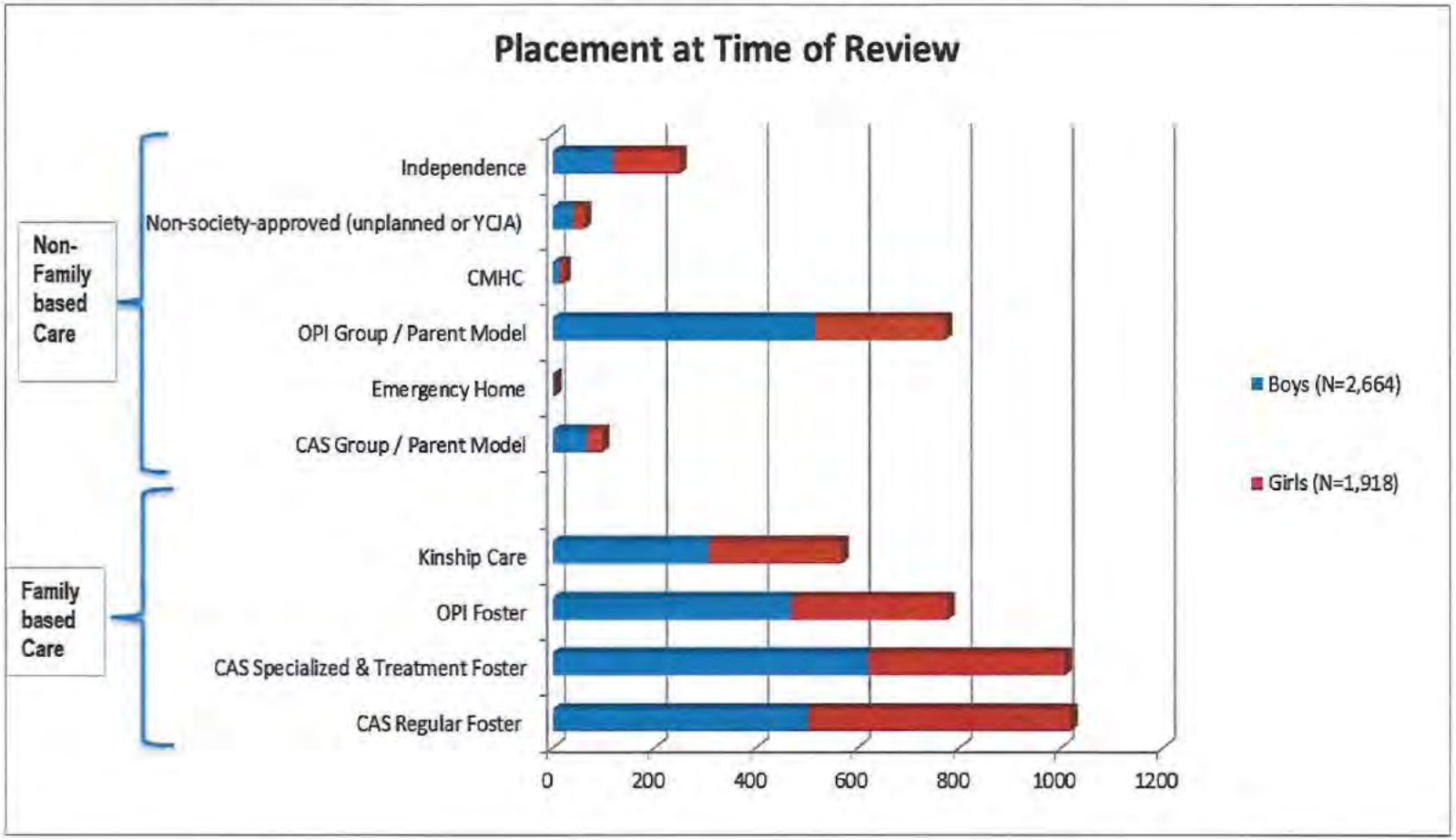
- The proportion of girls identified as "high risk" (12%) is similar to that of boys (13%).
- Based on analysis on adolescents (not shown), results indicate that 15% of adolescent girls (aged 13 to 18) and 16% of teenaged boys were identified as "high risk".
- Similar to previous years' findings, 14% of children identified as high risk were assessed as requiring further planning and safeguarding by the CAS.

2.4 *Permanency*

The following section explores the findings of the 2012 Crown ward review with respect to multiple measures of permanency, including the nature of permanency plans, placement stability, and continuity of relationships with birth families and child welfare workers. This section also includes the current placement type for the Crown wards reviewed.

2.4.1 Current Placement Type

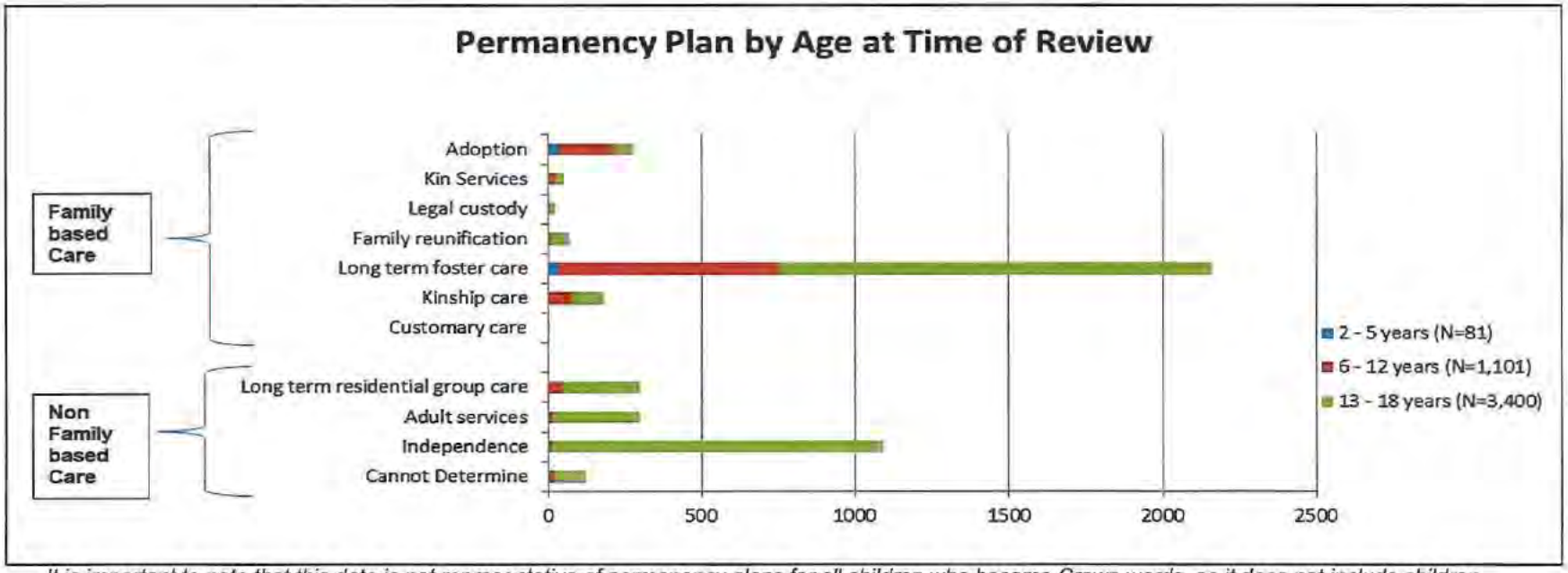
Family based care is generally accepted as the most appropriate placement type for the majority of children in care. Placement in family-based settings and the critical role that families and consistent caregivers play in children's development is particularly important for Crown wards – many of whom will spend several years in care.



- As illustrated in the "Placement at Time of Review", when the various forms of family based care are bundled together (i.e. all forms of foster care plus children living with their parents, relatives or community members), 74% of all Crown wards reviewed were placed in a form of family based care at the time of review.
- Further analysis (not shown) revealed that the rate of family based care for children 12 and under at the time of review was 93% for girls and 91% for boys, indicating a higher use of family based care for younger Crown wards.
- Overall, girls (77%) were more likely to be placed in family-based care than boys (71%).
- Placement in OPR group care / Parent model was the most prevalent non-family based care option for both girls (10%) and boys (16%).
- Girls were slightly more likely to be living in a kinship care arrangement at the time of review (14%) compared to boys (12%) and slightly more likely to be living independently (7%) than boys (5%).

2.4.2 Permanency Plans

A child's permanency plan reflects the CAS's aspiration for the child with respect to the most appropriate living arrangement over the longer-term. The chart below provides data about children's permanency plans at the time of review by age category. This method provides an understanding of the differences across developmental stages as some plans are more typically sought and completed for younger versus older children and vice versa. Overall, 47% of children have long term foster care as their permanency plan. This percentage is slightly lower than the findings from the 2010 (54%) report. The plan for children to remain in long term residential group care has remained consistent from 2009 (8%) to 2010 (6%) to 2012 (7%).



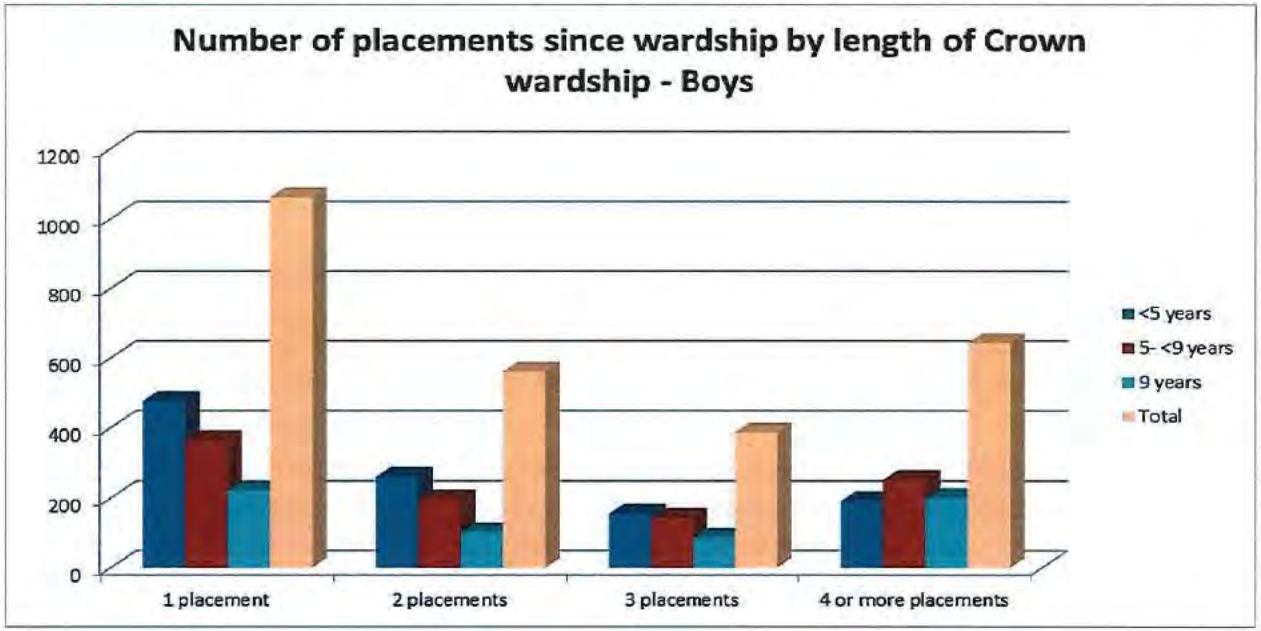
It is important to note that this data is not representative of permanency plans for all children who become Crown wards, as it does not include children who are recent Crown wards, or those children who were discharged to a permanent placement within the review period.

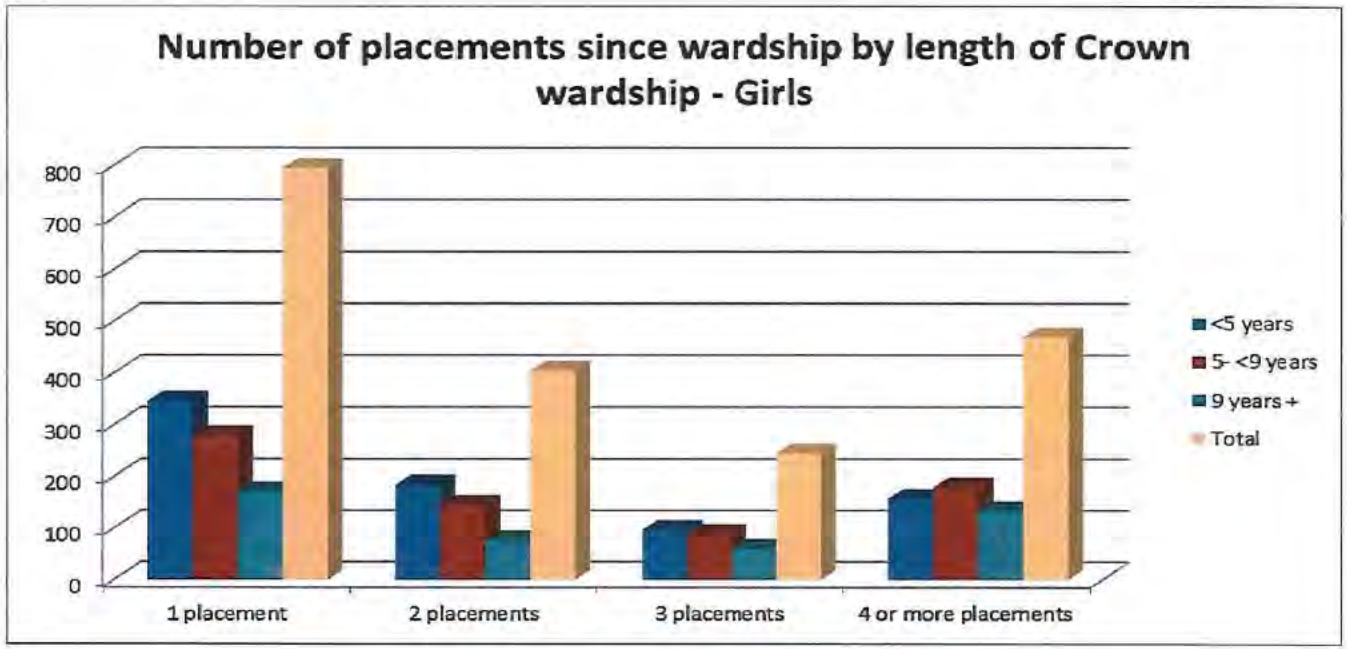
- The permanency plan for children under the age of six (44%) was adoption; the plan for a further 40% was long term foster care.
- For children aged 6 to 12.9 years, the majority of permanency plans were for long term foster care (65%), with an adoptive home being sought for 16% of children, and long term group care for 4% of these children.
- The plan for the majority of adolescents was to remain in long term foster care (41%) or proceed to independence (32%), a slight increase from 2010 (29%).

2.4.3 Placement Stability

Research indicates that placement stability is important for children to develop and maintain healthy, secure relationships with family, peers and the community. The importance of minimizing placement changes as part of permanency planning is well documented in research studies. A stable placement experience promotes attachment to a single primary caregiver, which is a critical outcome of early child development. While some placement changes may be beneficial, research indicates that multiple and unplanned placements are associated with negative outcomes for children, including increased behaviour problems, poor academic performance and mental health difficulties.

The graphs below show the number of placements since Crown wardship by categories (one placement, two placements, three placements and four or more placements) and stratifies the data by length of Crown wardship and sex of the child.



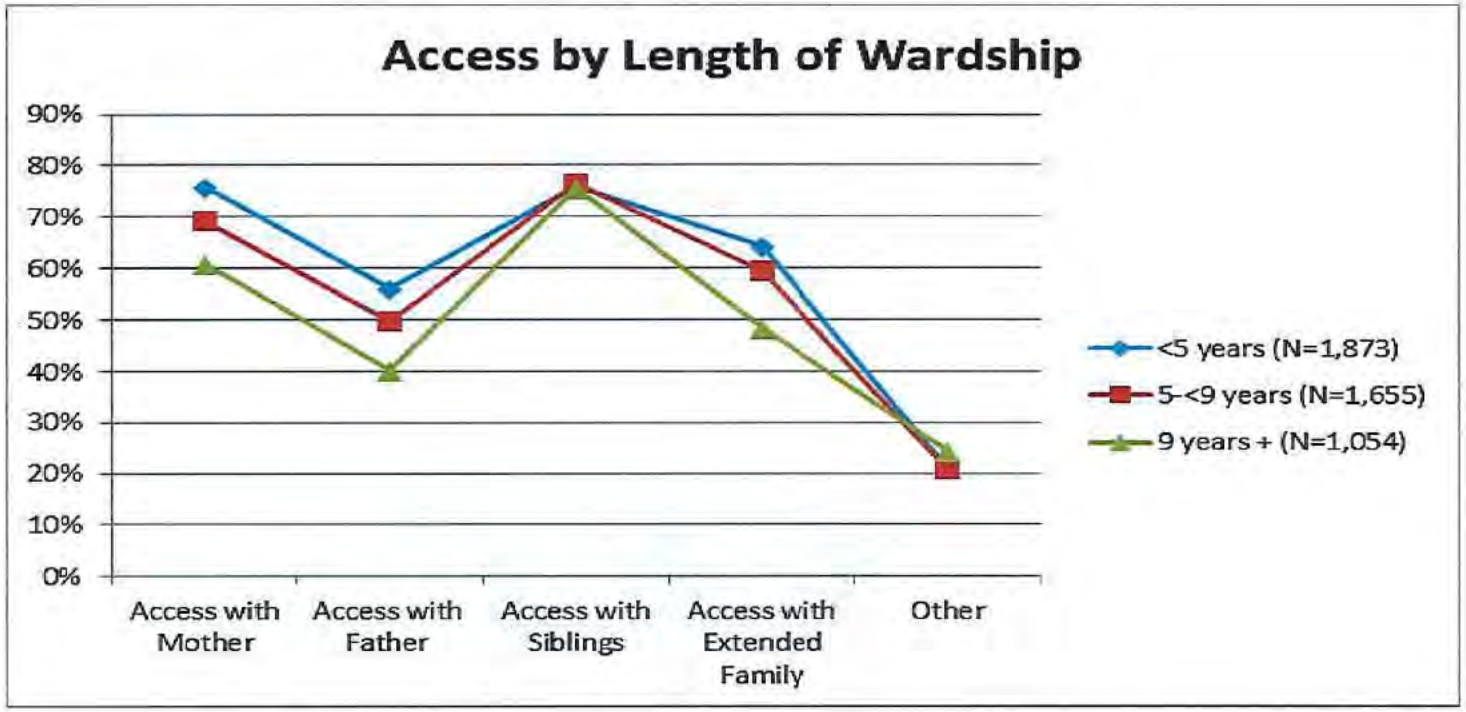


- Overall, 40% of boys and 42% of girls had one placement since Crown wardship.
- Girls were more likely than boys to have had only one placement across all lengths of Crown wardship.
- As length of Crown wardship increases, the likelihood of having only one placement decreases.

Data (not shown) indicate that the younger the child at Crown wardship, the greater the likelihood of placement stability even after controlling for length of Crown wardship. For example, for children who had been Crown wards for the longest (9 years or more), of those children who became Crown wards under the age of one, 55% were still in their initial placement. This proportion declines to 41% for those who became Crown wards between the ages of 1 and 5 years, and to 29% when the age at wardship was between 6 and 9 years.

2.4.4 Access to Parents, Extended Family and Siblings

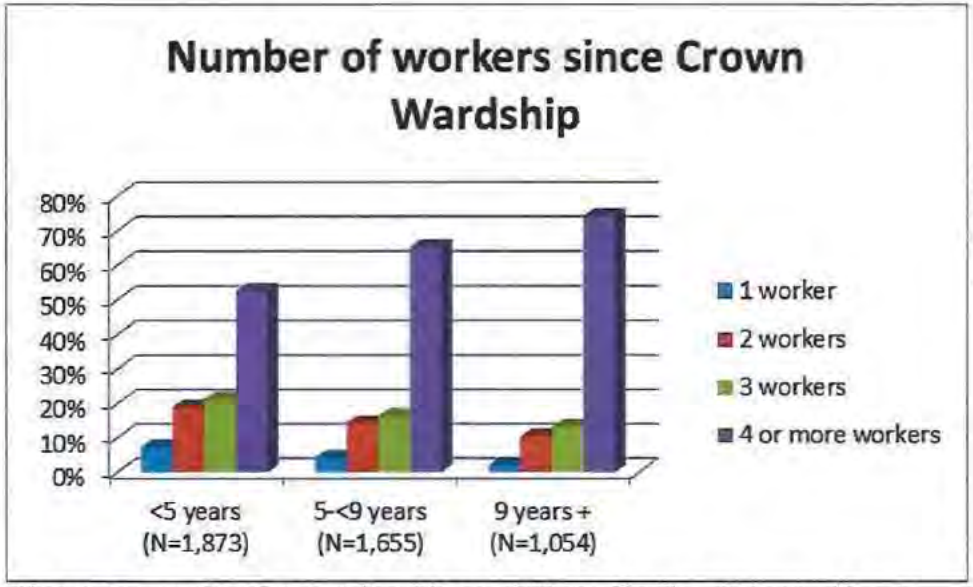
The graph below shows the proportion of children who exercised access with mothers, fathers, siblings and extended family, stratified by length of Crown wardship. Overall, 89% of children exercised some form of access with their families.



- Children who were Crown wards for 9 years or more had the lowest rates of access with their mothers (61%) and fathers (40%).
- Children who were Crown wards for 9 years or more also had less access with extended family (49%) compared to children who were Crown wards for 5 years or less (64%).
- Overall, access is significantly more likely to be exercised with mothers (70%) compared to fathers (50%).
- 76% of all children reviewed, regardless of length of wardship, maintained access/contact with their siblings.

2.4.5 Worker Continuity and Contacts

The graph below shows the number of workers since Crown wardship for children reviewed, by length of wardship duration.

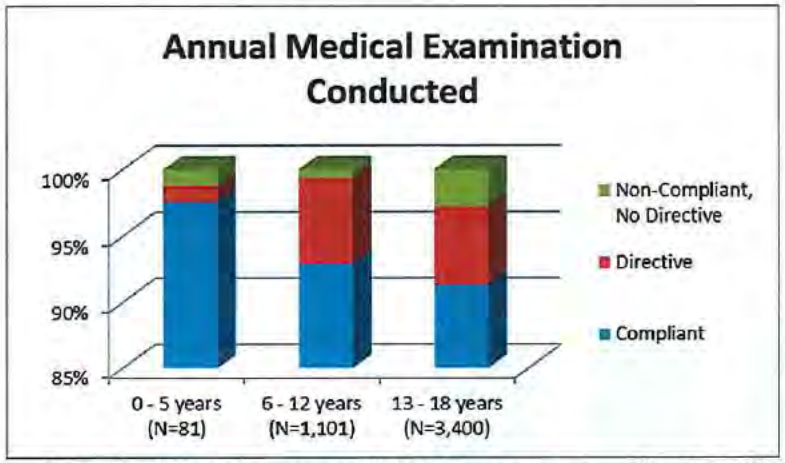


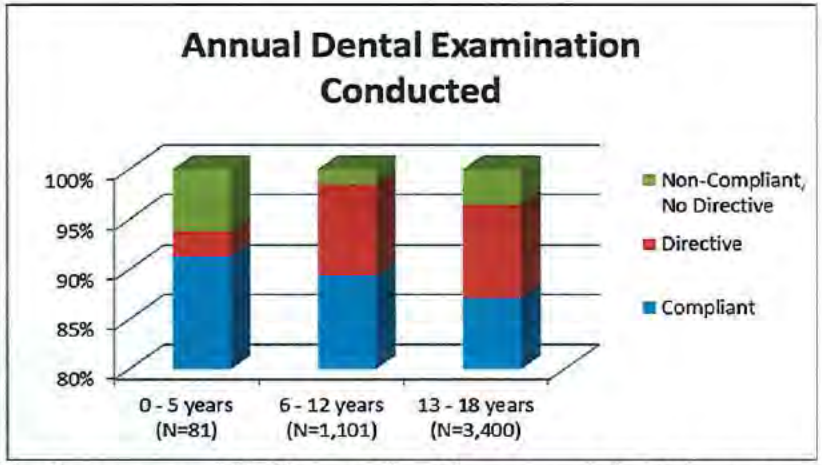
The average number of caseworker visits per child was 12 with a minimum of 1 and a maximum of 64 visits on a case-by-case basis over 2012.

- The average worker duration was 3.9 years, an increase from 2.4 years in 2010.
- The likelihood of having had the same caseworker since Crown wardship diminishes with time, with 7% of children who were Crown wards for less than five years having one caseworker compared to 2% of children who were Crown wards for 9 years or more.
- 59% of children who were Crown wards for more than 9 years had four or more caseworkers compared to 31% of children who were Crown wards for less than 5 years.

2.4.6 Annual Medical and Dental Exams

Annual medical and dental exams are required for all children in care. The CWR checks for compliance in these areas as part of the review. A common reason for a child not receiving an annual medical or dental exam is due to scheduling limitations with physicians/dentists and exams are still carried out, just not within the previous 12-month review period. In cases like these, a CAS can be in non-compliance, but not receive a directive if there are extenuating circumstances.





For annual medical exams, overall CASs were compliant in 92% of cases, and 88% compliant for annual dental exams.

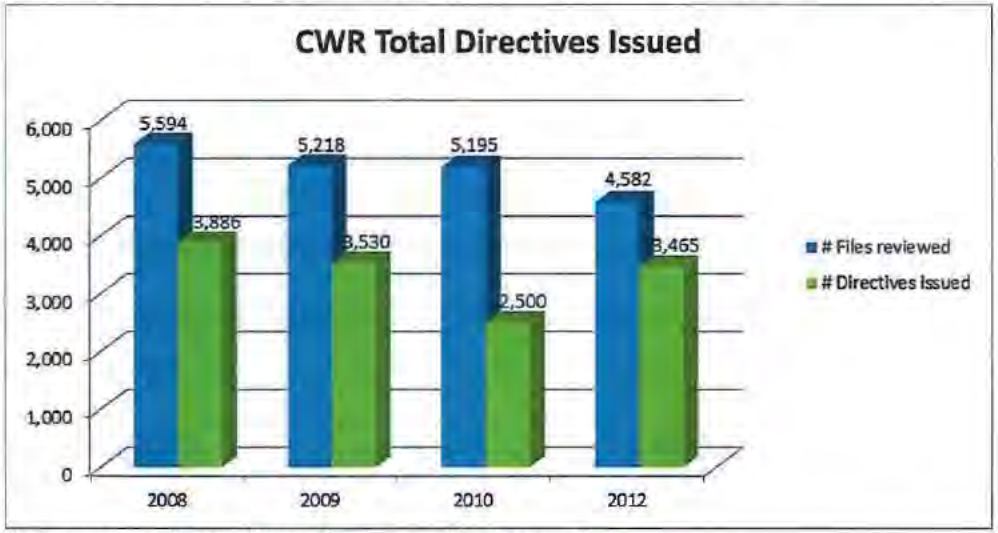
2.4.7 Questionnaires Completed and Interviews Requested

As part of the CWR, children are invited to complete a questionnaire regarding their care. The purpose of the questionnaire is to allow children to provide feedback directly to the review team about their feelings toward the care they are receiving. They may also request to be interviewed by a member of the CWR team. The following chart shows that 35% of all children reviewed completed a questionnaire and 6% requested an interview with the CWR team.

3.0 Legislative Compliance Results

3.1 Overall Compliance Rates

Children's aid societies receive compliance information based on the legislative and regulatory requirements they are mandated to fulfill. The following chart provides a summary of directives issued between 2008 and 2012. It is important to note that with the introduction of the revised CWR process in 2011, the number of issuable directives increases. This, coupled with CASs becoming accustomed to the revised process led to an increase in the overall number of directives issued from 2010 to 2012. The number of directives issued over the last four years (2008, 2009, 2010, 2012), however, has decreased by 11%.

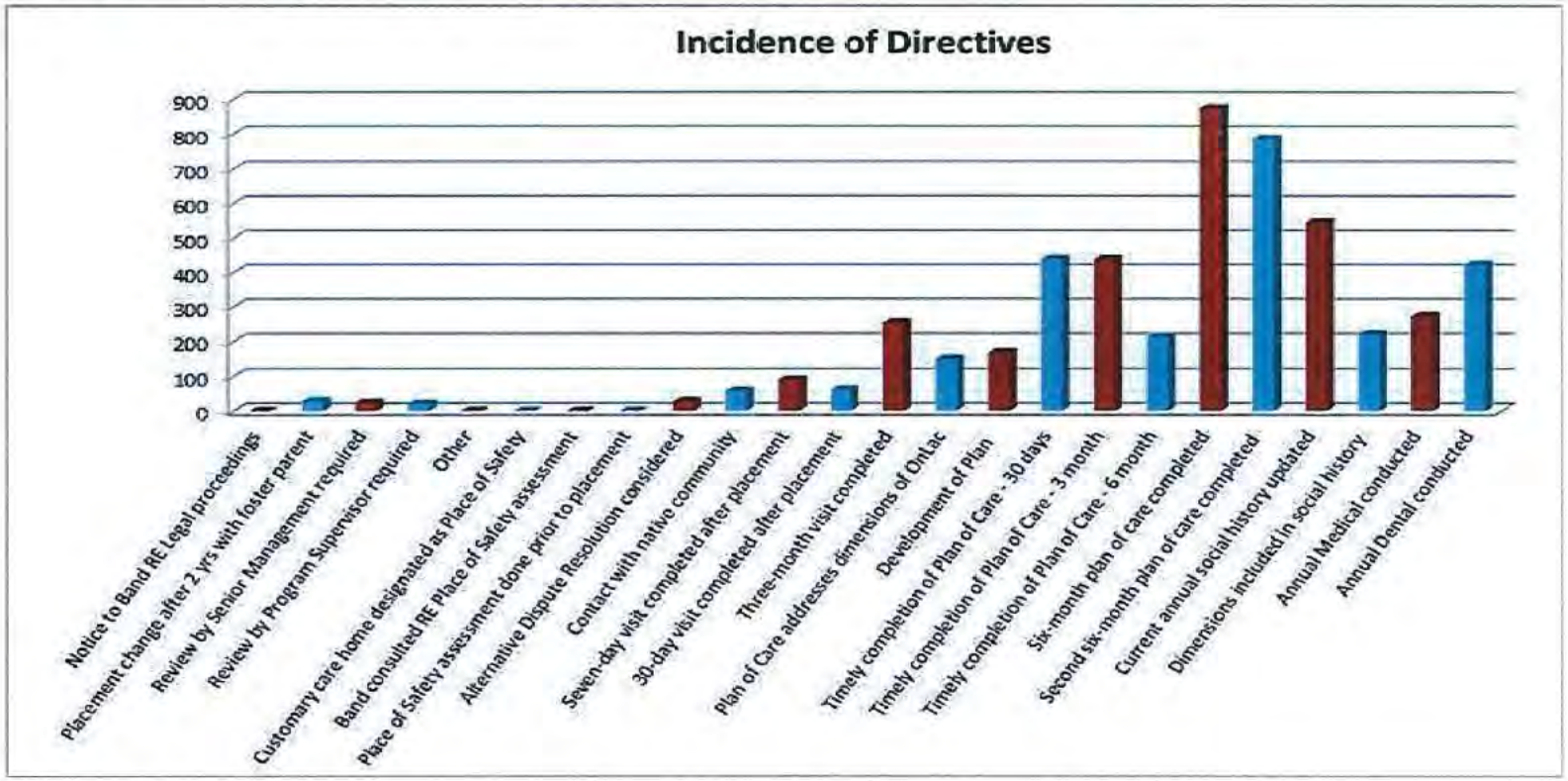


The following chart identifies the areas where directives can be issued:

• Notice to Band RE Legal proceedings • Placement change after 2 yrs with foster parent • Review by Senior Management required • Review by Program Supervisor required • Customary care home designated as Place of Safety • Band consulted RE Place of Safety assessment • Place of Safety assessment done prior to placement	• Alternative Dispute Resolution considered • Contact with native community • Seven-day visit completed after placement • 30-day visit completed after placement • Three-month visit completed • Plan of Care addresses dimensions of OnLac • Development of Plan • Timely completion of Plan of Care - 30 days • Timely completion of Plan of Care - 3 month Timely completion of Plan of Care - 6 month	• Six-month plan of care completed • Second six-month plan of care completed • Current annual social history updated • Dimensions included in social history • Annual Medical conducted • Annual Dental conducted • Other*

*CFSA s.66 authorizes crown ward reviewers to issue any directive that is in the child's best interests. A directive is issued if the reviewer identifies a serious concern that is not covered by other areas.

The following chart depicts the incidence of total directives in 2012:



- The highest rate of incidence was for the directive Six-month plan of care completed (875), followed by the Second six-month plan of care completed (785) and Current Social History updated (545).
- Overall, the number of directives issued in 2012 (3,465) has declined since 2008 (3,886). From 2010 to 2012, the number increased primarily due to the implementation of the revised CWR process that also introduced additional issuable directives.

At the conclusion of each review, CASs receive information related to their compliance broken down by the following categories: "full" (requirements that were 100% compliant), "high" (requirements that were compliant between 75 – 99%), "moderate" (requirements that were compliant between 50 – 74%) and "low" (below 50%). **A complete table with CAS compliance rates broken down by individual CAS is provided in Appendix A.**

4.0 Summary of Crown Ward Review Findings

The data collected through the Crown ward review represents a rich set of information that can be used to better understand a population to whom the sector and the Ministry have the highest obligation: to act as a parent would and provide Crown wards with every opportunity to reach their full potential. This report has provided an overview of the characteristics, needs and experiences of Ontario's Crown wards reviewed, including information about their well-being, safety and permanence while receiving care.

Analysis of Crown wards' special and behavioural needs speak to the complexities of serving this child and youth population and their vulnerability. These realities have remained consistent year after year with developmental and neurological issues particularly prevalent for the youngest children, and diagnoses of ADHD, psychiatric and other emotional issues, school and learning difficulties, and aggressive behaviour developing as important issue for older Crown wards.

Breaking out the analyses by child sex also highlights the specific struggles of boys compared to girls in the review population. In particular, adolescent boys emerge as a high needs population, struggling with high rates of AD(H)D, academic and school-related behavioural problems, and issues with aggression. Consideration needs to be given to how best to support all children and improve their trajectories as they transition to adulthood.

Other findings of the review have implications for practice. The data regarding permanency planning for Crown wards revealed that the permanency plan for many children, particularly as they age, is long-term foster care. Although adoption may not be appropriate for some children, ensuring that all other options are explored (e.g. placement with kin, customary care for Aboriginal children and youth, legal custody) should continue to be a focus and goal of permanency planning.

Societies have indicated their support of the revised CWR process and measuring compliance by legislative and regulatory requirement rather than by individual file. It has been shared that this provides a truer measure of agency compliance and better informs CASs' Quality Improvement Plans which they complete in consultation with their MCYS program supervisor following the review. While the number of directives issued rose from the last CWR Annual Summary Report, this is due to the implementation of the revised CWR process, with an increased number of issuable directives. Directives are predicted to decrease in subsequent years as CASs becoming accustomed to the new process.

5.0 Results from the 2012 Crown Ward Review – Adoption Probation

5.1 Introduction

The goal of the adoption probation review is to determine that an adequate plan of care is developed for Crown wards placed on adoption probation. The review is also intended to stimulate improvement in the overall service delivery to children.

The objectives of the adoption probation review are to:

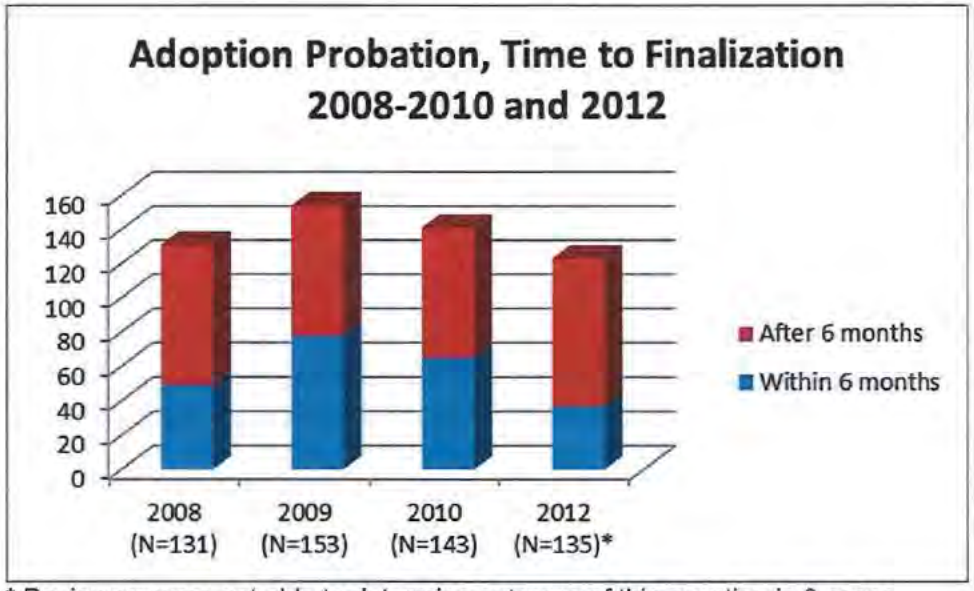
- Monitor compliance with the *Child and Family Services Act* and its regulations in relation to the care of each Crown ward placed on adoption probation;
- Determine whether there has been an adequate assessment of the child's needs, a suitable placement, supporting services, and realistic planning for and with the child, as appropriate;
- Issue directives regarding non-compliance and to make and encourage and monitor implementation of recommendations about particular cases and general policy and practices; and
- Provide information to the society under review about best practices employed in other societies and jurisdictions.

5.2 Scope of the Review and Profile of Children Reviewed

In 2012, 135 children on adoption probation were reviewed, representing a decrease of 6% compared to 2010 data. Of the 135 children reviewed, 69 were boys and 66 were girls. The average age of children at the time of review was 8.1 years, a slight decease from 2010 where the average age was 8.7 years. The average age at Crown wardship for children reviewed was 4.9 years.

5.3 *Adoption Finalization Findings*

The graph below describes CAS plans for adoption finalization. An adoption probation period of at least six months is typically required before an adoption proceeds to finalization.



* Reviewers were not able to determine outcome of this question in 8 cases

- In over half the files reviewed in 2012, adoptions were finalized after six months. This is a relatively stable trend with the exception of 2009 when 51% of adoptions finalized before 6 months.

Appendix A: Compliance Rates, by Children's Aid Society

CWR COMPLIANCE PERFORMANCE SUMMARY - 2012				
	Full	High	Moderate	Low
Anishinaabe Abinoojii Family Services	35.00%	65.00%	0.00%	0.00%
The Children's Aid Society of Algoma	100.00%	0.00%	0.00%	0.00%
The Children's Aid Society of Brant	20.00%	75.00%	5.00%	0.00%
Bruce Grey Child & Family Services	22.20%	27.80%	22.20%	27.80%
Chatham-Kent Children's Services	38.10%	57.10%	4.80%	0.00%
Dilico Anishinabek Family Care	14.30%	52.40%	4.80%	28.60%
Dufferin Child & Family Services	56.20%	12.50%	6.20%	25.00%
Durham Children's Aid Society	45.80%	54.20%	0.00%	0.00%
Family & Children's Services of St. Thomas & Elgin	70.60%	29.40%	0.00%	0.00%
Family & Children's Services of Frontenac, Lennox & Addington	30.40%	43.50%	21.70%	4.30%
Family & Children's Services of Guelph & Wellington County	11.80%	58.80%	23.50%	5.90%
Children's Aid Society of Haldimand & Norfolk	45.50%	40.90%	13.60%	0.00%
Halton Children's Aid Society	45.00%	50.00%	5.00%	0.00%
Children's Aid Society of Hamilton	38.10%	52.40%	9.50%	0.00%
Catholic Children's Aid Society of Hamilton	43.50%	34.80%	21.70%	0.00%
Highland Shores Children's Aid	19.00%	57.10%	14.30%	9.50%
Huron-Perth Children's Aid Society	12.50%	50.00%	25.00%	12.50%
Jewish Family & Child Service	70.60%	17.60%	11.80%	0.00%
Kawartha-Halliburton Children's Aid Society – 1st review (postponed from 2011)	33.30%	57.10%	9.50%	0.00%
Kawartha-Halliburton Children's Aid Society – 2nd review	100.00%	0.00%	0.00%	0.00%
Kenora-Rainy River Districts Child and Family Services	47.40%	36.80%	15.80%	0.00%
Family and Children's Services of Lanark Leeds and Grenville	36.80%	63.20%	0.00%	0.00%
Children's Aid Society of London & Middlesex	33.30%	54.20%	8.30%	4.20%
Children's Aid Society of London & Middlesex (2013 postponed until 2014)				
Family Youth & Child Services of Muskoka	68.80%	18.80%	6.20%	6.20%

Native Child and Family Services of Toronto	47.40%	42.10%	5.30%	5.30%
Family & Children's Services Niagara	52.40%	47.60%	0.00%	0.00%
Children's Aid Society of the Districts of Nipissing & Parry Sound	31.80%	59.10%	9.10%	0.00%
North Eastern Ontario Family and Children's Services	28.60%	61.90%	9.50%	0.00%
Children's Aid Society of Ottawa	36.40%	45.50%	13.60%	4.50%
Children's Aid Society of Oxford County	36.40%	59.10%	4.50%	0.00%
Payukotayno: James & Hudson Bay Family Services	55.00%	30.00%	15.00%	0.00%
Peel Children's Aid Society	26.10%	47.80%	4.30%	21.70%
Children's Aid Society of the County of Prince Edward	44.40%	44.40%	11.10%	0.00%
Family & Children's Services of Renfrew County	13.00%	52.20%	17.40%	17.40%
Sarnia-Lambton Children's Aid Society	33.30%	42.90%	19.00%	4.80%
The Children's Aid Society of Simcoe County	75.00%	5.00%	10.00%	10.00%
Children's Aid Society of the Counties of Stormont, Dundas & Glengarry	84.60%	0.00%	0.00%	15.40%
Children's Aid Society of the District of Sudbury & Manitoulin	87.50%	0.00%	0.00%	12.50%
Children's Aid Society of the District of Thunder Bay	78.90%	0.00%	5.30%	15.80%
Tikinagan Child & Family Services	20.00%	30.00%	35.00%	15.00%
Catholic Children's Aid Society of Toronto	18.20%	68.20%	4.50%	9.10%
Children's Aid Society of Toronto	27.30%	68.20%	0.00%	4.50%
Valoris for Children and Adults Prescott Russell	54.50%	45.50%	0.00%	0.00%
Family & Children's Services of the Waterloo Region	30.00%	70.00%	0.00%	0.00%
Weechi-it-te-win Family Services	42.10%	36.80%	10.50%	10.50%
Windsor Essex Children's Aid Society	33.30%	52.40%	14.30%	0.00%
York Region Children's Aid Society	15.00%	70.00%	5.00%	10.00%
Provincial Average	**42.75%**	**42.28%**	**8.99%**	**5.97%**

This is **Exhibit "29"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc., Province of Ontario, while a Student-at-Law. Expires May 9, 2019.

Year	Characteristics of Wardship			
	Average age at time of wardship	Average age at time wardship ceases	Average duration of wardship	
1980	0 - 4 years: 34.7%		2 - 3 years: 30.6%	Average duration between 1980 - 1984:
	5 - 8 years: 28.1%		4 - 6 years: 30.7%	2 - 3 years: 43.5%
	9 - 12 years: 29.7%		7 - 9 years: 15.8%	4 - 6 years: 29%
	13 - 14 years: 7.2%		10 - 12 years: 12.4%	7 - 9 years: 12.3%
	15 - 16 years: 0.2%		13 - 15 years: 9.2%	10 - 12 years: 7.5%
			16 - 17 years: 1.4%	13 - 15 years: 5.9%
				16 - 17 years: 1.8%
1981	0 - 4 years: 30.3%		2 - 3 years: 49.7%	
	5 - 8 years: 28.2%		4 - 6 years: 24%	
	9 - 12 years: 30.7%		7 - 9 years: 12.5%	
	13 - 14 years: 9.7%		10 - 12 years: 6.9%	
	15 - 16 years: 1.2%		13 - 15 years: 5.6%	
			16 - 17 years: 1.3%	
1982	0 - 4 years: 28.1%		2 - 3 years: 52.3%	
	5 - 8 years: 25.8%		4 - 6 years: 20.1%	
	9 - 12 years: 30.7%		7 - 9 years: 11.9%	
	13 - 14 years: 12.7%		10 - 12 years: 6.4%	
	15 - 16 years: 2.7%		13 - 15 years: 6.6%	
			16 - 17 years: 2.6%	
1983	0 - 4 years: 26.7%		2 - 3 years: 37.3%	
	5 - 8 years: 28.4%		4 - 6 years: 36.8%	
	9 - 12 years: 32.8%		7 - 9 years: 11.3%	
	13 - 14 years: 10.5%		10 - 12 years: 7.8%	
	15 - 16 years: 1.6%		13 - 15 years: 5.2%	
			16 - 17 years: 1.6%	
1984	0 - 4 years: 22.4%		2 - 3 years: 45.6%	
	5 - 8 years: 28.3%		4 - 6 years: 33%	
	9 - 12 years: 32. 5%		7 - 9 years: 10.9%	
	13 - 14 years: 12.4%		10 - 12 years: 5%	

	15 - 16 years: 4.4%		13 - 15 years: 3.5%	
			16 - 17 years: 1.9%	
1985				
1986				
1987				
1988	Not reported		5 years	
1989	0 - 9 years: 61.2%		5.1 years	
	10 - 12 years: 23%			
	13 - 17 years: 15.8%			
1990	0 - 9 years: 63%		5.2 years	
	10 - 12 years: 22.3%			
	13 - 17 years: 14.7%			
1991	0 - 9 years: 60.2%		4.8 years	
	10 - 12 years: 23.6%			
	13 - 17 years: 16.2%			
1992	0 - 9 years: 56.2%		5 years	
	10 - 12 years: 22%			
	13 - 17 years: 21.8%			
1993	0 - 9 years: 65.2%		5.1 years	
	10 - 12 years: 22.2%			
	13 - 17 years: 12.6%			
1994	0 - 9 years: 58.3%		5 years	
	10 - 12 years: 22.4%			
	13 - 17 years: 19.3%			
1995				
1996				
1997	8			
1998	7.8			
1999	Unreported			
2000	8.4			
2001	8.4			
2002	8.5			
2003	8.5			

2004	8.6			
2005	8.5			
2006	8.5			
2007	8.4			
2008	8.3			
2009	8.2			
2010	Under 1 year: 1%		6.1 years	
	1 - 5 years: 28%			
	6 - 12 years: 61%			
	13 - 18 years: 10%			
2011	**NO REPORT AVAILABLE**			
2012	Under 1 year: 2%		5.9 years	
	1 - <6 years: 29%			
	6 - <13 years: 59%			
	13 - <18 years: 10%			

This is **Exhibit "30"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Crown Wards Review Summary

Primary Reason for Admission to Care Leading to CASs Seeking Crown Wardship Orders			
Year	%	Categories	Data Source
1980	11.90%	Unmarried Parent	Crown Ward Administrative Review: Five Year Report, December 1984
	9.80%	Death of Parent	
	6.90%	Illness of Parent	
	34.20%	Parental Inadequacy	
	10.40%	Child's Need of Special Care	
	16.40%	Rejection of Child	
	5.90%	Neglect and Abuse	
	3.70%	Abandonment	
	0.50%	Alcoholism	
	0%	Parent-Child Conflict	
	0%	Unknown	
	0.40%	Other	
1981	7%	Unmarried Parent	
	7%	Death of Parent	
	8.70%	Illness of Parent	
	28.40%	Parental Inadequacy	
	18.40%	Child's Need of Special Care	
	11.80%	Rejection of Child	
	10.90%	Neglect and Abuse	
	4.20%	Abandonment	
	1.70%	Alcoholism	
	0%	Parent-Child Conflict	
	0%	Unknown	
	1.70%	Other	
1982	6.70%	Unmarried Parent	
	4.50%	Death of Parent	
	8%	Illness of Parent	
	21.30%	Parental Inadequacy	
	23.20%	Child's Need of Special Care	
	11.80%	Rejection of Child	
	10.40%	Neglect and Abuse	
	3.20%	Abandonment	
	5.10%	Alcoholism	
	0%	Parent-Child Conflict	
	0%	Unknown	
	6%	Other	
1983	5.30%	Unmarried Parent	
	4.10%	Death of Parent	
	8.40%	Illness of Parent	
	21.80%	Parental Inadequacy	
	20.20%	Child's Need of Special Care	
	10.80%	Rejection of Child	
	14.20%	Neglect and Abuse	
	2.70%	Abandonment	
	7.60%	Alcoholism	
	0%	Parent-Child Conflict	
	0%	Unknown	
	4.80%	Other	
1984	3.70%	Unmarried Parent	
	3.70%	Death of Parent	
	7.90%	Illness of Parent	
	20.70%	Parental Inadequacy	
	18.10%	Child's Need of Special Care	
	11%	Rejection of Child	
	17%	Neglect and Abuse	
	3.90%	Abandonment	
	6.20%	Alcoholism	
	3.70%	Parent-Child Conflict	

Crown Wards Review Summary

Primary Reason for Admission to Care Leading to CASs Seeking Crown Wardship Orders			
Year	**%**	**Categories**	**Data Source**
	1%	Unknown	
	3.10%	Other	
1985			1988 Annual Report: Crown Ward Administrative Review Unit
1986			
1987			
1988	34.10%	Physical and/or sexual abuse	
1989		Not reported	Crown Ward Administrative Review: 1989 & 1990 Report
1990			
1991	48.70%	Verified abuse (physical/sexual)	Crown Ward Administrative Review Statistics: 1991 - 1994
1992	42%		
1993	52%		
1994	41.10%		
1995			
1996			
1997	24%	Physical and/or sexual abuse	Crown Ward Review Summary Reports 1997 - 2010
1998	28%		
1999	28%		
2000	40%	Abuse	
2001	38%		
2002	45%		
2003	31%		
2004	37%		
2005	38%		
2006	34%		
2007	30%		
2008	24%		
2009	24%		
2010	54%	Caregiver capacity (including mental health and substance abuse issues)	
	16%	Physical or sexual abuse	
	14.50%	Neglect	
	13.50%	Abandonment/separation	
	2%	Emotional harm	
2011	**NO REPORT AVAILABLE**		
2012	50%	Caregiver capacity	Crown Ward Review Summary Report 2012
	15%	Physical/sexual harm by commission	
	15%	Harm by omission	
	15%	Abandonment/separation (including caregiver-child conflict/child behaviour)	
	5%	Emotional harm/exposure to conflict	

This is **Exhibit "31"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

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Crown Wards Review Summary

Verified Maltreatment of Crown wards while in care		
Year	**%**	**Data Source**
1980		Not Reported
1981		
1982		
1983		
1984		
1985		
1986		
1987		
1988		
1989		
1990		
1991	6%	Crown Ward Administrative Review Statistics: 1991 - 1994
1992	5%	
1993	6%	
1994	1%	
1995		
1996		
1997	5%	Crown Ward Review Summary Reports 1997 - 2010
1998	5%	
1999	6%	
2000	6%	
2001	6%	
2002	6%	
2003	5%	
2004	6%	
2005	5%	
2006	4%	
2007	4%	
2008	4%	
2009	4%	
2010	4%	
2011	**NO REPORT AVAILABLE**	
2012	2%	Crown Ward Review Summary Report 2012

This is **Exhibit "32"** referred to in the Affidavit of Kevin Morris, sworn on this 13th day of June, 2016.

A Commissioner etc.

Jessica Kras, a Commissioner, etc.,
Province of Ontario, while a
Student-at-Law.
Expires May 9, 2019.

Standards and Guidelines for the Management of Child Abuse Cases under The Child Welfare Act by the Children's Aid Societies

Community and Children's Services April 1979

STANDARDS AND GUIDELINES

FOR THE MANAGEMENT OF

CHILD ABUSE CASES

UNDER THE CHILD WELFARE ACT

BY THE CHILDREN'S AID SOCIETIES

ACKNOWLEDGEMENT

The Ministry of Community and Social Services is indebted to Ross Dawson for the development of these Standards and Guidelines for the Management of Child Abuse Cases under The Child Welfare Act, 1978 by the Children's Aid Societies. Mr. Dawson is Assistant Director of the Children's Aid Society of Sault Ste. Marie and the District of Algoma.

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1. INTRODUCTION

The goal in development of these standards and guidelines is to ensure, as far as possible, an adequate and uniform level of service for abused children, for children alleged to have been abused and children at risk throughout the Province. It is believed that many of the standards and guidelines contained in this document represent the level of service that currently exists. They formalize responsible case management rather than advocate entirely new approaches. Although the standards and guidelines are designed for use by the Children's Aid Societies they do not specify the responsibility of workers within a Society. This is left up to each Society.

It is expected that the Children's Aid Societies will incorporate the standards described in this document into their general intake and protection policies. Those case management processes described as guidelines represent desirable or optimal practice.

The Framework

The overall direction of a Society's child abuse program should be undertaken only by supervisors who have experience and appropriate specific knowledge, training and experience in all aspects of child protection service. Assignment of management responsibility for child abuse cases should be made only to case workers who have had training and experience in handling child abuse cases.

The management of child abuse investigations and cases must be given top priority in the services offered by the Society.

All Children's Aid Society staff must be aware of their responsibilities as stated in The Child Welfare Act, 1978. The Societies must ensure that all existing and all new protection staff dealing with or likely to deal with cases of child abuse receive appropriate and adequate training in child abuse case management. The Ministry of Community and Social Services must ensure that such training programs and other learning opportunities are provided for the Societies.

It is important to recognize that abuse or alleged abuse may occur in care as well as within the family and that the following standards and guidelines are applicable in these situations as in any other situation.

Casework in the protective service area is difficult, demanding and stressful, particularly in the management of child abuse cases. In recognition of this factor it is recommended that protection workers have generalized case loads as opposed to case loads composed entirely of child abuse cases. Where possible, specialized child abuse case loads should be significantly reduced. Provision should be made for the regular systematic monitoring of case load weighting both at intake and throughout case management, to prevent 'overload' and 'burn out'

In addition, provision should be made for a systematic annual review of each Children's Aid Society staff person's case load and performance in the area of child abuse. Included in this review should be the option and opportunity for reassignment within the Society at an early date and provision, as possible, for attendance at special educational opportunities such as conferences or seminars.

In all initial child abuse investigations, and at other appropriate stages of case management, where Children's Aid Society is providing service alone, the worker assigned to the case should have back-up assistance from a senior worker or from the supervisor. This will ensure that the family has access to persons in addition to the assigned worker who are knowledgeable about their situation. It will also provide the assigned worker with support and assistance as may be needed.

The Ministry of Community and Social Services is available for consultation at all stages throughout the management of child abuse cases. This consultation may be obtained by the Children's Aid Society through any of the following:

a) a Program Advisor,

b) Child Abuse Program Co-ordinator or Consultants,

c) Ministry of Community and Social Services, Legal Services Branch.

In addition, the Ministry personnel contacted may be able to facilitate further consultation with other professionals with specific or additional expertise in child abuse.

2. GLOSSARY OF TERMS

Assessment Team

The definition of assessment team refers generally to a team composed of professionals, colleagues and consultants who, with their combinations of knowledge and skill are able to provide a clearer understanding of a child and/or family. In these Standards and Guidelines the assessment team is usually the interdisciplinary child abuse team.

Case Conference

A case conference, in these standards and guidelines, refers to a meeting attended by as many people as possible involved in a case of child abuse for the purpose of evaluating facts and sharing professional opinions in an effort to arrive at decisions regarding a case of alleged abuse.

Emergency situations and availability of local child abuse teams or other resources will determine the form of such a conference. The following case conference models should be considered and the appropriate model utilized.

1) A conference should be held with all case related staff including the Children's Aid Society supervisor (See "Case Supervision")

2) A conference with the local child abuse team should be held. In addition to regular team members the following persons should be in attendance:

   Children's Aid Society protection worker
   Children's Aid Society child care worker
   Children's Aid Society supervisor (where appropriate)
   Alternate care providers (where appropriate)
   Any additional professionals involved in the assessment/ investigation
   Other professionals actively involved with the child/family

3) Where no formal child abuse team is in operation the case conference should include all professionals actively involved with the family, professionals who may not be actively involved but have significant data with respect to the family, a Children's Aid Society worker and a Children's Aid Society supervisor.

(Where possible, the multidisciplinary model is highly recommended.)

Central Register

The Central Register referred to in The Child Welfare Act, 1978 s.52, means a central file where all cases of verified abuse are recorded specifically for purposes of monitoring and tracking. For reporting requirements see Section 52, The Child Welfare Act, 1978, Guidelines to the Legislation - Child Abuse Legislation (January 1979).

Child Abuse

The definition of child abuse employed in these standards and guidelines is that used in Section 47 of The Child Welfare Act, 1978.

'Abuse' means any of the following conditions:

(i) physical harm,

(ii) Malnutrition or mental ill-health of a degree that if not immediately remedied could seriously impair growth and development or result in permanent injury or death,

(iii) Sexual molestation,

inflicted upon a child, or permitted to be inflicted upon a child by the child's parent or any person having the care, custody, control or charge of the child under sixteen years of age. These conditions are discussed in depth in the attached Resource Kit.

Emergency Situation

An emergency situation means any situation in which a child's physical or emotional well-being appears to be in immediate danger.

Investigation

Investigation is the process of interviewing, observing, evidence gathering and assessing through which reports of child abuse are verified or invalidated.

Parent

This is defined in The Child Welfare Act, 1978 s.19 and means

i) a guardian
ii) a person who has demonstrated a settled intention to treat a child as a child of the person's family, and
iii) a person who is not recognized in law to be a parent of a child but,

1. has acknowledged a parental relationship to the child and has voluntarily provided for the child's care and support,

2. by an order of a court of compentent jurisdiction or a written agreement, is under a legal duty to provide for the child or has been granted custody of or access to the child, or

3. has made a written acknowledgement of the fact of his or her parentage to the society having or applying for the care or supervision of the child.

In abuse situations it must be remembered that not only parents abuse children. The abuser may be anyone, from a babysitter to a teacher or any adult who has charge of the child, or a person who is a stranger to the child. In these standards and guidelines such persons are included in the general term "caretaker".

Place of Safety

The definition of "place of safety" employed in these standards and guidelines is that used in The Child Welfare Act, 1978 S.19(f) and means a receiving home, foster home, hospital, and such other place or class of places designated in writing by a Director, but does not include a training school under The Training Schools Act.

Verified Child Abuse

'Verified' as used in Section 52 of The Child Welfare Act, 1978 refers to cases in which a Children's Aid Society local director, based upon the finding of the Society's investigatory staff and where appropriate, in consultation with other relevant professionals, has reasonable grounds to believe that abuse has occurred. It is deemed highly desirable that a multi-professional assessment team (or child abuse team) be utilized in arriving at such verification. (see Assessment Team.) In most communities teams already exist and in communities where they do not exist the Ministry is prepared to assist agencies in developing such teams.

3. UTILIZATION OF RESOURCE KIT

The "Resource Kit" attached to this document is to be used in cases of child abuse. It is a compilation of articles and checklists designed to familiarize workers with the indicators of child abuse and other factors relevant to such cases.

In utilizing this kit it is important to remember that no one indicator, nor indeed a set of indicators, may confirm child abuse. It is emphasized that the full process of investigation, including assessment and verification be carried out in conjunction with the Resource Kit prior to a decision being made which may or may not confirm the existence of child abuse. The use of the Resource Kit goes hand in hand with in-depth training and clear judgement providing the basis for sound decision-making. (see section The Investigation Process.)

The attached "Resource Kit" includes two separate sections with subsections in each.

Identifiers

1) physical indicators of abuse and some questions to ask in the identification process

2) physician's index of suspicion

3) recognition, care and protection

4) high risk signals

   a) prenatal

   b) post partum

   c) delivery room

5) detection of high risk parents

6) characteristics of abuse and neglect

7) typical reactions of parents and children

8) behavioural indicators of abused children

9) indicators of neglect

10) indicators of emotional maltreatment

11) indicators of sexual abuse

12) indicators of potential of parent to abuse

Procedures

1) factors to consider in child abuse cases regarding admission to care

2) factors to consider regarding the decision to return a child to Parents

3) factors to consider in terminating service in child abuse cases.

4) procedures and information relating to the handling of all child abuse investigations for police and children's aid societies.

4. THE INVESTIGATION PROCESS

Commentary

Child abuse cases are given and should continue to be given the highest priority in the provision of Children's Aid Society service. The standards and guidelines written under this section describe a general process which should be followed by Societies in the investigation of all child abuse referrals. While it is desirable that Children's Aid Society intervention be as therapeutic as possible, the priority during the process of investigating an alleged child abuse is to determine the child's need for protection.

Investigation

The process of investigation has four phases:

1) receipt of report
2) information gathering
3) assessment
4) verification

Obtaining facts is crucial in order to make the correct diagnosis of a case; therefore, as extensive an evaluation as possible of a child's environment should be made to determine the appropriate service to be provided by the Children's Aid Society. In some instances, as in cases where there appears to be immediate danger to the child, it may not be possible to make the detailed recording of facts which are ultimately desired. The following standards and guidelines used in conjunction with the Resource Kit will help to determine the child's immediate need for safety and the appropriate course of action required by a Society. Information is obtained from, but not limited to, record checks, interviews, medical examinations, reports from other agencies, and examination of the child's environment.

The Child Welfare Act, 1978 makes provision for the Children's Aid Society to request information and reports from other agencies/professionals during the investigation process which will assist in determining the child's need for protection. Where the other agency refuses to share the information, the Children's Aid Society may seek a court order under Section 50 of the Act. It is reasonable to expect that in an effort to provide adequate service to children, close working relationships between the Children's Aid Societies and other service providers would naturally develop, making the use of Section 50 unnecessary.

The information acquired during the initial investigation phase will provide the factual basis for good decision-making. Equally important is experience, continuing staff training and supervision. In addition, information from the following specific areas should be considered. These indicators should serve simply as a guide to workers to assist them in weighing all the facts regarding a particular alleged child abuse case.

1) Physical Indicators

2) Behaviour Indicators

3) Relationship Indicators

4) Specific Family Dynamics

A detailed description of each area is outlined in the Resource Kit and should be studied thoroughly. It must be emphasized that no one factor or indicator by itself leads to a diagnosis, but rather a diagnosis is based on the accumulation of correlated facts and careful assessment.

A formal assessment of the child and family could take place through one of the following:

1) court-ordered assessment after finding a child in need of protection (Section 29, The Child Welfare Act, 1978).

2) expertise of a local child abuse team, e.g. pediatric examination, psychiatric consultation, etc.

3) through referral or utilization of existing community agencies, e.g. mental health clinic.

4) psychological/developmental/pediatric assessment of children who are admitted to a hospital or other place of safety.

The assessment of a child, who is in the care of a Society, may be undertaken without a court order prior to the finding that the child is in need of protection.

As a result of this assessment, a plan should be devised which represents the application of judgement, experience and knowledge in assessing the information available to determine what are realistic and attainable goals and how they may be achieved.

Verification may take place at any stage of the investigation into an allegation of child abuse, if sufficient documentation for such a decision is available. Generally the procedure used should be a case conference where all available information concerning the alleged abuse should be carefully evaluated.

IN-01 **General**

STANDARDS

INS-01.1 The initial investigation report shall be recorded within twenty-one days of the receipt of the complaint. (see CWA-Reg.)

INS-01.2 All Children's Aid Society officers shall carry cards identifying them as officers of a Society.

INS-01.3 Society management shall ensure that all staff, including after-hours duty staff are officers of a Society and thus empowered to apprehend children believed to be in need of protection.

IN-02 **Receipt of Report**

STANDARDS

INS-02.1 The investigation process of an alleged child abuse shall be initiated within one hour after receiving the report. (Note: This would require that a staff member is given responsibility for initiating a response to a complaint. This initial response may take one of many forms, depending on the facts known).

INS-02.2 Reports of alleged child abuse shall be recorded within twenty-four hours of receipt.

INS-02.3 Police shall be informed of all complaints received of alleged child abuse according to a predetermined plan that will have been worked out jointly by the police and local Children's Aid Society. (see POS-01.17) (see "Police Involvement" and "Supervision").

INS-02.4 In all cases where the Children's Aid Society has been informed of an alleged abuse, the Children's Aid Society shall initiate and proceed with an investigation even when police investigations are proceeding concurrently.

Guideline

ING-02.1 Upon receipt of an initial report, as complete details as possible regarding the allegation should be obtained and recorded and should include as much as possible of the following:

a) full name, age, birthdate, address, telephone number, religion of child

b) full names, ages, addresses, telephone number, religion of parents

c) current whereabouts of child

d) current whereabouts of and how parents can be contacted

e) as complete details as possible of alleged occurrence

f) complete details of other incidents or suspicions of abuse

g) a medical examination and documentation of results

h) names, ages and condition of siblings at home

i) name, address, telephone number of other possible witnesses or persons having relevant information about the child/family, e.g. school, doctor, public health person, social service agencies, etc.

j) name of family doctor

k) details of other agencies knowledgeable about the family

l) a record of police notification

m) name of school, nursery, day care centre which child attends

n) attempt to get name, address, phone number of the reporter and relationship to the family reported

o) some assessment as to the motivation of the person making the report

p) previous address or location of family.

IN-03 **Information Gathering Process**

STANDARDS

INS-03.1 When child abuse is suspected, the initial investigation process shall include the following interviews:

a) face-to-face interview with child and parent(s)-/caretaker(s)

b) interview with reporter of abuse, where the identity of the reporter has been ascertained

c) interview with siblings

d) interview with other witnesses, relatives, neighbours who may have information regarding the family

e) interview with other professionals knowledgeable about the family.

INS-03.2 The following record checks shall be made and documented either at the initial or at a subsequent phase of the investigation.

a) a check of local Children's Aid Society records for previous incidents of abuse

b) a check with Children's Aid Society in family's previous area(s) of residence

c) a check of records of Central Register

d) a check with other local agencies that have had or may have had contact with the family.

INS-03.3 The child alleged to have been abused shall be seen as soon as possible and no later than twelve hours after receipt of the initial report and the visit documented.

INS-03.4 The child shall be examined carefully without clothes with the permission of the parent(s)/caretaker(s) in the presence of the parent(s)/caretaker(s) and the Children's Aid Society worker and a record of the examination documented. Discretion shall be used relative to the age and sex of the child. Where physical injury is suspected, a medical examination shall be arranged as soon as possible within twenty-four hours.

INS-03.5 In all instances where the parent refuses access to or examination of the child, the child shall be apprehended and examined by a community health professional (see "Court", "Police Involvement", and Section 19(1)(b)(xi), The Child Welfare Act, 1978).

INS-03.6 Siblings shall be seen and examined and results documented where:

a) reporters suggest other children may be or have been abused

b) the identified child is injured or abused

c) present circumstances suggest other children may be abused or at risk.

INS-03.7 The examining doctor shall be advised that abuse is suspected and that a full and careful examination and report are required.

INS-03.08 Where young children have been or likely have been abused or where head or internal injuries are suggested, a skeletal survey by x-ray shall be requested.

INS-03.9 The date, doctor's name and details of exactly what evidence of injury/neglect is found, as well as opinion of the cause, shall be obtained and recorded.

Ministry of
Community and
Social Services
Ontario

Children's Services Division
700 Bay Street, 10th Floor
Toronto, Ontario
M7A 1E9

March 26, 1979

To All Local Directors of Children's Aid Societies:

We know you have anticipated the Standards and Guidelines for the Management of Child Abuse Cases and we are pleased to be able to send them to you now.

It is our belief that the procedures outlined in these Standards and Guidelines reflect good case management practices and therefore contain nothing that is new or different for many Children's Aid Societies. Rather, they are an attempt to formalize procedures that are generally acceptable and that are often already in place.

Thus there can be no magical date on which the procedures outlined will come into effect. In order to be sure that they are practical and realistic for all Societies, we are distributing this first printing only to Local Directors, CAS child abuse team leaders and protection supervisors. We ask that the Standards and Guidelines be examined and discussed within each Children's Aid Society. We will then meet with you to review the document, hopefully during May and June. Following this, we will revise as indicated and aim for distribution to all front-line protection staff during the summer months. The Standards and Guidelines will be incorporated into the training programs designed for supervisors and front-line protection workers. We are not anticipating substantially increased costs of staffing and administration of the Standards and Guidelines. Where necessary, some additional staff has been planned for in the implementation of the Garber Task Force on Child Abuse, and through staff supplementation by the Child Abuse Program.

Where necessary, we foresee a gradual phasing-in process, and expect that the revised procedures would generally be in place in all Societies by the end of 1979.

Sincerely,

Judge George Thomson
Associate Deputy Minister

INS-01.2 Reports of all verified cases of child abuse shall be forwarded by the Local Director to the Central Register.

Guidelines

ING-01.1 In all situations, it is recommended that the conference should:

a) review all relevant information obtained from the investigation/assessment

b) determine the facts obtained in the investigation that support or refute the allegations in the complaint, and/or additional allegations of abuse arising from the investigation

c) list all evidence/proof obtained in the investigation-/assessment that substantiate the facts in b) above

d) review all professional opinions which pertain to the existence of child abuse in the particular case

e) list all the factors which support the judgments

f) list all factors which do not support the judgments.

ING-01.2 The conference should then make one of the following determinations:

a) Abuse does not appear to exist.

b) Abuse is verified.

c) Abuse is not verified but high-risk conditions exist.

ING-01.3 Where abuse is verified or considered likely, the conference should then determine:

a) the child's immediate condition at home

b) the court process to be followed (see "Police Involvement" and "Court")

c) further investigatory/assessment steps to be undertaken

d) any treatment/management recommendations

e) any case monitoring strategies.

5. CASE MANAGEMENT

Commentary

Following the completion of a child abuse investigation, one of six decisions is possible.

1) Child abuse does not appear to exist.

2) Child abuse does not appear to exist but the family requests or agrees to Children's Aid Society services.

3) Child abuse is suspected; child remains with parents.

4. Child abuse is suspected, and while it has not been verified, factors warrant that the child be removed to a place of safety.

5) Child abuse is verified; child remains with parents.

6) Child abuse is verified; child is removed to a place of safety.

Each of these decisions requires a specific form of case management by the Children's Aid Society. In some situations another agency may assume partial responsibility for the care/treatment of a child. However, it must be emphasized that regardless of service assignments and shared responsibility, the ultimate responsibility for protection and case management rests with the Children's Aid Society.

CM-01 **Child Abuse Does Not Appear to Exist**

STANDARDS

CMS-01.1 Where the identity of the reporter has been ascertained this source shall be thanked for their interest, and informed in general terms about the Society's reponse to their concern.

CMS-01.2 Documentation of the investigation process and reasons behind disposition shall be made and placed on the file within twenty-one days of completion of the investigation (see CWA-Reg.).

CMS-01.3 The family shall be advised of the disposition within fourteen days of the completion of the investigation.

CMS-01.4 The report source and/or other agencies involved in the report, investigation or assessment process shall be notified of the disposition within fourteen days of the completion of the investigation.

CMS-01.5 In cases where, after investigation, the referral/report is considered to be malicious or without reasonable and probable cause, the file shall clearly indicate this finding. In addition, a face to face interview shall be arranged with the reporter where the identity of the reporter has been ascertained , who shall be advised of the finding and, in the case of a malicious report, the seriousness of such accusations and legal consequences which could arise from this or other similar behaviour.

CM-02 **Child Abuse Is Suspected**

STANDARDS

CMS-02.1 Following investigation/assessment where:

a) abuse is suspected

b) the family does not voluntarily use Children's Aid Society service

the situation shall be monitored by Children's Aid Society until such suspicion has been eliminated.

CMS-02.2 Where child abuse is suspected and where it is believed that the child is at great risk of abuse, the child shall be apprehended and a report recorded of why this action was taken in order to:

a) protect the child

b) complete the investigation/assessment

c) allow the courts to make a final disposition on the basis of available evidence.

CMS-02.3 Where child abuse is suspected but the child remains at home, the family shall be advised that child abuse is suspected and that other agencies which may be providing service to the family have been asked to involve the Children's Aid Society if required.

CMS-02.4 The Children's Aid Society shall be reponsible to see that monitoring is done in one or more of the following ways:

a) alerting other resources (e.g. doctor, public health nurse, schools) to those factors causing the suspicion in the case

b) checking with or conferencing at least monthly with those professionals/others having access to the child or family

c) requesting that such persons involve the Children's Aid Society immediately should there be a further cause for suspicion or any incident of abuse or lack of access to the child. The Children's Aid Society shall also be advised if the family moves so that monitoring can continue through other appropriate agencies/Children's Aid Society.

CMS-02.5 Action in a) and b) above shall be confirmed in writing by the Children's Aid Society.

CMS-02.6 Details of findings in b) above shall be recorded and placed in the protection file.

CMG-02.7 See CMS-01.4.

CM-03 **Where Child Abuse is Verified**

STANDARDS

CMS-03.1 In cases where abuse is verified the standards and guidelines under the following sections shall be utilized:

"Verification", "Court", "Police Involvement", "Report to Ministry", "Removal of Child", "Reviews", "Supervision".

CMS-03.2 Where the child remains with the parents there shall be regular visits by a Children's Aid Society worker at intervals not less than one week depending on the assessed degree of risk to the child.

CMS-03.3 These visits shall continue until the case is transferred or terminated or until the home is considered safe. (See TES-01.2.)

CMS-03.4 A missed visit by the family shall be seen as a danger signal and shall be followed up immediately within twenty-four hours. Under no circumstances shall the visit be dropped until the next regular time.

CMS-03.5 If a worker is unavailable and has to miss a visit the family shall be notified and, a replacement worker shall visit or another visit shall be arranged within twenty-four hours.

CMS-03.6 Regular physical examinations at intervals not less than once a month shall be conducted by a community health professional.

CMS-03.7 Where another professional/agency is providing additional service the Children's Aid Society shall:

a) determine clearly which agency is assuming the additional treatment role and the extent of that agency's responsibility

b) determine the treatment plan, and ensure that the other agency has a clear agreement with the family for service

c) determine that the other agency will obtain and provide information regarding incidents or suspicion of further abuse, any withdrawal or avoidance of service, or removal of the family to another location, or lack of access to the child.

d) ensure that a) b) and c) are confirmed in writing

CMS-03.8 Where the child remains at home, the Children's Aid Society shall ensure that the agency providing additional treatment and follow-up has direct access to and examines the child upon an agreed-upon frequency. Such examination and access shall be clearly delegated and carried out. At a minimum the child shall be seen on a weekly basis. The duration of such contact shall be as specified in CMS-03.3.

CMS-03.9 The Children's Aid Society shall ensure and participate in a case conference with the other agencies involved at a minimum of every three months and shall document results of such contact.

CMS-03.10 Where abuse has been verified a report shall be sent by the Local Director to the Central Register (see Guidelines for Reporting to Central Register).

CMS-03.11 The client shall be advised that a report is being sent to the Central Register within fourteen days of the completion of the investigation.

Guidelines

CMG-03.1 Recording of case conferences should be filed in the agency's case file.

6. POLICE INVOLVEMENT

Commentary

Children's Aid Societies and police have a duty to protect children from abuse and to ensure that they are afforded the protection of the criminal law.

Since both the Children's Aid Society and the police have legal responsibilities in the area of child abuse and both have much to contribute to the intervention and management of these cases, it is important that a working partnership be developed between the two services. Standards and guidelines forming the basis of such a partnership have been formulated by the Ministry of Community and Social Services and the Ministry of the Solicitor General and are set out below. While it is recognized that local partnership arrangements will vary greatly, it is expected that a spirit of mutual co-operation will be developed and that the best interests of both the child and the community will be promoted.

Some relevant provisions of law are as follows:

1) Section 47 of The Child Welfare Act, 1978 provides the definition of abuse which is contained in the glossary.

2) A "child in need of protection" is defined in section 19 of The Child Welfare Act, 1978.

3) Responsibilities of the Children's Aid Society and police are set out in section 21 of The Child Welfare Act, 1978 and in certain other sections.

4) Relevant offences are outlined under both the Criminal Code of Canada and The Child Welfare Act, 1978. (A list of these offences can be found in the Resource Kit.)

PO-01 **Police Involvement**

STANDARDS

POS-01.1 The local police shall be informed in all cases where the initial assessment of the report indicates the probability of abuse.

POS-01.2 A plan shall be developed jointly by the local Children's Aid Society and the police to ensure that there is a cooperative working agreement.

POS-01.3 Where the police are involved in an investigation of alleged child abuse, primary responsibility for the protection of the child shall remain with the local Children's Aid Society.

POS-01.4 Primary responsibility for the enforcement of law and the prosecution of offences shall remain with the police.

Guidelines

POG-01.1 At the time of notification and consultation, a decision should be made regarding the most appropriate and effective means of investigation.

Possible approaches are:

a) parallel Children's Aid Society/police investigation

b) joint Children's Aid Society/police investigation

POG-01.2 There should be mutual sharing of relevant information respecting the investigation.

POG-01.3 Where the police are considering a criminal prosecution, they should normally consult with the Children's Aid Society and other involved professionals prior to laying charges.

POG-01.4 Children's Aid Societies and police should both be involved in local Child Abuse Teams and conferences on cases of child abuse.

POG-01.5	Children's Aid Societies and police should work together to develop a better understanding of each other's concerns, responsibilities and problems.
POG-01.6	Children's Aid Societies and police should exchange information and training materials on child abuse.
POG-01.7	Children's Aid Societies and police should ensure that social workers, physicians, nurses, lawyers, judges and teachers in the community are kept informed of all aspects of child abuse, including indicators, investigation, reporting legislation and referral procedures.

7. COURT INVOLVEMENT

Commentary

Under The Child Welfare Act, 1978 a legal officer of the Children's Aid Society may apprehend a child apprently in need of protection with or without a warrant. In most situations a warrant should not be necessary. Specific guidelines for apprehension are outlined in this section.

Section 47 of The Child Welfare Act, 1978 provides for the laying of charges in certain cases involving child abuse. These charges are heard in Provincial Court (Family Division). Criminal charges layed under the Criminal Code of Canada are heard in the Provincial Court (Criminal Division). The charges which apply under the Criminal Code of Canada and under The Child Welfare Act, 1978 are outlined in the Resource Kit. Civil liability involves an application in civil court to effect recovery of damages or compensation on behalf of an abused child. The Child Welfare Act, 1978 s.51 provides for such proceedings. If either the Official Guardian or Children's Aid Society believe it to be in the best interests of the child, proceedings may be instituted and conducted on the child's behalf in respect of the abuse suffered.

Where a child is found to be in need of protection, various orders are permitted through application to the family court. An Order to Produce requires that the person(s) in whose care the child is in bring the child before the court and an Order of Society Supervision ensures upon court order, that the Children's Aid Society is involved in the care and management of the child. These procedures are discussed in the following standards and guidelines.

The Child Welfare Act, 1978 section 20 makes provision for independent legal representation of the child. The necessity for such representation is determined by the court.

CI-01 **Court Involvement**

STANDARDS

CIS-01.1 In cases where the child requires admission to care (see Resource Kit "Removal of Child from Parents"), the child shall be apprehended with or without warrant and taken to a place of safety. Temporary care by agreement shall not be considered in these situations.

CIS-01.2 In cases of second verified incidents of abuse, an application under The Child Welfare Act, 1978 shall follow, recommending either a period of wardship or a period of Children's Aid Society supervision.

CIS-01.3 In all child abuse cases where a child has been apprehended and has been in care, and where a recommendation of a return to parent(s) or other suitable person is made, that recommendation shall include a request for an Order of Society Supervision.

CIS-01.4 When Children's Aid Society supervision is being proposed the Society shall make specific reasonable recommendations to the court regarding the supervision of parent(s) and child, which may be accepted by the judge and included in the terms and conditions stated in the Court Order. These shall be documented and followed by the Society providing supervision.

CIS-01.5 "Factors to be considered in removing child from parents" and "Factors to be considered in returning child to parents" (see Resource Kit) shall be utilized for appropriate decision-making and the reasons for the decision documented.

Guidelines

CIG-01.1 In cases where abuse is verified but the degree of abuse or risk does not require immediate apprehension or placement outside of the home, an Order to Produce followed by an Application for Children's Aid Society supervision of the child in the home should be given serious consideration.

CIG-01.2 The decision regarding court involvement (whether to apprehend and seek wardship, the child remaining at home, whether to request an Order to Produce or an Order of Society Supervision, etc.), should be based on a full-case conference (see Glossary of Terms for details of Case Conference).

CI-02 **Apprehension**

STANDARD

CIS-02.1 The police shall be involved in situations where the use of force may be required to seek for or effect the apprehension of a child.

Guidelines

CIG-02.1 The apprehension of a child in need of protection should occur without a warrant specifically where:

a) the parents or others refuse entry

b) the parents or others refuse access to the child

c) the parents or others refuse to co-operate in effecting a physical or medical examination

d) the parents or others attempt to hide the child

e) the parent/others and child may abscond or disappear

f) the child is alone in locked premises

g) the parent(s)/caretaker(s) appear highly disturbed or unstable.

CIG-02.2 Warrants should be used to apprehend a child where the child is not in immediate danger but the parents refuse to give consent to the removal of the child.

CI-03 **Supervision Orders**

STANDARDS

CIS-03.1 The primary responsibility to carry out the Order of Supervision shall be with the Children's Aid Society no matter what form the supervision of the child takes.

CIS-03.2 The terms and conditions of the supervision order and what is expected of the Children's Aid Society shall be written into the Order and shall be made known to all persons who will be affected by them (see The Child Welfare Act, 1978 Section 30(4)).

CIS-03.3 The supervision of the child shall involve contact with the child for a length of time and at intervals as ordered by the Court. Where the Court has not specified the frequency of contact, this shall be at intervals no less than every seven days.

CIS-03.4 Society supervision shall be augmented by regular, scheduled physical examinations by a community health professional at intervals no less than once a month and specifically when there are reasonable concerns warranting an examination.

CIS-03.5 In situations involving supervision orders, The Children's Aid Society review of these cases shall be conducted as specified under "Case Supervision", which requires review at certain critical times, and at a minimum, on a monthly basis.

CIS-03.6 In situations where supervision orders are "frustrated" (e.g. parents refuse to co-operate, Children's Aid Society unable to effect, etc.) the matter shall be returned to court immediately for further review and where the child may be endangered, the child shall be apprehended and reasons for the decision documented.

Guidelines

CIG-03.1 Where an order of wardship has been refused by the Court but the Society believes that the child is still at risk, an appeal should be taken by the Society rather than returning the child to the parent under a Supervision Order.

CIG-03.2 Other agencies should be asked to assist in the supervision of the child (e.g. public health, day care, school, family doctor).

CIG-03.3 Where arrangements under the above are made, roles in the shared supervision of the child should be documented, and the responsibility for reporting and consulting clearly outlined and undertaken. (See CMS-03.6).

CI-04 **Legal Counsel**

STANDARDS

CIS-04.1 The Children's Aid Society shall consider representation by legal counsel in all contested child abuse cases where the child would be at risk if the application should fail. Guidelines related to this subject have been produced by the Ministry of Community and Social Services and shall be used to assist in decision making about the involvement of legal counsel. (see Legal Representation for Children's Aid Societies).

Guideline

CIG-04.1 Where a child has been apprehended and admitted to care in a child abuse situation, the Children's Aid Society should consider whether or not to make a recommendation to the court for independent legal representation for the child (see The Child Welfare Act, s. 26).

CIG-04.2 Community child abuse teams should make every effort to include a lawyer as a team member.

CI-05 **Review**

STANDARD

CIS-05.1 There shall be a full review by the Children's Aid Society of each case in advance of all scheduled court hearings and the results of such a review documented.

Guidelines

CIG-05.1 The review process should follow the same procedures as a case conference and should include a review of the decision regarding the type of court involvement recommended.

CIG-05.2 Legal counsel for the Children's Aid Society should be present at the review where counsel has been or is likely to become involved in the case.

8. REMOVAL OF CHILD

Commentary

The removal of the child from the family/caretaker is a step which requires serious consideration. This necessitates careful examination of all aspects of the case. Except in an emergency, where immediate decision making is required in order to protect the child, this decision should be made with the benefit of supervisory consultation and take the child's "best interests" into account. (See Case Supervision.)

"Best interests of the child" are described in Section 1(b) of The Child Welfare Act, 1978, as meaning the best interests of the child in the circumstances having regard to the following:

1) the mental, emotional and physical needs of the child and the appropriate care or treatment, or both, to meet such needs,

2) the child's opportunity to enjoy a parent-child relationship and to be a wanted and needed member within a family structure,

3) the child's mental, emotional and physical stages of development,

4) the effect upon the child of any disrupiton of the child's sense of continuity,

5) the merits of any plan proposed by the agency that would be caring for the child, compared with the merits of the child returning to or remaining with his or her parent,

6) the views and preferences of the child, where such views and preferences can reasonably be ascertained,

7) the effect upon the child of any delay in the final disposition in the proceedings,

8) any risk to the child of returning the child to or allowing the child to remain in the care of his or her parent.

In considering the factors, it is important to recognize that not all the factors may be applicable in any one case situation. In addition, no one factor by itself is sufficient in isolation to make a decision to remove a child from parent(s)/caretaker(s).

Supervisory consultation as a requirement in the decision-making process takes place through a case conference, consultation with a child abuse team or through individual consultation with the supervisor.

Also to be used are the "Factors to Consider in Child Abuse Cases Regarding Admission to Care", outlined in the Resource Kit attached to this document.

RC-01 **Removal of Child**

STANDARDS

RCS-01.1 Prior to removing a child from the home the Children's Aid Society shall consider the possibility of work being done in the home by the Society or by another agency.

RCS-01.2 The "Factors to Consider in Child Abuse Cases Regarding Admission to Care" shall be utilized in assessing whether the child's situation requires removal to a place of safety.

RCS-01.3 In all cases where a condition of physical harm, neglect or sexual molestation exists which necessitates removal of the child to a place of safety, the admission to care shall be by apprehension with or without a warrant (see The Child Welfare Act, 21). (Also refer to Guidelines for Reporting to the Central Register for more explicit definitions of abuse.)

9. RETURN OF THE CHILD

Commentary

The same analysis of factors that was discussed in the previous section applies when giving consideration to returning the child to the parents. Before a decision is made to return a child a thorough evaluation is necessary to ensure that the home or care situation has improved enough that the child's safety is no longer in peril.

This crucial decision requires the attention and supervisory consultation of a number of people involved in the case in order to evaluate changes which have occurred since admission to care and to consider what is in the "best interests of the child". (See Case Supervision.)

RP-01 **Return of Child**

STANDARDS

RPS-01.1 The "Factors to be Considered Regarding the Decision to Return a Child to Parent(s) shall be used in assessing whether or not is is safe to return a child (see Resource Kit).

RPS-01.2 In controversial or particularly problematic cases the Program Advisor shall be advised (see "Reporting to the Ministry").

RPS-01.3 The Ministry shall be informed when the Court has ordered that the child be returned to the parents and the Society feels that the child is still at risk.

RPS-01.4 In cases where a child has been admitted to care and then returned to parent(s)/caretaker(s) the follow-up period shall be as stated in the court order and the frequency of contact shall be at least every seven days.

10. "MISSING" FAMILY

Commentary

This section refers to situations where a family cannot be located but where the Children's Aid Society is attempting to provide or coordinate service to the family. In such cases, where abuse is suspected or verified and the child has remained with the family, the following standards and guidelines apply.

MF-01 **Missing Family**

STANDARDS

MFS-01.1 Every reasonable effort shall be made by the Children's Aid Society to discover the whereabouts of the family and to resume service. These efforts shall be documented and shall include but not be limited to the following:

a) immediate notification to Children's Aid Society supervisor and Local Director

b) immediate notification to the Central Register

c) ensuring that associate agencies, including the police, in the local Children's Service area of jurisdiction, are aware of the need to locate the family and that the Children's Aid Society is advised of the family's whereabouts if located

d) ensuring that other Children's Aid Societies or Child Welfare Agencies are advised of the relevant facts regarding the family if it is likely or possible that the family has moved out of the local Children's Aid Society area of jurisdiction

e) ensuring that the indicated province has been notified through the Ministry of Community and Social Services if it is likely or possible that the family has moved to another province and copies of all appropriate records forwarded to the local child protection agency if the family is located

f) ensuring that, if it is likely that the family has moved to another country then (e) above applies.

11. "LOST" CHILDREN

In this section a "lost" child refers to any of the following:

a) a child who is the subject of a child abuse investigation and cannot be found

b) a child who is the subject of a supervisory order and whose whereabouts are unknown

c) a child who is the subject of an order of wardship and is "missing", "lost" or "AWOL".

LC-01 "Lost" Children

STANDARDS

LCS-01.1 In situations where a child is "lost" the following efforts shall be made to locate the child and recorded in the case file:

a) immediate notification to Children's Aid Society supervisor and Local Director

b) notification to parent/caretaker

c) immediate notification to the Central Register

d) notification to other Children's Aid Societies or child welfare agencies if it is likely that the child has moved

e) notification to another province through the Ministry of Community and Social Services if it is likely that the child has moved to another province

f) ensuring that if it is likely that the child has moved to another country, that country is notified.

LCS-01.2 The police shall be notified as soon as possible and no later than twenty-four hours after receipt of the information.

LCS-01.3 In the case of "lost" children subject to supervisory orders, the Children's Aid Society shall return to court for review (see "Court").

LCS-01.4	In urgent cases with specific clues as to the child's whereabouts, the appropriate child welfare agency shall be advised by phone requesting immediate assistance and action.
LCS-01.5	Any new information shall be communicated to the police and/or other appropriate child welfare agencies.
LCS-01.6	The local Children's Aid Society shall continue to monitor efforts to locate the "lost" child for a minimum of one year.

12. DEATHS OF CHILDREN

Commentary

The standards outlined in this section are designed to assist the Children's Aid Society in the management of cases where children die or are likely to die as a result of suspected or verified child abuse.

DC-01 **Deaths of Children**

STANDARDS

DCS-01.1 The Children's Aid Society shall make immediate contact with the local law enforcement agency regarding details, possible charges and the conducting of an investigation into the death of a child. This contact shall be made no later than one hour after receiving the initial report (see "Police Involvement").

DCS-01.2 The Children's Aid supervisor and/or local director shall be advised of the death of a child within one hour of the receipt of the information.

DCS-01.3 The Ministry of Community and Social Services shall be advised of a child's death as soon as possible within forty-eight hours of the receipt of information. (see section on Reporting to the Ministry.)

DCS-01.4 The Children's Aid Society shall be responsible for appropriate steps to investigate, assess and protect any other children in the family (see "Investigation", "Assessment", Police Involvement).

DCS-01.5 The Children's Aid Society shall ascertain if an inquest is to be held and document reasons given for decision.

DCS-01.6 The Children's Aid Society shall be represented at an inquest if one is being held.

Guidelines

DCG-01.1 The Children's Aid Society should review the necessity and desirability of being represented by legal counsel at the inquest.

13. CASE SUPERVISION

Commentary

Case supervision of child abuse investigations and case management should be undertaken by a fully qualified supervisor who has had experience and training in the management of child abuse cases. (see Regulations to The Child Welfare Act, 1978).

CS-01 **Case Supervision**

STANDARDS

CSS-01.1 The Children's Aid Society shall ensure 24-hour availability of qualified supervisory consultation to Society case workers.

CSS-01.2 Except in emergency situations, workers who are investigating or managing child abuse cases shall review these cases with the supervisor on a monthly basis and specifically:

a) at the point of initial referral. This will ensure that all necessary steps are considered and taken during the investigation stage.

b) at any point during the investigation stage where the worker has concern or difficulties.

c) at the completion of the initial investigation.
This will provide a review of the investigation and an opportunity to consider the disposition which may be:

i) non verification
ii) verification
iii) open case
iv) monitor case
v) case plan

d) in preparation for all case conferences.

e) when consideration is being given to removing a child from the home.

f) when consideration is being given to involving the police or the courts.

g) when consideration is being given to returning the child to his home/parent.

h) when a case is to be transferred.

i) when a client is "missing".

j) when a child in care or subject to a supervision order is "lost", "missing" or AWOL.

k) when consideration is being given to terminating a case.

l) when there are significant changes in the treatment plan.

m) when there are major crises in the family.

n) any situation which requires reporting to the Ministry of Community and Social Services.

o) before the assigned case worker leaves for any extended absence from the agency, or permanently leaves the agency.

p) at the option of the supervisor.

CSS-01.3 Each Children's Aid Society shall establish and maintain a documented plan for child abuse case management which shall include but shall not be limited to:

a) access for supervisors to more senior staff for consultation about difficult case decisions.

b) the designation of alternative workers in the absence of a senior staff member.

Guidelines

CSG-01.1 In order that supervisors remain in touch with front line service, and to maximize their assistance to front line staff, supervisors should participate in the management of a small number of child abuse cases.

14. CASE REVIEWS

Commentary

The purpose of this section is to promote the uniform understanding and use of "case review". Case review provides the method by which workers, supervisors and other professionals on a child abuse case may examine facts and evaluate or modify a case plan as a means of continuing adequate service to a child and/or, a family. In cases where abuse occurs in care the Children's Aid Society is responsible for providing internal review of the case and would follow the same procedures of assessment and verification as in any other abuse investigation.

CR-01 **Case Reviews**

STANDARDS

CRS-01.1 All child abuse investigations, open protection cases, and child care cases where abuse has occurred, shall be reviewed on a monthly basis and according to the times indicated under "Supervision" and in keeping with the process indicated under the following sections:

a) removal of child from parents

b) return of child to parents

c) termination of case

d) police involvement

e) court involvement.

CRS-01.2 Records of all case reviews shall be filed in accordance with procedures outlined under Record Keeping.

CRS-01.3 The Children's Aid Society shall establish a system, by which all cases designated as child abuse could be reviewed as outlined under Case Supervision.

15. TERMINATION OF CHILD ABUSE CASES

Commentary

The closing of child abuse cases and termination of Children's Aid Society service requires most careful consideration. The procedure for such decision-making must involve a full case conference (see "Case Conference" in Glossary). "Factors to Consider in Terminating Service" are discussed in detail in the Resource Kit and are to be used in conjunction with the following standards and guidelines.

TE-01 **Termination of Child Abuse Cases**

STANDARDS

TES-01.1 The "Factors to Consider in Terminating Service" shall be used in the assessment before a decision is made to terminate.

TES-01.2 Termination shall only be considered in child abuse cases when no episodes of child abuse have been suspected or verified during the previous twelve months.

TES-01.3 Other agencies and professionals shall be informed of a decision to terminate service and shall be made aware of the Children's Aid Society's availability for future contacts.

TES-01.4 The Children's Aid Society shall advise the Central Register of termination decisions.

TES-01.5 If there are any outstanding court orders respecting the child or family, the matter shall be returned to court for review and recommendation prior to termination of service.

16. REPORTING TO THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Commentary

There are a number of specific instances of verified and suspected child abuse where consultation with and reporting to the Ministry are required. The Ministry of Community and Social Services will be issuing a paper which clarifies which instances should be reported and outlines the procedures and requirements for dealing with such situations. In such cases reports are to be made directly to the Ministry in addition to reporting to the Central Child Abuse Register.

STANDARDS

RMS-01.1 The following situations shall be reported to the appropriate Program Advisor or to a Director of Child Welfare by telephone within forty-eight hours of referral:

a) when abuse is alleged or occurs in alternate care situations

b) when abuse is alleged or occurs in any institutional setting (e.g. nursery school day camp, recreation programs, volunteers, etc.)

c) when abuse occurs in any place of safety operated by a Children's Aid Society

d) when abuse occurs to a child on adoption probation

e) when children are returned home by a court order and the Children's Aid Society feels that the child is still at risk

f) when severe abuse or death occurs:

i) without Children's Aid Society involvement
ii) during Children's Aid Society involvement
iii) after Children's Aid Society involvement

g) when a child who is the subject of a child abuse investigation or is the subject of a supervisory order cannot be found, or is "missing" or "lost"

h) when child abuse is suspected or verified, and the family with which the child remains disappears (see "Missing Family")

RMS-01.2 In all of the above situations a written report shall follow within fourteen days and shall include the following details:

a) full name of child
b) sex of child
c) date of birth
d) legal status
e) summary of circumstances respecting the situation
f) other pertinent information/reports, including autopsy and inquest record.

17. TRANSFERS

Commentary

From time to time, due to worker or family mobility, it is necessary to transfer management of a child abuse case to another worker or agency. Such a transfer is difficult for most clients. This difficulty is heightened in abusing families which frequently have problems in trusting others and in reaching out for help. In many cases, a transfer can become a 'crisis' for the family, therefore the worker should be sensitive to this possibility and should be readily available during this period.

TR-01 Transfers Within the Agency

Guidelines

TRG-01.1 The transfer plan should be developed in consultation with the supervisor.

TRG-01.2 The transfer should be effected through a full case review involving both workers and the supervisor.

TRG-01.3 All related agencies actively involved with the family should be advised of the transfer, and should be given the name of the new worker responsible for the case.

TRG-01.4 Transfers should be effected as gradually and as sensitively as possible, in the following manner:

i) The family should be advised and preparation should begin well in advance of the impending transfer.

ii) The new worker should be introduced gradually to the family.

iii) Where possible, both workers should have several contacts with the family before the transferring worker terminates services to the family.

TR-02 **Transfers Within Ontario to Geographically Adjacent Children's Aid Society**

STANDARDS

TRS-02.1 The transferring agency shall send complete records regarding the family which shall include the following:

a) copy of case recording including details regarding incidents of abuse, dynamics of the family, involvement with the agency, degree of cooperativeness, degree of risk, goals achieved (not achieved), treatment needs and plans for the family at point of transfer, areas of sensitivity, list of possible crises for the family, any other important or special considerations (see "Record Keeping" as per Section I, case file).

b) copy of photographs (where applicable)

c) copy of court orders (where applicable)

d) copy of any other relevant reports

TRS-02.2 In urgent situations, relevant information shall be telephoned directly to the agency receiving the transfer within two hours and followed by written referrals and records within fourteen days.

Guidelines

TRG-02.1 The guidelines under Transfers Within the Agency should be utilized.

TRG-02.2 Participation in the case review should include representatives of all agencies having significant responsibility in the case and their counterparts in the adjacent jurisdiction.

TRG-02.3 The previous worker should disengage when the new worker has assumed responsibility for the family.

TR-03 **Transfer to Other CAS**

STANDARDS

TRS-03.1 The transferring agency shall send complete records regarding the family (see TRS-02.1)

Guidelines

TRG-03.1 The guidelines under Transfer Within Agency should be utilized.

TRG-03.2 The transfer should be discussed in advance, by telephone, with the Children's Aid Society assuming responsibility (see TRG-02.2).

TR-04 **Transfers Outside of Ontario**

STANDARDS

TRS-04.1 Complete details regarding the case (see TRS-02.1) shall be sent to the child protection agency in the province/state where the family is residing and shall be sent via normal interprovincial channels.

TRS-04.2 See TRS-02.2.

TRS-04.3 In cases involving transfer to countries other than the United States, referral via normal international channels shall be utilized and complete details of the case forwarded to the agency providing service.

TRS-04.4 The Ministry of Community and Social Services shall be advised of the transfer (see "Reporting to the Ministry").

Guidelines

TRG-04.1 The transfer plan should be developed in consultation with the supervisor.

18. RECORD KEEPING

Commentary

The following procedures are important steps in standardizing record keeping and facilitating access to records in child abuse cases for those providing service to individuals and families. For the Children's Aid Society, record-keeping is a crucial tool as there are many instances where a worker's notes or a file are required for evidentiary purposes. This necessitates that recording information is done as closely as possible to the actual interview/observation. All regulations and requirements for record keeping, as outlined by The Child Welfare Act, 1978 or Ministry of Community and Social Services directives, shall be observed.

RK-01 **Record Keeping**

STANDARDS

RKS-01.1 Every Children's Aid Society shall make suitable arrangements to ensure the safekeeping of all Children's Aid Society records and shall provide documentation of these arrangements.

RKS-01.2 Every Children's Aid Society protection case file and every Children's Aid Society child care file shall be divided into four separate sections with the following contents:

SECTION I

All case recordings, case notes, case review recording and social history.

SECTION II

All special reports directly related to the case including:

- psychological assessments or tests
- reports from various medical specialists (doctors, psychiatrists)
- school reports
- police occurances
- alternate case reports

SECTION III

All court documentation.

SECTION IV

All other correspondence and case material.

RKS-01.4 All sections of the file shall appear in chronological order.

RKS-01.5 Every Children's Aid Society shall establish and maintain an internal registry of active and closed child abuse investigations and cases.

RKS-01.6 Access to the internal registry shall be limited to Society staff.

RKS-01.7 Every Children's Aid Society shall record any report respecting child abuse within twenty-four hours.

RKS-01.8 A detailed recording of the initial investigation of alleged abuse shall be completed within twenty-one days of receipt of the allegation.

RKS-01.9 Case recording shall be ongoing and shall be completed at least every three months. (The Ministry of Community and Social Services will provide consultation with respect to means of improving case recording.)

RKS-01.10 In addition to quarterly case recording, recording shall be placed on the file regarding all major case review/conferences/decision-making (see "Case Supervision").

RKS-01.11 All case recording shall be initialed by the case worker and read and initialed by the supervisor.

RKS-01.12 All Society case workers shall be provided with and utilize a daily case notebook, which shall be the property of the Society and shall contain the worker's handwritten notes regarding:

a) interviews and collaterals, clients

b) descriptions and/or diagrams of injuries, abuse and physical surroundings.

RKS-01.13 The case notebook shall also indicate:

a) date and time of interview/observation

b) details of interview/observation

c) date and time of recording.

Guidelines

RKG-01.1 Information from the internal registry should be available on a 24-hour basis.

RKG-01.2 Emergency after-hours staff should have access to an updated listing from this registry.

RKG-01.3 All case files listed in this registry should be colour coded to facilitate identification and urgency.

RKG-01.4 All case files listed in this registry should be readily accessible on a 24-hour basis.

RESOURCE KIT

Standards and Guidelines For The Management of Child Abuse Cases Under the Child Welfare Act by The Children's Aid Societies

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APPENDIX A

CHARGES UNDER THE CRIMINAL CODE OF CANADA WHICH PERTAIN TO CHILD ABUSE

APPENDIX B

CHARGES UNDER THE CHILD WELFARE ACT, 1978 WHICH PERTAIN TO CHILD ABUSE

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CHILD ABUSE - DEFINITIONS

Considerable confusion exists regarding the definition of child abuse. A variety of definitions have been advanced and few reflect the same condition. Some definitions are too narrow, some too broad and others too vague. Some definitions are difficult to operationalize or unsuitable for court proceedings. Accordingly, there is no uniformity in what we are all discussing or observing when we consider child abuse. In attempting to define abuse, it is important to distinguish between

1) child abuse and physical abuse and

2) physical abuse and physical and emotional neglect.

With respect to (1) most people consider that child abuse is physical abuse. The problem with such an equation is that it limits public and professional conceptualization of child abuse to acts of physical abuse. Such a narrow conceptualization hinders the understanding and acceptance that many forms of abuse are perpetrated upon children which, although not as visible and abhorrent as physical abuse, are equally serious and damaging.

With respect to (2) many professional helping people consider physical abuse as part of, or the same as neglect. Consequently, there is confusion as to where physical abuse begins and neglect ends. There is also confusion as to what is reportable as physical abuse.

To assist in overcoming some of these difficulties and confusion the following definitions are offered.

Child Abuse

"Every child, despite his individual differences and uniqueness, is to be considered of equal intrinsic worth, and hence should be entitled to equal social, economic, civil and political right, so he may fully realize his inherent potential and share equally in life, liberty and happiness.

In accordance with these value premises then, any act of commission or omission by individuals, institutions or society as a whole, and any conditions resulting from such acts or inaction which deprive children of equal rights and liberties, and/or interfere with their optimal development, constitute, by definition, abusive or neglectful acts or conditions."

Physical Abuse

Physical abuse consists of any nonaccidental form of injury or harm inflicted on a child (under 16) by a caretaker. This includes but is not necessarily restricted to, physical beating, wounding, burning, poisoning and related assaults causing visible or not visible physical harm.

Sexual Abuse

Sexual abuse is the use of a child (under 16) for the sexual or erotic gratification of a caretaker or other person, performed with or without resistance on the part of the child and with or without accompanying physical abuse. This may range from exposure and fondling to intercourse, incest and rape. Sexual acts between consenting peers are generally excluded from this definition.

Neglect (General)

Child neglect may be defined as a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities.

Neglect (Specific)

Emotional Neglect

Failure of the caretaker to provide appropriately for the developmental needs of the child, or

Failure to have age appropriate expectations for the child, or

Failure of the caretaker to provide consistency and continuity in the love of the child, or

Failure of the caretaker to provide nurturing and affection necessary for the emotional health of the child.

Each of these definitional components must be measurable in terms of the harmful effects on the child.

Physical Neglect

Includes those conditions or situations in which the caretaker fails to provide the essentials for normal life. It may include:

a) Abandonment

Children who are abandoned totally or for long periods of time.

b) Nutritional Neglect

Failure to provide sufficient quantities of specific types of food, or

Failure to provide acceptable quality of diet.

c) Medical and Dental Neglect

Failure to recognize medical and dental problems and obtain appropriate treatment, or

Failure to obtain preventive medical or dental care through examinations, immunizations, etc.

d) Educational Neglect

Failure to provide for an acceptable educational environment for the child.

e) Clothing Neglect

Failure to provide minimum quantity of clothing necessary for cleanliness of clothing; protection from cold, rain, snow, etc.; acceptance of community and peers, e.g., free from rips and tears.

f) Hygiene Neglect

Failure to provide suitable standard of physical cleanliness of child.

g) Shelter Neglect

Failure to provide basic minimum standards of adequate shelter, e.g., space, heat, plumbing, structurally safe, etc.

h) Lack of Supervision

Failure to provide adequate supervision and a safe environment for the child.

1. PHYSICAL INDICATORS OF ABUSE

A. Bruises and welts that may be indicators of physical abuse:

1. bruises on any infant, especially facial bruises
2. bruises on the posterior side of a child's body
3. bruises in unusual patterns that might reflect the pattern of the instrument used, or human bite marks
4. clustered bruises indicating repeated contact with a hand or instrument
5. bruises in various stages of healing.

B. Burns that may indicate abuse:

1. immersion burns indicating dunking in a hot liquid ("stocking" burns on the arms or legs or "doughnut" shaped burns of the buttocks and genitalia)
2. cigarette burns
3. rope burns that indicate confinement
4. dry burns indicating that child has been forced to sit upon a hot surface or has had a hot implement applied to the skin.

C. Lacerations and abrasions that may indicate abuse:

1. lacerations of the lip, eye, or any portion of an infant's face (e.g., tears in the gum tissue which may have been caused by force feeding)
2. any laceration or abrasion to external genitalia.

D. Skeletal injuries that may indicate abuse:

1. metaphyseal or corner fractures of long bones--a kind of splintering at the end of the bone (these are caused by twisting or pulling)

2. epiphyseal separation--a separation of the growth center at the end of the bone from the rest of the shaft (caused by twisting or pulling)

3. periosteal elevation--a detachment of the periosteum from the shaft of the bone with associated hemorrhaging between the periosteum and the shaft (also caused by twisting or pulling)

4. spiral fractures--fractures that wrap or twist around the bone shaft (caused by twisting or pulling).

E. Head injuries

1. absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair-pulling

2. subdural hematomas--hemorrhaging beneath the outer covering of the brain (due to shaking or hitting)

3. retinal hemorrhages or detachments (due to shaking)

4. jaw and nasal fractures.

F. Internal injuries

1. duodenal or jejunal hematomas--blood clots of the duodenum and jejunem (small intestine) (due to hitting or kicking in the midline of the abdoment)

2. rupture of the inferior vena cava--the vein feeding blood from the abdomen and lower extremities (due to kicking or hitting)

3. peritonitus--inflammation of the lining of the abdominal cavity (due to a ruptured organ, including the vena cava).

G. Injuries considered to be indicators of abuse should be considered in light of:

1. inconsistent medical history
2. the developmental abilities of a child to injure itself
3. other possible indicators of abuse.

H. Questions to ask in identifying indicators of abuse:

1. Are bruises bilateral or are they found on only one surface (plane) of the body?

2. Are bruises extensive--do they cover a large area of the body?

3. Are there bruises of different ages--did various injuries occur at different times?

4. Are there patterns caused by a particular instrument (e.g., a belt buckle, a wire, a straight edge, coat hanger, etc.)?

5. Are injuries inconsistent with the explanation offered?

6. Are injuries inconsistent with the child's age?

7. Are the patterns of the injuries consistent with abuse (e.g., the shattered egg-shell pattern of skull fractures commonly found in children who have been thrown against a wall)?

8. Are the patterns of the burns consistent with forced immersion in a hot liquid (e.g., is there a distinct boundary line where the burn stops--a "stocking burn," for example, or a "doughnut" pattern caused by forcibly holding a child's buttocks down in a tub of hot liquid)?

9. Are the patterns consistent with a spattering by hot liquids?

10. Are the patterns of the burns consistent with the explanation offered?

11. Are there distinct patterns caused by a particular kind of implement (e.g., an electric iron, the grate of an electric heater, etc.) or instrument (e.g., circular cigarette burns, etc.)?

2. PHYSICIAN'S INDEX OF SUSPICION

History

1. Parents often relate story that is at variance with clinical findings.
2. Multiple visits to various hospitals.
3. Familial discord of financial stress, alcoholism, psychosis perversion, drug addiction, etc.
4. Reluctance of parents to give information.
5. Admittance to hospital during evening hours.
6. Child brought to hospital for complaint other than one associated with abuse and/or neglect, e.g., cold, headache, stomach ache, etc.
7. Date of injury prior to admission.
8. Parent's inappropriate reaction to severity of injury.
9. Inconsistent social histories.

Physical Examination

1. Signs of general neglect, poor skin hygiene, malnutrition, withdrawal, irritability, represses personality.
2. Bruises, abrasions, burns, soft-tissue swellings, hematomac, old healed lesions.
3. Evidence of dislocation and/or fractures of the extremities.
4. Coma, convulsions, death.
5. Symptoms of drug withdrawal.

Differential Diagnosis

1. Scurvy and rickets.
2. Infantile cortical hyperostocis.
3. Syphilis of infancy.
4. Accidential trauma.

Radiologic Manifestations

1. Subperiosteal hemorrhages.
2. Epiphyseal separations.
3. Periosteal shearing.
4. Metaphyseal fragmentation.
5. Previously healed periosteal calcifications.
6. "Squaring" of the metaphysic.

3. RECOGNITION, CARE AND PROTECTION

Table 1. The Diagnosis of Physical Abuse Should be Considered When Some of the Following Are Present.

When the parent:

1. Shows evidence of loss of control, or fear of losing control.
2. Presents contradictory history.
3. Projects cause of injury onto a sibling or third party.
4. Has delayed unduly in bringing child in for care.
5. Shows detachment.
6. Reveals inappropriate awareness of seriousness of situation (either overreaction or underreaction)
7. Continues to complain about irrelevant problems unrelated to the injury.
8. Personally is misusing drugs or alcohol.
9. Is disliked for unknown reasons, by the physician.
10. Presents a history that cannot or does not explain the injury.
11. Gives specific "eye witness" history of abuse.
12. Gives a history of repeated injury.
13. Has no one to "bail" her/him out when "uptight" with the child.
14. Is reluctant to give information.
15. Refuses consent for further diagnostic studies.
16. Hospital "shops".
17. Cannot be located.
18. Is psychopathic or psychotic.
19. Has been reared in a "motherless" atmosphere.
20. Has unrealistic expectations of the child.

When the child:

1. Has an unexplained injury.
2. Shows evidence of dehydration and/or malnutrition without obvious cause.
3. Has been given inappropriate food, drink and/or drugs.
4. Shows evidence of overall poor care.
5. Is unusually fearful.
6. Shows evidence of repeated injury.
7. "Takes over" and begins to care for parents' needs.
8. Is seen a "different" or "bad" child by the parents.
9. Is indeed different in physical or emotional makeup.
10. Is dressed inappropriately for degree or type of injury.
11. Shows evidence of sexual abuse.
12. Shows evidence of repeated skin injuries.
13. Shows evidence of repeated fractures.
14. Shows evidence of "characteristic" X-ray changes to long bones.
15. Has injuries that are not mentioned in history.

4. HIGH RISK SIGNALS

I Prenatal

A high risk situation is not just any one of the items listed below; but varying combinations of these signes; the family's degree of emphasis on them, and their inflexibility to changes. The interviewer must take into consideration the patient's age, culture and education, combined with observations of her affect and significance of her feelings. Many of these signs can be assessed interchangeably throughout the entire prenatal period, but are listed in this order because they are found most commonly at these times.

1. Over-concerned with the unborn baby's sex.

    a. Reasons why a certain sex is so important, i.e. to fill mother's needs.
    b. The mother's need to please the father with the baby's sex.
    c. The quality and rigidity of these needs.

2. Expressed high expectations for the baby.

    a. Over-concern with the baby's physical and developmental progress, his behaviour and discipline.
    b. The parents' need to have control over his/her actions and reactions.
    c. This child is wanted in order to fulfill unmet needs in parents' lives.

3. Is this child going to be one too many?

    a. Is there adequate spacing between this child and the next older child?
    b. During the pregnancy has there been evidence of a disintegratng relationship with the older child(ren), i.e. physical or emotional abuse for the first time.

4. Evidence of the mother's desire to deny the pregnancy.

    a. Unwillingness to gain weight.
    b. Refusing to talk about the pregnancy in a manner commensurate with the reality of the situation.
    c. Not wearing maternity clothes when it would be appropriate.
    d. No plans made for baby's nursery, layette, etc., in the home.

5. Great depression over the pregnancy.

    a. Date onset of depression to this pregnancy.
    b. Report of sleep disturbances that cannot be related to the physical aspects of pregnancy.
    c. Attempted suicide.
    d. Dropping out socially.
    e. Bland affect.

6. Did either parent formerly ever seriously consider an abortion?

   a. Why didn't they go through with it?
   b. Did they passively delay a decision until medically a therapeutic aborton was not feasible?

7. Did the parents ever seriously consider relinquishment?

   a. Why did they change their minds?
   b. The reality and quality expressed in the change of decision.

8. Who does the mother turn to for support?

   a. How reliable and helpful are they to her?
   b. Who accompanies the mother to the clinic?
   c. Are any community agencies involved in a supportive way?

9. Is the mother very alone and/or frightened?

   a. Is this just because of lack of education and understanding of pregnancy and delivery?
   b. Is she overly concerned about the physical changes during pregnancy, labor and delivery?
   c. Especially if careful explanation, prenatal classes, etc. do not dissipate these fears.
   d. The mother tends to keep the focus of the interview on her fears and needs rather than any anticipation, excitement or joy projected onto the new baby.

10. Because of #9, the mother has many unscheduled visits to the prenatal clinic or the emergency room.

    a. With exaggerated physical complaints that cannot be substantiated on physical examination or by laboratory tests.
    b. Multiple psychosomatic complaints.
    c. An over-dependence on the doctor/nurse.

11. What are the patient's living arrangements?

    a. Are the physical accommodations adequate?
    b. Do they have a telephone?
    c. Is transportation available?
    d. Are there friends or relatives nearby?

12. The parents can't talk freely on the above topics and avoid eye contact.

13. What can you find out about the parents' background.

    a. Did they grow up in a foster home?
    b. Where they shuffled from one relative to another?
    c. What type of discipline was used? (They may not see this as abusive)
    d. Do they plan to raise their children the way their parents raised them?

II Post Partum

A high risk situation is not just any one of the items listed below; but varying combinations of these signs; the family's degree of emphasis on them, and their inflexibility to changes. The interviewer must take into consideration the patients' age, culture and education; combined with observations of her affect and the significance her feelings. Many of these signs can be assessed interchangeably throughout the entire prenatal period, but are listed in this order because they are found most commonly at these times.

1. Does the family remain disappointed over sex of baby?

2. What is the child's name?

   a. Who is he named for/after?
   b. Who picked the name?
   c. When was the name picked?
   d. Is the name used when talking to or about the baby?

3. Is the mother bothered by the baby's crying?

   a. How does it make her feel?

      i) Angry?
      ii) Like crying herself?
      iii) Can she comfort the baby?

4. Does the mother view the baby's needs to eat as too demanding?

   a. Does she ignore the demands?
   b. Is she repulsed by his messiness, i.e., spitting up?
   c. Is she repulsed by his sucking noises?

5. How does the mother view changing diapers?

   a. Is she repulsed by the messiness?
   b. Is she repulsed by the smells?
   c. Can she ask for help and then utilize it?

6. What is the husband's and family's reaction to the new baby?

   a. Are they supportive?
   b. Are they critical?
   c. Do they attempt to take over and control the situation?
   d. Is the husband jealous of the baby's drain on mom's time and energy?
   e. Are there sibling rivalry problems? Or; does she deny that a new baby will change existing family relationships.

7. Is the mother attuned to the baby's needs?

   a. Does she attempt to maintain control over these needs? Or
   b. Does she relinquish control to others?
   c. Does she do the holding of the baby, the undressing, the comforting?
   d. If she does relinquish control, is this in an attempt to focus the attention on herself?

8. Can the mother express that she is having fun with the baby?

   a. Can she view him/her as a separate individual?
   b. Can attention be focused on the infant, and she see something positive in that for herself?
   c. Are her verbalizations about the child usually negative? What is her affect during these times?
   d. Can she establish and maintain eye-to-eye contact with the baby?
   e. How does she talk with the baby? Is she always expressing a demand, or is it pleasurable interaction?

9. Does she have complaints about the child that cannot be verified?

   a. Multiple emergency calls for very minor complaints.
   b. The baby does things "on purpose" just to aggravate the parents.
   c. In your presence the mother describes characteristic you can't verify -- baby cries continually.
   d. Tells you essentially unbelievable stories about the baby -- i.e., has not breathed for the past 30 minutes and now seems fine.

10. When did the mother first feel the baby was hers?

    a. Was this greatly delayed?
    b. When did she first feel a mother's love for the baby? (Beyond a duty, her definition of love).

III Delivery Room

A high risk situation is not just any one of the items listed below; but varying combinations of these signs, the family's degree of emphasis on them and their inflexibility to changes. The observer must take into consideration the patient's age, culture and education; in addition to the character and length of her labor, and the amounts and timing of any medications; as well as family support during labor and delivery. Many of these signs can be assessed interchangeably throughout the entire prenatal period, but are listed in this order because they are found most commonly at these times.

1. Totally passive reaction.

   a. No active interest in baby.
   b. Doesn't want to see or hold baby even when she's told this is permissible.
   c. Keeps the focus of interaction on herself.

2. Definite hostility expressed.

   a. Toward father, who put her "through all this".
   b. Inappropriate verbalizations directed at the baby with definite hostile feelings expressed.
   c. Refuses to hold baby, establish eye contact, etc.
   d. Hostile remarks about the baby's sex or physical appearance.

IV Follow-Up Recommendations

If a family is felt to be at risk for establishing a solid parental-child relationship it is important to have close continuity of care. A strong supportive relationship should be initiated between family and professionals.

A. These are considered essential:

1. Most important is that the family have one person giving continuity of care to the child. This can be a pediatrician, family practitioner, CHAP or PNP, but it must be someone who is willing to initiate contacts with the family. The family should receive a telephone call within several days of discharge from the newborn nursery and frequent (weekly) calls thereafter. Also, it is a good idea to see the baby in the clinic about every 2 weeks during the first few months. Well baby visits of these families usually require scheduling for 45 minutes.

2. A Visiting Nurse Service referral should be made and personal contact made with the nurse. Weekly visits are most desirable. The nurse must be supportive, sympathetic and understanding. She must also be willing to allow the parents to call her outside of working hours.

3. If Welfare has been involved, it is worthwhile to call the worker, and arrange for her to be another contact for the parents.

4. Give the parents a list of telephone numbers for the helping people involved. Include both home and work numbers and encourage the family to use them.

B. In varying circumstances, any of the following could be used when such services exist, and family expresses interest or need.

Job or school training

Homemaker

Day Care

Babysitters

Young mother's groups

Planned Parenthood

Church organizations

Interests--yoga; hobbies (YWCA, etc.)

5. DETECTION OF HIGH RISK PARENTS

In considering patterns of behaviour of abusive parents, it seems well to keep a firm footing in patterns which represent nurturing, protective parenthood. There is a most active process new mothers go through with each new baby, a process of claiming the new infant, fitting him into already existing relationships--with herself, the baby's father and other significant figures in the mother's relationship fabric, toward some meaningful place in the hierarchy of relationship values. This process entails investigation of the baby's body, assessment of feature likenesses and differences to self and others, physical handling of some of the tasks of motherhood such as feeding and changing. This claiming process has the task of making positive identifications possible. When a mother can identify her infant with attributes which she values as "good" in herself, a positive feedback within which sensing infant cues which signify specific needs appears as a rewarding dividend to the mother. At the same time infant needs are met, and growth supported, within which infant development of perceptions can take place with some degree of constancy of experience.

There are several criteria which can be used to assess the adequacy of meternal claiming behavior in the early weeks and months of life. Mother-infant unity can be said to be successful when a mother can:

1. find pleasure in her infant and tasks done for and with him/her
2. understand the infant's emotional states and comfort him/her appropriately
3. read the infant's cues for new stimuli, sense his/her fatigue points. For example:

She can receive the infant's attempts at eye contact with pleasure, promote his/her new learning through permitting the baby to watch her face, use her hands for contact, provide objects which encourage tactile response. Yet, she does not over-stimulate her infant for her own pleasure.

When the claiming process fails, a kind of psychological miscarriage results and, in contrast, the following signs of maladaptation in the maternal role appear:

1. infants are seen as ugly or unattractive
2. the odor of their infants is perceived as revolting
3. disgust in association with the baby's drooling and sucking sounds
4. upset by vomiting, revolted and often fascinated by it
5. repulsion by and of the infant's body fluids which touch them
6. annoyance and disgust at having to clean up infant stools
7. preoccupation with the odor, consistency and numbers of infant stools
8. allowing the infant's head to dangle, without support or concern
9. holding infants away from their own bodies
10. picking up infants without warning by touch or speech
11. juggling and playing with infants, roughly, after feeding, even though vomiting follows
12. thinking infant's motor activity is somehow dangerous, and becoming apprehensive at normal moves

13. worrying about infant's relaxation after feeding
14. avoiding eye contact with infants, or staring fixedly into their eyes
15. absence of cooing or talking to infants
16. thinking that their infants do not love them
17. believing that their infants expose them as unlovable, unloving persons
18. thinking of their infants as judging them as an adult would
19. perceiving their infant's natural dependent needs as dangerous
20. envisioning death at mild diarrhea or cold
21. believing that their infant has some basic defect despite repeated negative findings
22. often fearing that infants may have an "eating-up" disease--leukemia, cystic fibrosis, diabetes or one of the malignancies
23. demanding that feared defects be found and relieved
24. cannot discriminate between infant signals of hunger, fatigue, stimulation need, eye and body contact comfort needs
25. developing paradoxical attitudes to the infant
26. developing inappropriate responses to infant needs: overfeeding or underfeeding; over or under-hold; tickle or bounce the baby when he is fatigued; talk too much, too little, at the wrong times; forcing eye contact sometines, refusing it at others; remove face from sight of infant, refusing body contact; leaving infant unprotected in noisy room where family fights and massive auditory stimulation takes place
27. last--and probably the most important signal of maladaptive maternal behavior--cannot find in their infant any physical or psychological attribute which they value in themselves.

These signs of maternal maladaptation are grouped in relation to the sensory modalities which are pleasurable to mothers when they are adapting to the nature and needs of infancy. Thus, when things are not going well, these same sensory avenues become in-put areas of displeasure, in high degree, and furnish signs of maladaptation to the infant and to the maternal role. I have avoided the usual term of "rejection" because I wished to high-light the active nature of claiming in contrast to the more passive connotation of "acceptance"--and because the wholly rejected child is not a living child, as we have all reason to know . . .

The above signs, then, appear when maternal protective behavior is not established in durable, dependability degree. When, in over-stressed situations (whatever they may constitute for the individual parent or parents) the limit of endurance of the parent has been reached, it often appears that the degree and placement of the injury is a matter of chance since, from our own experience, the burst of attacking behavior tends to blow itself out, unless it is distracted or interrupted from the outside. There seems to be a special proclivity for people who attack children to attack the head. This raises the nasty question of why the head is such a prime target in abusive behavior.

Once the abuse has occurred and the child comes by chance or design to the Receiving Ward, our group noticed characteristic behavioral signs in those parents who presented children who could not have incurred injuries under the circumstances of age, the laws of physics--and the contradictory nature of the stories as given by his parents. These signs are also based on interviews in which parents admitted to causing the child's injuries. There seemed no appreciable difference in the way these two groups of parents presented themselves, originally. The differences were rather in the levels of sophistication and behavioral controls of medical students, intern, residents and chiefs who introduced accusatory attitudes in the early moments of presentation of the child for care--or the avoidance of accusatory comunications. In the event parents felt accused, attempts to refute and defend simply enlarged parental attempts to justify the injury, it did not change other aspects of their relationship to the child and responses to his injury, treatment or prognosis.

In the few instances where we thought it had, it turned out that parents were using diagnostic material about the extent of the child's injury to refute the doctor as having accused them of a too severe injury, say the difference between a linear fracture and a fracture with compression. It was disappointing, but true, that on this difference their interest hinged, not on the fact that the child was injured--but that the doctor was wrong in saying that there was a skull fracture. After all the child did not need an operation for decompression, did he? So in effect, what was all the furor and concern about?

Difficult as these departures from concerns we consider "motherly, fatherly, parental" are, they do in our experience exist, requiring the nicest degree of logic and reality testing not to be carried along in ther irrational world and value system so sturdily represented by abusive parents. As we have found them, in the Hospital Setting they are:

1. do not volunteer information abut the child's illness or injury
2. are evasive or contradict themselves regarding the circumstances of injury, when questioned
3. show irritation at questioning, even when accusation is not inherent at the beginning
4. are critical of the child and angry with him/her for being injured
5. give no open signs of guilt or remorse about the child's injury
6. show little or no concern about the injury per se
7. show little or no interest in the treatment of the injury
8. show little or no interest in the prognosis
9. often disappear from the hospital during history taking and admissions procedures
10. tend not to visit child while in hospital
11. seldom touch or look directly at the child
12. do not involve themselves in the child's care in hospital--feeding and so on
13. usually do not inquire about the discharge date
14. ask to have child home, only when interrogation has motivated
15. do not ask about follow-up care

16. show concern about what will happen to them and others rather than about the child
17. maintain that the child has injured himself, usually maliciously
18. behave as if the child's injury is an essential assault on them, the parent(s)
19. fail to respond to the child's pain, discomfort, or respond inappropriately, i.e., not with comforting behavior but with irritation or by asking that he not cry, complain and thus not bother them with his/her physical or emotional feelings
20. give no indication that they perceive that a child has bona-fide feelings of his/her own
21. constantly criticize the child
22. fail to mention any good quality in the child
23. show no true concept of the rights of others
24. are preoccupied with their own feeling and the concrete things in life
25. are often most neglectful of their own physical health
26. exhibit violent feelings about past life and other relationships
27. indicate that their past lives were lived in a brutal physical or emotional milieu
28. reveal feelings of having been abandoned by an "uncaring mother", whom they direct hate filled feelings toward, while they still long for the caring, giving mother they never had
29. show strong, overwhelming feelings of worthlessness, fear and anger.

These signs are seen in parents, post injury. There is no reason to suppose that they did not antedate the abuse, but rather to suppose that they are familiar parts of parental life, from which the abuse has sprung, in part, as the parent lives the present in whatever real life-added stresses have occured.

6. CHARACTERISTICS OF ABUSE AND NEGLECT

Recognizing a child's need for protection is obviously more important than determining the form of maltreatment involved. In confronting a possible case of child maltreatment, the operational problem is not how to classify it, but whether or not to report it. Unfortunately, many of those who might report are not acquainted with the characteristics of abuse and neglect, and are, therefore, not alert to signs of possible maltreatment.

The following lists include both general characteristics of maltreated children and their parents, and some indicators of specific forms of maltreatment. The categories are not necessarily mutually exclusive; any of the forms of maltreatment can occur separately or together. Moreover, the characteristics listed are not proof of maltreatment, since any one or several can reflect situations other than abuse or neglect. But awareness of these characteristics helps in understanding the nature of abuse and neglect and, in practical terms, can help in identifying children in need of protection.

General

Abused or neglected children are likely to share at least several of the following characteristics:

- They appear to be different from other children in physical or emotional makeup, or their parents inappropriately describe them as being "different" or "bad".
- They seem unduly afraid of their parents.
- They may often bear welts, bruises, untreated sores, or other skin injuries.
- They show evidence of overall poor care.
- They are given inappropriate food, drink, or medication.
- They exhibit behavioral extremes: for example, crying often, or crying very little and showing no real expectation of being comforted; being excessively fearful, or seeming fearless of adult authority; being unusually aggressive and destructive, or extremely passive and withdrawn.
- Some are wary of physical contact, especially when it is initiated by an adult; they become apprehensive when an adult approaches another child, particularly one who is crying. Others are inappropriately hungry for affection, yet may have difficulty relating to children and adults. Based on their past experiences, these children cannot risk getting too close to others.

- They may exhibit a sudden change in behaviour: for example, displaying regressive behaviour - pants wetting, thumb-sucking, frequent whining; becoming disruptive; or becoming uncommonly shy and passive.

- They take over the role of the parent, being protective or otherwise attempting to take care of the parent's needs.

- They have learning problems that cannot be diagnosed. If a child's academic, IQ, and medical tests indicate no abnormalities but still the child cannot meet normal expectations, the answer may well be problems in the home - one of whoch might be abuse or neglect. Particular attention should be given to the child whose attention wanders and who easily becomes self-absorbed.

- They are habitually truant or late to school. Frequent or prolonged absences sometimes result when a parent keeps an injured child at home until the evidence of abuse disappears. In other cases, truancy indicates lack of parental concern or ability to regulate the child's schedule.

- In some cases, they frequently arrive at school too early and remain after classes rather than going home.

- They are always tired and often sleep in class.

- They are inappropriately dressed for the weather. Children who never have coats or shoes in cold weather are receivng subminimal care. On the other hand, those who regularly wear long sleeves or high necklines on hot days may be dressed to hide bruises, burns, or other marks of abuse.

The parents of an abused or neglected child may exhibit any of the following traits:

- They are isolated from family supports such as friends, relatives, neighbours, and community groups; they consistently fail to keep appointments, discourage social contact, and never participate in school activities or events.

- They seem to trust no one.

- They themselves were abused or neglected as children.

- They are reluctant to give information about the child's injuries or condition. When questioned, they are unable to explain, or they offer far-fetched or contradictory explanations.

- They respond inappropriately to the seriousness of the child's condition; either by overreacting, seeming hostile or antagonistic when questioned even casually; or by under-reacting, showing little concern or awareness and seeming more preoccupied with their own problems than those of the child.

- They refuse to consent to diagnostic studies.
- They fail or delay to take the child for medical care - for routine checkups, for optometric or dental care, or for treatment of injury or illness. In taking an injured child for medical care, they may choose a different hospital or doctor each time.
- They are overcritical of the child and seldom if ever discuss the child in positive terms.
- They have unrealistic expectations of the child, expecting or demanding behaviour that is beyond the child's years or ability.
- They believe in the necessity of harsh punishment for children.
- They seldom touch or look at the child; they ignore the child's crying or react with impatience.
- They keep the child confined -- perhaps in a crib or playpen -- for overlong periods of time.
- They seem to lack understanding of children's physical, emotional, and psychological needs.
- They appear to be misusing alcohol or drugs.
- They cannot be located.
- They appear to lack control, or fear losing control.
- They are of borderline intelligence, psychotic, or psychopathic. While such diagnoses are the responsibility of a psychiatrist, psychologist, or psychatric social worker, even the lay observer can note whether the parent seems intellectually capable of child-rearing, exhibits generally irrational behaviour, or seems excessively cruel and sadistic.

Physical Abuse

More specifically, physically abused children will probably fit some of the following descriptions:

- They bear signs of injury -- bruises, welts, contusions, cuts, burns, fractures, lacerations, strap marks, swellings, lost teeth. The list of possibilities is long and unpleasant. While internal injuries are seldom detectable without a hospital workup, anyone in close contact with children should be alert to multiple injuries, a history of repeated injury, new injuries added to old, and untreated injuries -- especially in the very young child.

- The older child may attribute the injury to an improbable cause, lying for fear of parental retaliation. The younger child, on the other hand, may be aware that severe beating is unacceptable and may admit to have been abused.

- They are behaviour problems. Especially among adolescents, chronic and unexplainable misbehaviour should be investigated as possible evidence of abuse. Some children come to expect abusive behaviour as the only kind of attention they can receive, and so act in a way that invites abuse. Others have been known to break the law deliberatley so as to come under the jurisdiction of the courts to obtain protection from their parents.

- Their parents generally provide such necessities for the child as adequate food and clean clothes; but they anger quickly, have unrealistic expectations of the child, use inappropriate discipline, and are overly critical and rejecting of the child.

Sexual Abuse

Sexual abuse, a form of physical abuse, ranges from exposure and fondling to intercourse, incest, and rape. Approximately 75 percent of the offenders, usually males, are known to the child or the child's family. Some 90 percent of the victims are girls, from infants through adolescents.

Since the sexually abused child lacks the tell-tale symptoms of battering, sexual abuse is difficult to identify and even harder to prove. Short of the child telling someone, the best indicators are a sudden change in behaviour and signs of emotional disturbance. The child, for example, may unexplainably begin to cry easily and seem excessively nervous. Dr. Vincent De Francis reported in 1969 that two-thirds of the children detected in a three-year study of sexual abuse in New York City evidenced some degree of emotional disturbance.

Physical Neglect

To some extent, neglect "defies exact definition, but it may be regarded as the failure to provide the essentials for normal life, such as food, clothing, shelter, care and supervision, and protection from assault." Physically neglected children tend to exhibit at least several of the characteristics below:

- They are often hungry. They may go without breakfast, and have neither food nor money for lunch. Some take the lunch money or food of other children and hoard whatever they obtain.

- They show signs of malnutrition -- paleness, low weight relative to height, lack of body tone, fatigue, inability to participate in physical activities, and lack of normal strength and endurance.

- They are usually irritable.

- They show evidence of inadequate home management. They are unclean and unkept; their clothes are torn and dirty; and they are often unbathed. As mentioned earlier, they may lack proper clothing for weather conditions, and their school attendance may be irregular. In addition, these children may frequently be ill and may exhibit a generally repressed personality, inattentiveness, and withdrawal.

- They are in obvious need of medical attention for such correctable conditions as poor eyesight, dental care, and immunizations.

- They lack parental supervision at home. The child, for example, may frequently return from school to an empty house. While the need for adult supervision is of course, relative to both the situation and the maturity of the child, it is generally held that a child younger than 12 should always be supervised by an adult or at least have immediate access to a concerned adult when necessary.

- Their parents are either unable or unwilling to provide appropriate care. Some neglecting parents are mentally deficient; most lack knowledge of parenting skills and tend to be discouraged, depressed, and frustrated with their role as parents.

Emotional Abuse or Neglect

Emotional abuse or neglect is far more difficult to identify than its physical counterparts. Such maltreatment includes the "parents's lack of love and proper direction, inability to accept a child with his potentialities as well as his limitations, . . . (and) failure to encourage the child's normal development by assurance of love and acceptance." The parents of an emotionally abused or neglected child may be overly harsh and critical, demanding excessive academic, athletic, or social performance. Conversely, they may withhold physical and verbal contact, care little about the child's successes and failures, and fail to provide necessary guidance and praise. Though emotional maltreatment may occur alone, it is almost always present in cases of physical abuse or neglect. The emotional damage to children who are physically abused or whose basic physical needs are unattended is often more serious than the bodily damage.

The indicators of emotional maltreatment are often intangible, but sooner or later the consequences become evident. The child may react either by becoming "hyperaggressive, disrupting and demand . . . shouting his cry for help," or by becoming "withdrawn . . . whispering his cry for help." In a class of psychologically healthy children, the emotionally abused child often stands out unmistakably. Emotional maltreatment has a decidedly adverse effect on a child's learning ability, achievement level, and general development. The strongest indicators are unaccountable learning difficulties and changed or unusual behaviour patterns.

7. TYPICAL REACTIONS OF PARENTS AND CHILDREN

a) Typical Reactions and Attitudes of Protective Parents to Children's Injuries

1. Are voluble and spontaneous in reporting details of injury.
2. Show concern about the degree of damage.
3. Show concern about treatment.
4. Show concern about the possibility of residential damage.
5. Exhibit a sense of guilt increased if child is young or if they were not directly involved.
6. Ask questions regarding prognosis.
7. Have difficulty detaching from child on admission.
8. Attempt restitution through visits, gifts etc.
9. Ask questions about discharge date.
10. Ask about after care.
11. Identify with the childs feeling both physical and emotional.
12. Are positively related to child.

b) Typical Reactions and Attitudes of Neglecting Battering Parents

1. Do not volunteer information re: injury.
2. Evasive or contradictory regarding circumstances surrounding child's symptoms.
3. Show irritation at being asked about the development of the child's symptoms.
4. Critical of child and angry at him/her for being injured.
5. No indications of guilt or remorse.
6. Little or no concern re: injury.
7. Little or no concern re: treatment.

8. Little or no concern re: progress.
9. Leave hospital quickly.
10. Tend not to visit.
11. Seldom touch the child or look at him/her.
12. Do not involve themselves with the child's care while in hospital.
13. Don't inquire about discharge date.
14. Ask to have child home only when questioned.
15. Don't ask about after care.
16. Not concerned re: child but with what will happen to them.
17. Maintain that the child has injured him/herself.
18. Act as though the child's injuries are an assault on them.
19. Fail to respond or respond inappropriately to child.
20. No indication of empathy.
21. Constantly critize child.
22. Don't mention positives.
23. Exhibit violent feelings and behaviour and past.
24. Reveal that they are concerned re: abandonment, punishment as child and long for mothering.
25. Feel overwhelmingly worthless.

c) Typical Behaviour of Well Cared For Children

1. Cling to parent when brought in.
2. Turn to parents for reassuring.
3. Turn to parents for comfort during exam and treatment.
4. Constantly show by work and action that they don't want parents to leave and that they want to go home.
5. Are reassured by their parents visits.

d) Typical Behaviour of Abused Children

1. Cry hopelessly under treatment and exam.
2. Cry very little in general.
3. Don't look to parents for reassurance.
4. Show no expectation of being comforted.
5. Wary of physical contact by parent or adult.
6. Apprehensive when other children cry and watch them curiously.
7. Apprehensive when adults approach crying child.
8. Seem less afraid than other children when admitted and settle quickly.
9. Always on alert for danger.
10. Always asking or wondering what will happen next.
11. Constantly in search of something, food, favours, things, services.
12. Show little emotion re: mention of going home etc.

8. BEHAVIOURAL INDICATORS OF ABUSED CHILDREN

Children who are abused physically or emotionally display certain types of behaviour. Many of these are common to all children at one time or another, but when they are present in sufficient number and strength to characterize a child's overall manner, they may indicate abuse. More than simple reactions to abuse itself, these behaviours reflect the child's response to the disturbed dynamics of the family, and especially to parent-child interactions. They are mechanisms for survival in a world where a child is either unable to fulfill certain basic needs at all, or can fulfill them only by denying or suppressing important parts of him/herself. Frequently learned in infancy, these behaviours become a child's "mode of operation" used to cope with the world at large. The behaviours which characterize abused children fall into four categories:

1. Overly compliant, passive, undemanding behaviours aimed at maintaining a low profile, avoiding any possible confrontation with a parent that could lead to abuse. In cases of severe abuse, this could mean avoiding any situation in which the abusive parent even notices the child.

2. Extremely aggressive, demanding and rageful behaviours, caused by the child's repeated frustrations at getting basic needs met. These behaviours are more common in a child who is mildly or inconsistently abused, since such a child has learned to have some expectations for love and support.

3. Overly adaptive behaviour in response to unresolved needs of the parent. Abusive parents have been unable to satisfy certain of their needs appropriately and so turn to their children for fulfillment. Their failure can produce two opposite sets of behaviour in their children. If a parent needs parenting him/herself, the child may be expected to assume this task, and become inappropriately adult and responsible. Other parents, with a need to keep their child dependent, will produce clinging, babyish behaviour in that child long after a child in a healthy family would have become more self-reliant.

4. Lags in development. Children who are forced to siphon off energy normally channeled towards growth into protecting themselves from abusive parents will fall behind the norm for their age in toilet training, motor skills, socialization and language development.

Mildly Abused Children

Mildly abused children live in an uncertain environment where requirements for behaviour are inconsistent and unclear. Abuse in such a family is enough to be provocative but insufficient to threaten physical survival. Frequently, discipline is meted out only in response to the parent's needs and feelings at the moment, rather than to punish a child for transgressing clear limits. Mildly or inconsistently abused children receive some love, affection, and security from their parent but are also often frustrated in attempts to fulfill their needs. The effect of this uncertainty is to create anger and frustration in the child which is frequently expressed indirectly with the parents, or by explosions with others outside the home. Behaviours of mildly abused children include:

- hyperactivity
- temper tantrums
- short attention span
- aggression

Severely Abused Children

Severely abused children have learned to do what the abusive parent wants or expects without considering their own needs. They rarely make demands and usually adapt quickly to others' expectations. Unlike mildly abused children, who experience frustration from never knowing what to expect, severely abused children have learned not to expect anything in the way of love or support. Their best efforts are directed to avoiding conflict which, in the context of a severely abusive family, can be triggered by expressing almost any kind of personal need, curiosity, anger, or playfulness. Specific behaviours of severely abused children include:

- inhibited verbal or crying responses
- inordinate shyness
- immobility
- dependence
- lack of curiosity, a fear of appearing curious
- wariness of physical contact
- excessive concern for the parent's needs
- excessive self-control

Behaviours of Abused Children in Selected Settings

Because the dynamics of abusive families vary, along with the individual personalities of the parents and children, an abused child's behaviour is often sporadic and unpredictable, and a list of behavioural indicators is useful only as a general guide. Some behavioural indicators are evidenced in a change in behaviour over time. The quality of an abused child's dependence illustrates the point. Abused children have many needs, but because they have few expectations that these needs will be met, often they will not express them. In a safe environment, however, where the child perceives that it is acceptable to express needs, they will be many. Efforts to always "do the right thing" will soon disappear and be replaced by what can seem to be insatiable demands. The following settings and situations permit observations of some behaviour that could indicate abuse.

Foster homes or hospitals - Depending on the severity of abuse and the degree of openness permitted in a hospital or foster home, the behaviour of abused children may vary. Some may whimper for their parents, while others will respond to the presence of adults who can give them more complete and loving care. If the rules are strict, severely abused children are likely to be fiercely compliant; if the rules are more relaxed, they may eventually relax and begin to express all the various needs that had been bottled up at home.

With strangers - Mildly abused children are likely to be indiscriminately friendly, attaching themselves to any stranger in a search to find someone to fulfill their needs. Severely abused children, fearful of abuse from everyone, tend to be inhibited, withdrawn and wary of contact with strangers.

Eating - If eating is a specific area of conflict between a child and an abusive parent, any specific departures from the "normal" method of eating for a child that age can indicate abuse. An 18-month-old baby who is inappropriately neat in his or her eating habits may be responding to an abusive situation in the family; the four-year-old who is totally compliant in eating behaviour rather than very controlling of the environment may also be abused.

Playing - The way children play offers insights into their inner state. A five-year-old who cleans up after every other child in kindergarten likely has some severe restraints on him at home, which could include abuse. Furthermore, many abused children, conditioned to be extraordinarily aware of their parents and the danger they present, will tend not to be aware of other children, in that they don't engage in much socialization. (They are also insufficiently able to protect themselves from dangers in the environment other than their parents, since that is the overwhelming source of their anxiety.) Mildly abused children may pick frequent fights with playmates, or disrupt other children, since that is the behaviour their parents apply to them.

Going home - Normal children will not want to stop play to go home; they may express some "crankiness" on the way home, but will in general be happy to see their parents. Abused children will not want to go home, but will almost instantaneously adapt to the request to go home without protest, and will not show much enthusiasm on seeing their parents.

Ultimately, a list of specific behaviours to identify child abuse is useful only if the family dynamics which produce those behaviours are clearly understood. The behaviours, verbal and physical, indicate both the survival techniques the child has learned in order to exist in his or her family, and attempts - frequently inappropriate or overstated - to get from others what the parents do not provide. The greater the abuse, the less the child will trust other people or reach out to them, and the more time he or she will require to respond to love and care.

9. INDICATORS OF NEGLECT

A. Abandonment

1. Children who are abandoned totally or for long periods of time.

B. Lack of supervision

1. Children who are inadequately supervised for long periods of time or when engaged in dangerous activities.

2. Children left in the care of other children too young to protect them.

C. Lack of adequate clothing and good hygiene

1. Children dressed inadequately for the weather or suffer persistent illnesses like pneumonia or frostbite or sunburn that are associated with excessive exposure.

2. Severe diaper rash or other persistent skin disorders resulting from improper hygiene.

3. Children who are chronically dirty and unbathed.

D. Lack of medical or dental care

1. Children whose needs for medical or dental care or medication and health aids are unmet.

E. Lack of adequate education

1. Children who are chronically absent from school.

F. Lack of adequate nutrition

1. Children lacking sufficient quantity or quality of food.

2. Children who consistently complain of hunger or rummage for food.

3. Children who suffer severe developmental lags.

G. Lack of adequate shelter

1. Structurally unsafe housing or exposed wiring.

2. Inadequate heating.

3. Unsanitary housing conditions.

H. In identifying neglect, be sensitive to:

1. Issues of poverty vs neglect.

2. Differing cultural expectations and values.

10. INDICATORS OF EMOTIONAL MALTREATMENT

Legal Definitions

The concept of emotional maltreatment of children -- or emotional neglect, or mental injury -- is a relatively new one. In the past, it was covered in law by such general phrases as "acts or omissions injurious to the child's health or welfare". There has been a recent trend to include emotional maltreatment in the state reporting laws on child abuse and neglect. Twenty-eight of the 50 states with such reporting laws refer to emotional maltreatment, although the references themselves are not very helpful, as the following examples suggest:

- mental injury
- serious nonaccidental mental injury
- gross neglect which would affect mental or emotional well-being
- emotional maladjustment
- emotional abuse
- protracted impairment of emotional health
- commission or omission of any act or acts which materially affect normal emotional development
- mental health adversely affected

The Model Child Protective Services Act, in an attempt to further explicate the meaning of emotional maltreatment, combines the concepts of parental acts or omissions with consequent harm or threatened harm to the child. It refers to "mental injury" and defines it as "injury to the intellectual or psychological capacity of the child as evidenced by an observable and substantial impairment in his ability to function within a normal range of performance and behaviour, with due regard to his culture."

In our state, the concept of emotional maltreatment is handled as follows:

> If it is mentioned in your state's reporting law,
> read that section of the law and describe it briefly.

Parental Behaviours

Such definitions of emotional maltreatment are so broad that they could conceivably be applied to almost all forms of ineffective parenting. The breadth of the laws places a great deal of responsibility on professionals in child protective work to develop methods of distinguishing between ineffective parenting which they would wish to see improved for the benefit of the child -- and emotional maltreatment, which might ultimately require the removal of the child from the home. Moreover, they must do this within the context of changing "rules" of parenting and variations in child-rearing practices among cultures.

Although most professionals in the field of child care have some visceral sense of what emotional maltreatment is, conceptualizing that sense in a way that indicates when and how to report and intervene is not an easy task. There is a spectrum of parental behaviours ranging from infrequent, isolated emotionally detrimental acts to a chronic, pervasive pattern of parenting which in its totality is psychologically destructive. As children; most of us were at times treated cruelly or clumsily by our parents; and most, if not all, of us have at times reacted to children in ways we knew were unkind or hurtful. Parents are human, after all, and cannot be expected to be perfect. At the other end of the spectrum, however, are parents whose acts or omissions are so outrageous by any standards of acceptable parenting as to make a determination of emotional maltreatment virtually automatic. Such examples include:

- shutting a child in a dark closet for a day at a time, or longer
- locking an adolescent in the house for months at a time
- tying a young child to a bedpost for hours or days
- treating a child like an animal, as sometimes happens with retarded children
- engaging in bizarre acts of torment or nonphysical torture.

But what about the middle of the spectrum? Where can the line be drawn between emotional maltreatment and ineffective parenting? To a greater degree than for other types of child abuse and neglect, emotional maltreatment in the abstract resists such demarcation, and must be examined case by case. In the first place, emotional maltreatment is seldom the result of a single act, or even the repetition of a single act, but rather the product of a constellation of frequently quite subtle parent-child interactions. Also, within the totality of these interactions, what a parent does not do is as important as what he or she does. For example, constantly belittling a child, while it might be detrimental to a child's development in a family where parents also provide some love and emotional nurturance, could constitute emotional maltreatment if it were totally unmitigated by any kind of emotional support whatsoever. Finally, because emotional maltreatment is incremental, building up over time, it is frequently impossible for a social agency or court to point to a specific act or precipitating incident which can be labeled emotional maltreatment.

One way for professionals to learn to identify emotional maltreatment is to be aware of indicators in children that point to the existence of emotional maltreatment. They are:

1. Overly compliant, passive, undemanding behaviours
2. Extremely aggressive, demanding, and rageful behaviours
3. Overly adaptive behaviours in response to unresolved parental needs -- either inappropriately adult or inappropriately childish
4. Lags in physical, emotional, and intellectual development.

In instances of physical abuse, such indicators can be used as corroborations in cases where more tangible evidence, such as physical injuries, exists. What this means is cases of emotional maltreatment, where behavioural indicators may be the only evidence, is that the behaviours must be more exteme for a situation to qualify as reportable emotional maltreatment, as against ineffective parenting.

Intervention in Cases of Emotional Maltreatment

When emotional maltreatment is coupled with physical abuse or neglect, intervention is easier, since the reporting laws are more clear-cut, and the evidence required to determine a case is more tangible. To prove emotional maltreatment, however, it is often necessary to rely on indirect or subsequent evidence of maltreatment. Expert psychiatric or psychological examination can often establish the degree of emotional damage to a court's satisfaction (if it is necessary) and the relationship between the child's emotional damage and acts or omissions of the parents. Another means of proof is the degree to which a child's condition improves during a temporary removal from the home, or while the family is under an agency's supervision.

Frequently, however establishing the existence of emotional maltreatment to a degree necessary for intervention by the courts is difficult, especially in those states where willful intent by the parents must be proved. Furthermore, many professionals hesitate to report emotional maltreatment because facilities for treatment of the problem in their communities are inadequate or lacking altogether. When it is not possible to report a suspected case of emotional maltreatment, there are still several steps professionals can take to protect the child's welfare:

- Continue to document specific behaviours of parents, children, and their interactions, for use in a possible report at a later time.
- Encourage parents to seek or accept help voluntarily.
- Report and request intervention on grounds of physical abuse, sexual abuse, or neglect, if any of these conditions are present.

Carefully narrowing the definition of emotional maltreatment is not intended as a tacit endorsement of other, less tangible (but frequently just as emotionally damaging) parent-child interactions that produce severely disturbed, unhappy and malfunctioning children. Nor is it meant to limit professionals who are aware of such children from doing everything possible to help them. What it does intend is to conceptualize emotional maltreatment in such a way that society can 1) protect the child from grossly injurious parental acts or omissions not covered by abuse and neglect laws without 2) opening the door to governmental infringement on a family's right to function as it sees fit, no matter how actually or potentially harmful to a child's emotional well-being it may appear to be. Clearly the issue of emotional maltreatment will always be problematic, requiring on the part of the professional a constant awareness of the rights of the child and of the family -- and the ability to determine the type of intervention, if any, that will protect each right as much as possible.

11. INDICATORS OF SEXUAL ABUSE

Scope of the Problem

Intra-family sexual abuse -- sexual abuse, in other words, which is perpetrated on a child by a member of that child's family group -- includes not only sexual intercourse, but also any act designed to stimulate a child sexually, or to use a child for the sexual stimulation, either of the perpetrator or of another person. "Family", in this case, includes parents and parent surrogates -- people who, by sexually abusing a child, are exploiting some kind of nonsexual, parental relationship, no matter how indirect or temporary, with that child.

Legal definitions of sexual abuse of children vary from state to state, as reflected in the following terms which range from specific acts to more broadly defined phrases that could include different kinds of activity:

- indecent exposure
- impairing the morals of a minor (or contributing to the delinquency of a minor)
- rape
- attempted rape
- sodomy
- exploitation
- incest

Intra-family sexual abuse of children violates one of society's strongest taboos, that against incest. Although, strictly speaking, incest refers only to sexual intercourse between two people who are so closely related by blood that they are forbidden by law to marry, any kind of intra-family sexual abuse of children arouses many of the strong feelings of revulsion evoked by incest per se. Society's responses indicate the depth of these feelings. On one hand, if a case of sexual abuse is overwhelmingly well documented, the responses of the courts and social agencies tend in most communities to be swifter and more definitive than for other types of child abuse: the abused child, more often than not, will be removed from the home, and the offending party is more likely to be liable for criminal prosecution. On the other hand, there is a reluctance on the part of many professionals to recognize, gather documentary information on, and report suspected cases -- resistance, in part, to dealing with problems that stir up powerful sexual fears and conflicts present in everyone. Compared with physical abuse, for example, sexual abuse has not received a great deal of attention from the helping professions, and as a result we know less about the incidence of sexual abuse than about other forms of maltreatment of children.

All evidence points to the fact that sexual abuse of children is under-reported. In the 1960's the American Humane Association conducted a three-year study of child molestation in New York City in which it estimated that approximately 3,000 cases a year took place, three-fourths of which were intra-familial -- an estimate further research has proven conservative. The year after Connecticut passed an expanded child abuse reporting law, which included a $500 fine for mandated reporters who failed to report suspected cases, the number of incidents of sexual abuse reported jumped 200 percent. According to Connecticut's statistics, three-fourths of the cases were intra-familial, and most of these were perpetrated by a father, male relative, or a boyfriend of the child's mother.

Professionals must be as receptive to the possibility of sexual abuse as they are to other kinds of abuse. As Suzanne Sgroi wrote in the May-June, 1975, issue of Children Today:

> For too long health professionals have skirted the issue of reporting suspected sexual molestation when an unmistakable diagnosis of acquired veneral disease has been made in a child . . . Because of reluctance to entertain the possibility of sexual molestation, we have often postulated modes of transmission of veneral disease to children within the family circle that were long ago discarded in relation to adults, such as the possibility of transmission via clothing, towels and bedsheets.

Only when professionals recognize, corroborate, and report cases of sexual abuse with the same sense of commitment that they bring to other forms of child abuse, will the extent and nature of the problem be known, and appropriate methods of treatment become widespread.

Underlying Family Conditions

Intra-family sexual abuse occurs in families under stress of various kinds. Some researchers, in fact, postulate that such sexual abuse is an extreme manifestation of a family breakdown. In addition to parent's low self-esteem, lack of proper nurturance as children, and inadequate "coping" skills, the following conditions are characteristic in cases of sexual abuse:

- prolonged absence of one parent from the home
- loss of one parent through death or divorce
- severe overcrowding in the home, especially in sleeping arrangements
- marital problems causing one spouse to seek physical affection from a child rather than the other spouse (a situation the "denying" husband or wife might find acceptable)
- alcoholism

- lack of social and emotional contacts with people outside the family
- geographical isolation, as in the case of some families in very rural areas
- a multi-generational pattern of intra-family sexual abuse
- cultural standards in a family which determine the degree of acceptable body contact

Definitions of sexual abuse must always be viewed from the vantage point of the community in which it occurs. Be aware of the cultural make-up of the trainee population and relate the contents of this lecture to the cultural standards and expectations of the group. For example, Native Americans may have a different cultural relationship to certain kinds of body contact than do white middle class Americans.

A typical form of intra-family sexual abuse occurs between an adult male, either the father or the mother's sexual partner, and a female child living in the same house. Charles McCaghy, writing in Sexual Behaviour, describes such a case:

> Because of these circumstances he has had several sexual contacts with his victim before he is apprehended. Furthermore, these contacts tend to develop into more serious types over time: while they may begin as caressing contact, subsequent contacts become genital-genital and oral-genital in nature. The molester's ability to prolong the sexual relationship is often due to the reluctance of his wife, who frequently knows about the situation, to report the behaviour; obviously, if a report is made the husband will be taken from the home and the wife left on her own. Many such cases become known to the authorities because the wife finally decides to report for one reason or another, or because the victim reveals the activity in school or to police while being questioned about other delinquent activity. Alcohol appears to play an important role for this type; in many cases drinking preceded the sexual contact, particularly for the first offense. As with most child molesters; coercion plays a minor part in incestuous offenses. Of course, there is a built-in factor of parental authority operating.

From this description, two further common conditions emerge: first, a family relationship in which one of the parents is extemely passive and reluctant to assert him/herself in ways that would seem to destroy the family unit. It frequently happens that a mother is aware, or has very strong suspicions, of sexual activity between her husband/boyfriend and her child -- but does not deal with it (or, often even permit herself to recognize it) out of fear that the perpetrator would leave, or seek some kind of revenge. Second, there is the part the child plays in encouraging the sexual activity. In some cases the child can engage in frankly seductive behaviour. Usually, however, the interaction is more subtle, such as those situations, conscious or unconscious, in which an adult plays on a child's need for affection and/or simple human contact, and makes it clear to the child that the only way he or she can meet this need is through some kind of sexual

activity. As McCaghy notes, this type of interaction can start out as simple physical caressing which gradually becomes more sexual. At this point the child may have to be forced into overt sexual activity, but the coercion can include, along with force or the threat of harm, the warning that unless the child cooperates, the perpetrator will withdraw his or her love, and implicate the child for his or her "bad behaviour".

Physical Indicators

Identifying and documenting a case of intra-family sexual abuse can be difficult. In addition to the family dynamics which operate to protect the perpetrator (and thereby keep the family unit intact), there is the reluctance on the part of some professionals to subject a child to medical examinations, questioning, and court appearances that they feel will be more harmful to the child than the sexual abuse itself. Fortunately, however, many hospitals and health professionals are revising their examination procedures in such cases to avoid causing the child psychological damage. And there is a trend on the part of some communities to consider instances of intrafamily sexual abuse as symptoms of severe family problems, whenever possible to be treated within the context of the family rather than to be dealt with simply by punishing the perpetrator.

The following indicators can be discovered by a physician during an examination. Expecially when they are found in young children, they are very strong indicators of sexual abuse:

- bruises in external genitalia, vagina, or anal regions
- bleeding from external genitalia, vagina, or anal regions
- swollen or red cervix, vulva, or perineum
- semen around the genitals, or on clothing
- veneral disease in young children

The existence of any of the following may indicate sexual abuse:

- veneral disease in older children
- pregnancy
- broken hymen

Indicators which a parent can identify include pain, itching, bleeding, spotting, and torn or stained clothing which the child has hidden away.

Behavioural Indicators

Short of a child's recounting of an incident of sexual abuse (and these reports, too, must be thoroughly investigated), behavioural indicators serve more to corroborate other indicators and provide clues to a situation requiring further examination than to conclusively substantiate suspected cases. Such indicators include:

Regression: Sexually abused children, especially young children, may retreat into fantasy worlds, or adopt infantile behaviours. Sometimes such children may even give the impression of being retarded.

Delinquency or aggression: Sexually abused children, especially teenagers, may act out their anger and hostility towards the perpetrator in delinquent or aggressive behaviour towards others.

Poor peer relationships: If sexual abuse is a pattern and not an isolated incident, a child may have such a poor self-image ("I am guilty for what I do"), may be so isolated by the parent, and may otherwise be so emotionally disturbed that he or she will not be able to form friendships with other children his or her age.

Extremely protective parenting: The perpetrator may be exceedingly jealous of the child, often refusing him or her any social contact -- in part from fear that he or she will "tell", but also to avoid losing the child to someone else. An example is the sexually abusive father who picks up his teenage daughter every day after school, and becomes furious if he sees her talking to anyone.

Unwillingness to participate in physical activities: Young children who have been highly stimulated sexually or have been forced to have sexual intercourse with any adult may find it painful to sit in their chairs at school, or to play games which require a lot of movement.

Running away from home: This may be one method by which a sexually abused child seeks to escape the situation at home. It may also be an indirect way of asking for help in a situation in which they feel powerless. It may appear to be the only way out for a child caught in a conflict between continued sexual abuse and his or her loyalty to the family or fears of retaliation.

Drug usage and drug abuse: The abuse of alcohol or other drugs may be one way an abused child has of coping with overwhelming and complex feelings of guilt and/or anxiety.

Indirect allusions: A sexually abused child may seek out a special friend or a teacher to confide in. These confidences may frequently be vague and indirect, such as "I'm afraid to go home tonight," "I'd like to come and live with you," or "I want to live in a foster home."

Responsibility of the Professional

In order to protect a sexually abused child from further assaults -- either by removal from the home, punishment of the perpetrator, or treatment of the underlying family problems — the case must be well documented. Especially if the courts become involved, this means the collection of medical evidence of sexual assault. Without such evidence, any kind of professional response is almost impossible in the absence of parental cooperation. A well-meaning professional who does not insist on a complete interview and physical examination for all the physical indicators listed above may be overlooking exactly the kind of evidence necessary to take appropriate action. Medical exams, if gentle, cannot only be nonthreatening to a child, but actually reassuring to a child who fears he or she has been harmed. And a complete interview with the child concerning what happened, if separated from the physical exam and conducted thoroughly and with understanding, should obtain all the information needed and will obviate the need for additional, repetitive questionings. Without this kind of thorough investigation at the outset, valuable medical evidence may be lost, and a professional who decides six months later that sexual abuse is in fact taking place may have no way of helping the child.

12. POTENTIAL OF THE PARENT TO ABUSE

I. The background of both parents and in particular their childhood experiences and the way they were reared.

Some key questions for parents in this area are:

1. How did your parents punish you when you misbehaved or displeased them as a child?
2. Do you feel that the way your parents punished you is the best way to get children to behave?
3. Do you feel your parents were pleased with you?
4. Do you feel you have let your parents down?
5. What kind of relationship did you have with your mother when you were younger? With your father?
6. What kinds of things did you try to do to please your parents?
7. How would you describe your relationship with your mother now? With your father now?

II. Self Esteem

The self image or self concept of each parent should be assessed. The following questions will assist in this regard.

1. Do you feel that people would not like you if they really knew you well?
2. Do you feel that others get along much better than you do?
3. Do you feel that you are a beautiful person?
4. When you are with other people, do you feel that they are glad they are with you?
5. Do you feel that people really like to talk to you?
6. Do you feel that you are a very competent person?
7. Do you think you make a good impression on others?
8. Do you feel that you need more self-confidence?

9. When you are with strangers, are you very nervous?
10. Do you think you are a dull person?
11. Do you feel ugly?
12. Do you feel that others have more fun than you do?
13. Do you feel that you bore people?
14. Do you think your friends find you interesting?
15. Do you think you have a good sense of humour?
16. Do you feel self-conscious when you are with strangers?
17. Do you feel that if you were more like other people you would have it made?
18. Do you feel that people have a good time when they are with you?
19. Do you feel like a wallflower when you go out?
20. Do you feel that you get pushed around more than others?
21. Do you think you are a nice person?
22. Do you feel that people like you a lot?
23. Do you feel that you are a likeable person?
24. Are you afraid you will appear foolish to others?
25. Do your friends think highly of you?

III. Marital Relationship

Here it is important to determine the degree of compatibility/satisfaction in the marriage. If one spouse is considered the possible abusive parent, the degree of understanding and support of the partner should be examined. The following questions to the suspected abuser will assist you in this area.

1. Do you feel your partner shows you enough affection?
2. Do you feel that your partner treats you badly?

3. Do you feel that your partner really cares for you?
4. Do you feel that you would not choose the same partner if you had it to do over again?
5. Do you feel that you can trust your partner?
6. Do you feel that your relationship is breaking up?
7. Do you feel that your partner doesn't understand you?
8. Do you feel that your relationship is a good one?
9. Do you feel that you have a very happy relationship?
10. Do you feel that your life together is dull?
11. Do you feel that you have a lot of fun together?
12. Do you feel that your partner doesn't confide in you?
13. Do you feel that your relationship is a very close one?
14. Do you feel that you cannot rely on your partner?
15. Do you feel that you do not have enough interests in common?
16. Do you feel that you manage arguments and disagreements well?
17. Do you feel that you do a good job of managing your finances?
18. Do you feel that you never should have married your partner?
19. Do you feel that you and your partner get along very well together?
20. Do you feel that you have a stable relationship?
21. Do you feel that your partner is pleased with you as a sex partner?
22. Do you feel that you should do more things together?
23. Do you feel that the future looks bright for your relationship?
24. Do you feel that your relationship is empty?
25. Do you feel that there is no excitement in your relationship?
26. Do you feel that your partner does/doesn't know when you are uptight or nervous?

27. Do you feel that your partner does/doesn't help you when you need help with your children?

28. Do you feel that your partner does/doesn't help you enough with the child caring role?

IV. Isolation

The degree of isolation of the family unit and in particular the spouse with the abusive potential should be considered carefully. In this regard, the isolation within the family should be considered as well as the isolation from extended family, neighbours, community, etc. Intra-family isolation can be assessed by addressing the following questions to the suspected abuser.

1. Do the members of your family really care about each other?
2. Do you think your family is terrific?
3. Does your family get on your nerves?
4. Do you really depend on your family?
5. Can you really depend on your family?
6. Do you really not care to be around your family?
7. Do you wish you were not a part of your family?
8. Do you get along well with your family?
9. Do members of your family argue too much?
10. Do you feel that there is no sense of closeness in your family?
11. Do you feel like a stranger in your family?
12. Do you feel your family does not understand you?
13. Do you feel that there is too much hatred in your family?
14. Do you think members of your family are really good to one another?
15. Is your family well respected by those who know you?
16. Does there seem to be a lot of friction in your family?
17. Is there a lot of love in your family?

18. Do members of your family get along well together?

19. Is life in your family generally unpleasant?

20. Is your family a great joy to you?

21. Do you feel proud of your family?

22. Do other families seem to get along better than yours?

23. Is your family a real source of comfort for you?

24. Do you feel left out of your family?

25. Is your family an unhappy one?

Extra-family isolation can be assessed by discussing relationships outside of the family and the family's integration within society.

V. Role/Reversal/Unrealistic Expectations of the Child

It is important to determine the attitude of both parents to their children, and in particular the abusive parent's attitude and expectations towards the abused child.

In this regard questions should be asked regarding the expectations the parent has of the child. The reasonableness of the answers should be assessed in light of the child's age and abilities. It is also important to ascertain whether or not the child/ren is expected to meet the needs of parents (role reversal) to a significant degree.

Some questions in this area are as follows:

1. Does your child get on your nerves?

2. Do you get along well with your child?

3. Do you feel that you can really trust your child?

4. Do you dislike your child?

5. Is your child well behaved?

6. Is your child too demanding?

7. Do you wish you did not have your child?
8. Do you really enjoy your child?
9. Do you have a hard time controlling your child?
10. Does your child interfere with your activities?
11. Do you resent your child?
12. Do you think your child is terrific?
13. Do you hate your child?
14. Are you very patient with your child?
15. Do you really like your child?
16. Do you like being with your child?
17. Do you feel that you do not love your child?
18. Do you feel your child is irritating?
19. Do you feel very angry toward your child?
20. Do you feel violent toward your child?
21. Do you feel proud of your child?
22. Do you wish your child were more like others you know?
23. Do you feel you do not understand your child?
24. Is your child a real joy to you?
25. Do you feel ashamed of your child?
26. Does the parent identify with the nurturing parent role?
27. How does the parent respond to the child's needs? (e.g., natural and acceptable, simple interference, assaultive or oppressive.
28. Does the parent attribute irrational degrees of motivation, responsibility and judgement to the child?
29. Does the parent expect the child to protect him rather than he protect the child?
30. Is the child held responsible for the neglect or abuse?

SECTION II

PROCEDURES

1. FACTORS TO CONSIDER IN CHILD ABUSE CASES REGARDING ADMISSION TO CARE

1. Maltreatment in the home, present or potential, is such that a child left there could suffer serious damage to body or mind.
2. If an infant or pre-school child is abused.
3. Child's age, physical or mental condition renders him/her incapable of self protection.
4. Serious abuse (e.g., life threatening abuse, malnutrition, incest, multiple injuries, head injuries, wilfully inflicted burns, broken bones, sadistic injuries.)
5. Child is in immediate need of medical treatment and the parents refuse to obtain this.
6. Evidence of repeated and frequent abuse (by history, examination of X-ray).
7. Reabuse after initial report and intervention.
8. Child is unwanted or rejected.
9. Child's behaviour is unduly provocative or obnoxious to the parents.
10. Child is extremely fearful of parent(s)/caretaker(s), or is fearful of remaining in or returning to his home.
11. Any parent has been diagnosed recently by a qualified medical practitioner as being sociopathic, psychotic, suicidal, homocidal or sadistic.
12. Any parent has been diagnosed recently by a qualified medical practitioner as being sociopathic, psychotic, suicidal, homocidal or sadistic.
13. Non-perpetrator parent is not protective.
14. Parent wants the child placed after intervention.
15. Parents persistently refuse intervention and treatment services.
16. Multiple ongoing crises are affecting the family functioning.
17. Parents refuse access to child or have history of hiding child, moving, etc.

18. Parents deny obvious abuse or injury, or seem indifferent or unaware of the seriousness of their actions.

19. Where, after intervention, the parents continue to believe that severe discipline is appropriate behaviour.

20. Parent has grossly unrealistic expectations of the child's behaviour.

21. Child is deserted or abondoned.

22. Parents are for any reasons incapable of adequately parenting/protecting the child.

23. Marriage relationship is highly abusive or otherwise seriously unstable.

3. FACTORS TO CONSIDER IN TERMINATING SERVICE IN CHILD ABUSE CASES

I. The Parents

1. If either parent has been diagnosed as extremely disturbed and this person is permanently out of the home, or a recent evaluation finds the parent no longer dangerous.

2. The abusing parent has been out of the home, over a reasonable period of time, as verified by suitable evidence.

3. The parents have utilized therapy, e.g., kept appointments, kept contracts, talk freely, considered therapy valuable.

4. The parents have completed therapy and no additional therapy is recommended.

5. There is concensus that parents will seek additional assistance on their own initiative when needed.

II. Child Management

1. Specific improvements in the parents' understanding of the child and their ability to cope with child have been documented by CAS staff or other involved professionals.

2. The parents can talk about and have demonstrated alternative ways to dealing with their anger/impulses.

3. The parents have demonstrated impulse control.

4. The parents can tolerate the child's expression of negative feelings towards them.

5. Parents use discipline techniques that are fair, non-punative, consistent and appropriate.

6. The parents ask for advice regarding child rearing and are able to implement this advice.

7. The parents recognize and have solved specific problems of child rearing.

8. The parents recognize the child as an individual with needs, desires and rights of his/her own, and they are able to respond appropriately to these needs.

9. The parents' perceptions and expectations of the child are realistic.

10. The parents speak in positive terms about the child.

11. The child is no longer seen as special, different, difficult or provocative.

12. The parents keep all scheduled visits with their child.

13. The abusing parent (perpetrator) has shown the most improvement in these skills.

14. The abusing parent (perpetrator) has shown he/she can recognize potentially dangerous or abusive situations and knows how to remove himself from the child at these times.

III. Relationships

1. The marriage is stable, the parents have demonstrated that they are supportive of each other and can relieve each other in child care and housework responsibilities.

2. Open communication, sensitivity and understanding between the parents has been sustained over a period of time.

3. The parents recognize and meet each others needs more appropriately and effectively.

4. The parents needs are being met other than through the child.

5. The parents are less isolated and feel better about themselves (improved self-image).

6. The parents have demonstrated that they can resolve conflicts within their relationship without involving the child.

7. Interpersonal relationships have improved; isolation has decreased. The parents have supportive and available friends, relations or group affiliation.

IV Crisis Management

1. CAS staff or other involved professionals have documented specific improvement in the parents' ability to cope with crisis.

2. The parents no longer live in the chaos of multiple, overwhelming, ongoing crisis.

3. The parents can talk about methods of dealing with crises.

4. The parents have solved specific crises.

5. The parents have asked for help during crisis and have been able to utilize this help.

6. The parents have recognized and solved specific problems before they turn into major crises.

V. The Child

1. The parents recognize ongoing treatment needs of the child (medical, educational, psychological).

2. The parents support the child's treatment progress and follow through on this.

3. The parents are involved in assisting in the child's treatment.

4. The child's provocative/difficult behaviour has been significantly reduced.

5. The parents have deomonstrated an ability to cope with this behaviour.

6. The child demonstrates affection and bonding with parents.

7. The child is no longer fearful of his/her parents.

8. The child's condition has improved or special needs have been met to the point where further ongoing treatment can reasonably be provided through the family without CAS assistance/monitoring.

PROCEDURES & INFORMATION RELATING TO THE HANDLING OF ALL CHILD ABUSE INVESTIGATIONS REGARDING POLICE AND CHILDREN'S AID SOCIETY INVOLVEMENT

Sample Procedure I

Procedures regarding joint investigations by Children's Aid Society and Police into complaints of suspected child abuse. These procedures have been drawn up to accommodate whichever agency receives the initial phone call (the police or Children's Aid Society)

Initial Call/Suspected Child Abuse to Police
9:00 a.m. - 5:00 p.m.

If initial call comes to the Police, they will take the information and assess from the phone call whether the Children's Aid Society is required immediately. If unsure, the Police will attend the scene and conduct an initial investigation. If Child Abuse suspected, the Police will notify the Children's Aid Society to attend and a joint investigation will follow.

After 5:00 p.m. Initial Call to Police

If call is received after 5:00 p.m. the Police will attend the scene and assess the situation. If Child Abuse is suspected, Police will notify the Children's Aid Society Night Duty to attend for an intial joint investigation.

As soon as possible after the joint investigations, a meeting should be held between Police, Children's Aid Society, and other agencies involved with the family, to share and evaluate, and to make recommendations and decisions. This will include what recommendations should be made to the Court regarding criminal charges and custody of the child.

Initial Call/Suspected Child Abuse to Children's Aid Society
9:00 a.m. - 5:00 p.m.

If the initial call comes to the Children's Aid Society, the Intake Worker will take the information and assign to a caseworker. The Police will be notified of the information. If the Police are NOT required immediately (or unsure), the Children's Aid Society will attend the scene and assess the situation. If there is no Abuse, the Police will be notified that they are not required. If Abuse is suspected, the Children's Aid Society will request the Police attend, and a joint investigation will follow.

After 5:00 p.m. Initial Call to Children's Aid Society

If initial phone call comes to the Children's Aid Society Night Duty Worker, they will immediately notify the Police who will attend the scene to assess the situation. If Child Abuse is suspected, the Police will notify the Night Duty Worker to attend for an initial Joint Investigation. If there is Abuse suspected, Police will advise the Night Duty Worker of the results.

Orientation Regarding Procedures
Children's Aid Society

It would seem a good idea for us to share information as to how each of the agencies (Police and Children's Aid Society) conduct abuse investigations. The Police could illustrate how they look for evidence and what evidence is important for Court purposes in relation to physical and sexual abuse. Also what can the Police tell us about the Courts' response to their recommendations in relation to the disposition of cases?

The Children's Aid Society can illustrate how decisions are made to leave a child at home or remove the child to a place of safety, i.e., what are the stresses which led to the abuse? Do the parents show a willingness to make an effort to alleviate the stresses which led to the abuse? Do the parents show a willingness to accept responsibility for their hitting out or abusive tendencies? What is the effect of separation from the family on the child? etc.

One suggested method of conducting a joint orientation is to have the team leaders and their staff and/or abuse co-ordinator meet with the Youth Bureau Officers from their respective areas.

Police Procedures/Information
Child Abuse Investigations:

Youth Bureau Officers, where practical, will do the initial investigation into child abuse. But must keep the C.I.B. Office advised of all investigations. When charges pending, Youth Bureau Officers will consult (and seek assistance if necessary) from the C.I.B. Office re: proper charges etc., to be laid.

Children's Aid Society will be advised that should there be no Youth Bureau Officer available, the C.I.B. Office to be contacted, or, if no C.I.B. personnel available, a uniformed constable can attend and take necessary reports and initiate an initial investigation.

NOTE:

Since January, 1978, Youth Bureau Officers and Children's Aid Society workers in this District have leaned towards joint investigations, information sharing, meetings, and have found that both agencies have benefited from this type of procedure. Investigations are now being handled more quickly and efficiently with the co-operation of both parties.

Occurrences

Occurrences will be submitted on all child abuse cases. Occurrence to be submitted under the actual offence, adding child abuse in brackets, i.e., assault bodily harm (child abuse) or common assault (child abuse) or child unattended CWA 40 (2) (child abuse) etc., etc. A copy of the occcurrence to be forwarded to (Youth Bureau Supervisor) in an effort to keep a record of the child abuse investigations for a six month period.

SAMPLE PROCEDURE II
CHILDREN IN NEED OF PROTECTION

Police and Children's Aid Society Priority and Action List

24 Hour Telephones
Police:
C.A.S.:

PRIORITY	DESCRIPTION	POLICE ACTION	C.A.S. ACTION
1.	- Evidence of any child in Imminent Physical or Sexual danger (i.e., in one hour or less physical or sexual injury could result) - Any preschool age child left unattended.	1. Call CAS immediately 2. Remain with child until CAS worker arrives.	1. Respond immediately 2. Contact police officer on arrival 3. Assume responsibility.
2.	- Reason to believe any child might be in physical danger (but not imminent type) - School age child (not teenager) left unattended - No evidence of effective adult control at the time	1. Call CAS immediately 2. Ensure physical safety of child	1. Respond within one hour 2. Personally attend to child
3.	- Teenager out of control or there is evident lack of supervision such that immediate control is necessary to prevent danger to self or others - Old enough to handle himself for a couple of hours	1. Take necessary action to ensure safety of teenager (possible arrest) 2. Contact CAS as soon as practical	1. Respond as required within two hours 2. Personally attend to child if required
4.	- Teenager who alleges physical maltreatment by parent or guardian (cultural factors will be considered after the fact)	1. Take appropriate action to ensure physical safety of teenager 2. Advise CAS at earliest opportunity.	1. Personally confirm child is in place of safety 2. Personally visit child within 24 hours

Police and Children's Aid Society Priority and Action List
(cont'd)

PRIORITY	DESCRIPTION	POLICE ACTION	C.A.S. ACTION
5.	- Psychological abuse of elementary school age child, complains or alleges continual verbal abuse from parent or guardian (harassment, downgrading. . .)	1. Advise CAS at earliest opportunity	1. Begin investigation within 24 hours
6.	- Psychological abuse of the teenager - Same essential elements as priority 5	1. Encourage teenager to report to CAS 2. Forward written report to CAS	1. Investigate within three days of receipt
7.	- Other children appearing to have need of assistance or guidance under the Child Welfare Act	1. Refer to CAS in writing or by phone during normal working hours	1. Investigate as required under Child Welfare Act.

Appendix A

SOME OFFENCES UNDER THE CRIMINAL CODE OF CANADA

Common Assault and Assault Causing Bodily Harm, section 245

Rape, sectipn 144

Sexual Intercourse with Female under 14, section 146

Indecent Assault on Female, section 149

Incest, section 150

Sexual Intercourse with step-daughter, section 153

Buggery, section 155

Indecent Assault on Male, section 156

Acts of Gross Indecency, section 157

Parent or Guardian procuring defilement, section 166

Corrupting Children, section 168

Duty of Persons to Provide Necessaries, section 197

Abandoning Child, section 200

Causing Bodily Harm by Criminal Negligence, section 204

Infanticide, section 216

Manslaughter, section 217

Murder, section 218

Neglect to Obtain Assistance in Childbirth, section 226

Concealing body of Child, section 227

Causing Bodily Harm with Intent, section 228

Administering Noxious thing, section 229

Overcoming Resistance to Commission of Offence, section 230

This list by no means limits the range of offences within which child abuse cases may fall and is intended to stress the importance with which child abuse must be regarded.

Appendix B

OFFENCES UNDER THE CHILD WELFARE ACT, 1978

The following, in summary form, constitute offences under the Child Welfare Act, 1978.

Every person who,

a) knowingly furnishes false information in any application under this Act or in any statement, report or return required under the Act or its regulations.

b) fails to comply with the terms of an access order: 35 (4)

c) fails to comply with an order made by a Director to expunge, or otherwise alter, information in the Central Register and in a society's records; 52 (17)

d) hinders, obstructs or interferes with, or attempts to do so with any person acting in the performance of duties under

Section 21:	the apprehension of child apparently in need of protection,
Section 22:	searching for a child believed to be in need of protection,
Section 23:	homemaker placed on the premises by a Court order to care for a child in need of protection.

e) is a parent and who permits his or her child:

- to engage in any trade or occupation in a public place between the hours of 9 p.m. and 6 a.m.; 54 (1)

or

- to loiter in a public place between the hours of 10 p.m. and 6 a.m. unaccompanied by the parent or a person appointed by the parent; 54 (2)

f) contravenes any provision of:

i) Section 46. Unauthorized contact with a child in the care of a society for the purpose of interfering with the child's placement.

ii) Section 49 (2). A professional person, who in the course of his or her duties, has knowledge of abuse of a child must report this (lawyers excepted).

iii) Section 50 (3). Appropriate use must be made of information obtained from records by a Court order.

iv) Section 54 (4). Information contained in the central register of child abuse is confidential.

(7) Persons using the register for authorized research must not reveal the identity of persons named in the register

(8) A registered person or his or her agent may inspect the information in the register but only as it pertains to the registered person.

v) Section 53 (1). No person shall cause a child to beg or perform in a public place.

vi) Section 69 (14). No unauthorized person shall interfere with a child who has been placed for adoption.

Persons, including employees of a corporation, who knowingly concur in any of the above contraventions of the Act, on conviction are liable to a fine of not more than $1,000 or, except for contravention of Section 49 (2), to imprisonment for a term not more than one year, or to both.

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2) Every person who contravenes the provisions of,

a) Section 47 (2). No person having the care, custody, control or charge of a child shall abandon or desert the child or inflict abuse upon the child or permit the child to suffer abuse.

b) Section 65 (1). No person other than an adoption agency or lisencee shall place or cause a child to be placed for adoption.

(2). No person shall receive a child for adoption without prior approval of a Director.

Contravention of the above sections carry a penalty, upon conviction of a fine of not more than $2,000 or imprisonment up to two years, or both.

3) Every person who contravenes the provisions of,

Section 48 (1). No person having the care, custody control or charge of a child shall leave the child without making reasonable provision for the child's supervision, care or safety.

Contravention of this Section carries a penalty, upon conviction of a fine of not more than $1,000 or to imprisonment for a term up to one year, or both. Subsequent offences carry a fine up to $2,000 and imprisonment for a term up to two years, or both.

4) Every person who contravenes the provisions of,

> Section 60 (1). No person other than a society shall establish, operate or maintain an adoption agency without a lisence issued by a Director.

Contravention of this Section carries a penalty of not more than $5,000 for each day on which the offence continues, or to imprisonment up to three years, or both.

5) Every person who contravenes the provisions of,

> Section 67 (1). No person shall make, give or receive any payment or reward in relation to,
>
> a) the adoption or proposed adoption of a child,
> b) the giving of a consent to the adoption of a child,
> c) the transfer of custody of the child with a view to the child's adoption,
> d) the conduct of negotiations or arrangements with a view to adoption of the child.

Contravention of this Section carries a penalty of not more than $5,000 or imprisonment up to three years, or both.

6) Every person who contravenes the provisions of,

> Section 57 (7). A person authorized to attend a hearing under Part II shall not publish or in any way make public any part of the proceedings that may identify the child, the child's family or foster parents.

Contravention of the Section carries a penalty of not more than $10,000 or imprisonment up to three years, or both.

Court File No.: CV-14-0018

HOLLY PAPASSAY et al. - and - **HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ONTARIO, et al.**

Plaintiffs/Moving Parties | Defendant/Responding Party

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT
THUNDER BAY

VOLUME III OF VI: MOTION RECORD OF THE DEFENDANT, HER MAJESTY THE QUEEN IN THE PROVINCE OF ONTARIO
(Motion for Certification, returnable January 24, 2017)

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