2008

Province of
Newfoundland and
Labrador

Department of Health and
Community Services

Child, Youth and Family
Services (CYFS)

# CYFS
# CLINICAL SERVICES REVIEW

## FINAL REPORT

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## DECEMBER 2008

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External Consultants:

Susan Abell M.S.W.

Sandy Moshenko B.S.W.

Judy van Leeuwen M.S.W.

## AUTHORSHIP & CURRICULUM VITAE

In February of 2008 an agreement was signed between the Minister of the Department of Health and Community Services and Susan Abell, Consultant, to perform the analysis of clinical services in the Child, Youth and Family Services Programs.

The project team members from Ontario are:

**External Consultant, Project Manager: Susan Abell, M.S.W.**

Currently a consultant in social services and management, she has broad experience in child welfare from frontline to executive positions over 40 years. Included in her career is almost 20 years at the executive director level in two Children's Aid Societies (Kingston and Ottawa) and one children's mental health centre (Toronto). She has been a reviewer on the Paediatric Death Review Committee for the Coroner's Office (Ontario) for over 10 years.

**External Consultant: Sandy Moshenko, B.S.W.**

As a child welfare consultant she has completed comprehensive reviews of child fatality cases for various Children's Aid Societies. Her extensive experience over more than 30 years has included leadership roles such as Director of Client Services for a large agency, Director of Quality Assurance for the Ontario Association of Children's Aid Societies and a Senior Program Manager position. She is also a reviewer on the Paediatric Death Review Committee.

**External Consultant: Judith van Leeuwen, M.S.W.**

She has performed a wide range of projects on behalf of the Ministry of Children and Youth Services and for Children's Aid Societies in the role of consultant including a plan for a mediation project, reviews of child deaths, complaints and contentious files. At a large Children's Aid Society she held positions as Director of Services, Director of Intake and Child Abuse and Co-director of Family Services following many years at the frontline and supervisory level. Judy has over 30 years of child welfare experience.

Data Analysis: Carrie Smith, M.S.W.

Data Input: Lee-Ann Watson

# ACKNOWLEDGEMENTS

This review of clinical services has been challenging. Many of the results point to gaps and weaknesses in a system whose staff cares deeply about service to children. All of those who have participated in the project have done so with a sustained focus on learning about quality, how to measure it and how to make improvements. Their dedication to this purpose has been impressive. In particular the Department staff Michelle Shallow, Program Manager and Project Manager and Lynette West, Consultant for Quality Improvement have been key resources to the project. Susan Walsh, Project Manager for CYFS, provided early leadership and essential support. Ivy Burt in her role of Provincial Director has been highly participative.

Thanks go to the Working Group (Appendix 2) for exceptional discussion and input into the design of the project and the interpretation of findings, both qualitative and quantitative.
The file review team showed diligence and true collaboration over the weeks of reading through the files and ferreting out important data. The Advisory Committee (Appendix 1) has been most helpful in providing a broad context for both the work of child protection and the findings of this project.

# TABLE OF CONTENTS

## List of Tables



## List of Figures

# 1.0 EXECUTIVE SUMMARY

Part of the legacy of Zachery Turner, the subject of a judicial review following his murder by his mother, Dr. Shirley Turner, has been to illuminate the delivery of child protection services in Newfoundland and Labrador. This report is an evaluation of the clinical services being provided to children, youth and their parents. It is based on a review of 400 files from across seven program areas that resulted in an assessment of the clinical services. Further the report recommends how to build the system to alleviate the limitations.

The child protection system, like many of the children that it serves, has been the victim of neglect over many years. Prior to the review of the life of Zachery Turner, the system had received no new funds for over a decade; it was working under legislation that had been in place for fifty years; there had been no ongoing training provided for social workers or managers in recent memory; and it was unable to attract staff to sustain adequate levels of human resources.

The *Deloitte Organizational and Operational Review* completed in March of 2007 concluded that:

> "*No one would suggest that the CYFS program in Newfoundland is operating in an ideal environment today. All would agree that there are significant shortcomings."*

The report goes on to identify five inter-connected elements of an ideal work environment, all of which must be in place to create a well functioning system. These elements are: strategy, structure, process and tools, people and organizational culture.

The delivery of child protection services is a high-risk business. To be successful it requires well-trained and supported staff working with a clear purpose, in a culture that supports and recognizes their work, equipped with the knowledge, skills and resources necessary for success.

The child protection system as the *Clinical Services Review* found it can be compared to a vehicle and driver that have embarked on a long journey over rough terrain and under grueling environmental conditions without any attention being paid to the need for tune-ups, oil changes, new tires or rest for the driver. Sooner or later something is bound to fail, be it the vehicle or the driver or both.

Under such circumstances it is no surprise that a tragedy such as the one that befell Zachery Turner occurred. What is surprising is that there have not been more such tragedies.

## 1.1 WHAT WAS THE PURPOSE OF THE CLINICAL REVIEW?

Given the desire of Child, Youth and Family Services (CYFS) to make appropriate investments to improve the child protection system, the *Clinical Services Review* was pursued in order to develop recommendations that would assist in directing the planning and implementation of any needed additions or changes in policies, programs, standards, practices and methods of service delivery. This was achieved through the following process:

- A review of recent reports and materials including the *Turner Review and Investigation (October 2006)* and the *Deloitte Organizational and Operational Review (March 2007).*
- The design of data collection instruments for seven service areas (family services; protective intervention program including cases screened out of service; children in care and custody; child welfare allowance; caregiver homes; youth services, both residential and non residential).
- Review of 400 case files.
- The collation and analysis of the collected data in conjunction with both a Working Group and an Advisory Committee.
- The development of observations, findings, conclusions and recommendations regarding clinical services.
- The final report includes recommendations for policies and procedures; service models and tools; training and development; quality improvement practices and programs; and structural reform and leadership.

## 1.2 WHAT ARE THE KEY FINDINGS?

The achievement of an acceptable standard of clinical services is being undermined by the following systemic barriers:

- **Workforce instability** that results in service discontinuity that is compromising the welfare of children. This is seen in casework where there are repeated worker changes; contacts with clients that are significantly below what is necessary for maintaining a clinical relationship to support client change; lack of planning with clients; incomplete or missing client records; low levels of compliance with current service standards.
- **Sufficient leadership and resources** to focus on a realistic set of goals and tasks related to a clear vision of child protection. The current system is working under a conflicting array of purposes and a vision in which child protection is virtually

invisible. As a set of high-risk activities, child protection services require a concerted and sustained focus on key activities, risk indicators, service targets and client feedback. The profile of the child protection needs to be heightened and more systematic attention paid to indicators of quality at all levels of the system.

- **Legislation, policies and procedures** that fail to adequately position the safety, protection and well-being of the child as paramount.

- **Lack of training and professional development** at all levels of the system to support a professional and competent service response.

- **Lack of timely and accurate data** about the work being done and how information about that work can be used to plan for services to children.

## 1.3 WHAT ARE THE KEY RECOMMENDATIONS?

This review was positioned to closely examine the system through its clinical work - that is the work that directly affects the safety and well-being of the province's children. The clinical perspective examined such factors as the timeliness of response to complaints that children were in need of protection; the thoroughness of assessments of family needs, strengths and risk factors; the frequency of contact with clients; adherence with department policies and procedures; the development of plans of service.

This vantage point also provided a view of how other systems support the achievement of protecting and safeguarding children. As described by the *Turner Review and Investigation:*

> *The shortcomings that contributed to Zachary's death did not originate at the front line level. [They are] systemic problems pervasive at all levels, provincially and regionally…*

The picture that has emerged is a troubling one with few of the essential components of an ideal work environment as described by the Deloitte Review.

Recommendations from the *Clinical Services Review* are focused on the following areas:

- **Leadership:** The need for a mandated leadership team with sufficient resources and time within which to undertake the necessary reform of the child protection system.

- **Legislative Reform:** The current legislation requires review and updating in several areas in order to achieve greater clarity of purpose with a more child-centered focus.

- **Stabilization of the Workforce:** There is an urgent need to stabilize the province's workforce through the development of a coordinated, province-wide recruitment

and retention program. Such a program will recognize the risks inherent in child protection work as the most difficult form of social work practice. Workforce stabilization will require incentives, both financial and other, in order to attract, support and keep people on the job.

- **Training and Development:** The development of a comprehensive training and development program which includes both mandatory and specialized components. The training should be focused on the development of core competence required to deliver clinical services. At a minimum the training should include orientation and basic training for new staff and review and refresher opportunities for experienced staff. Training should address the core competencies identified by the *Clinical Services Review* including risk assessment, planning, comprehensive assessment, client engagement, documentation and clinical supervision.

- **Quality Improvement:** Development of a quality improvement program that will utilize the baseline data extracted from this project and develops strategies for improving on the results. Accurate and timely information regarding casework and flow, human resources and financial resources is essential to the development of such a program.

- **Management of Complex Cases:** A system for the management of complex cases is needed. This should include the routine review of certain types of cases according to an agreed-upon format. Findings and recommendations coming out of these reviews should be aggregated and utilized to make service improvements.

- **Policy and Procedure:** Work already undertaken to develop the *Child, Youth and Family Services Policy and Standards Manual* should be continued in order to develop greater clarity regarding requirements and expectations for service delivery Methods must be developed for ensuring that staff are knowledgeable about the contents of the *Manual* and that supervisors are ensuring that review and monitoring of requirements occurs. A system for the ongoing review and revision of the *Manual* and a communications plan is required.

- **Workload:** An accurate picture of the workload and the current work needs to be ascertained. From this, workload benchmarks must be developed and implemented to direct staff recruitment, management and assignment of work.

- **Documentation:** Current standards of documentation are a serious concern throughout all of the programs. Attention needs to be given to the implementation of formats, file organization and timeliness for the system. This should be complimented by training on use of the case file as a clinical tool.

- **Infrastructure and Information Technology:** Accurate, timely information and training on how it is to be utilized to set targets, monitor and evaluate service goals is basic to system improvement. This will promote a system view and reduce the reliance on often faulty anecdotal information.

The priorities listed above will require a concerted and sustained focus of strong leadership over several years in order to achieve the improvement of the child protection system that is urgently required. If this report is received as another that can be responded to with a patchwork of "quick fixes" it will fail to make significant improvement and be viewed as a disincentive to those working in the system.

The lives of children in Newfoundland and Labrador depend on this.

# 2.0 INTRODUCTION

## 2.1 BACKGROUND TO THE CLINICAL SERVICES REVIEW PROJECT

In Newfoundland and Labrador the tragic death of a child in 2003 was a catalyst for a careful examination of the entire system, as has been the case in other child welfare services. The death by homicide of Zachery Turner at thirteen months of age raised many questions regarding the practice of child protection, the legislation from which it derived its authority and the overall human capacity to address the complex challenges of keeping children safe from abuse and neglect.[1] A number of interrelated inquiries into the operation, structure, funding and legislative authority of the child welfare system highlighted the need for extensive change to the child protection system, operation and management. In particular, over the period between 2005-07 three reports on the activities of *Child, Youth and Family Services* pointed to the need to improve the system.

The Ministers Advisory Committee (MAC) on the CYFS Act is mandated under Section 75 of the legislation to review every 2 years the operation of the Act and report to the minister concerning its operation, stating whether, in its opinion, the principles and purposes are being achieved. The report, titled "***How Are We Doing? A Report of the Ministers Advisory Committee on the Child, Youth and Family Services Act"***[2]was tabled in the House of Assembly December 5, 2005.

The *Child, Youth and Family Services* (CYFS) *Act*, which was proclaimed January 5, 2000, outlines the philosophical, service and best interests principles under which child protection practices must operate. The overriding and paramount consideration in any decision made under the Act is the best interests of the child including safety, developmental needs, cultural heritage, a child's views and wishes, stability and continuity of care, continuity of relationships with family members, geographic and social environment, supports outside the family and the effect upon the child of judicial delay. Child, Youth and Family Services principles which apply in the provision of services as outlined in section 8 of the Act include the expectation that services will utilize the least intrusive means of intervention in a manner that acknowledges a child's overall requirements for safety, health and well-being. When proclaimed, the principles and purposes represented a significant shift in child protection practice. The new legislation had replaced the C*hild Welfare Act* which was over fifty years old and no longer supported contemporary and preferred practices in the child welfare field.

The Minister's Advisory Committee concluded that the principles of the *Act* were being seriously compromised by a variety of factors. The service shift was intended to be child centered and family focused. It was to shift from the provision of remedial services to a focus on prevention and early intervention. The necessary shift had not occurred as a result of a lack of adequate human and fiscal resources, essential and ongoing training and

[1] Turner Review and Investigation: Markesteyn & Day, September 2006
[2] Minister's Advisory Committee: Final Report 2007

education, limited public awareness and the absence of a framework for ongoing evaluation.

The *Turner Review and Investigation,* the inquiry into the death of Zachery Turner, provided a detailed description of the life of Zachery Turner, his mother Dr. Shirley Turner and the events leading up to Zachery's death by homicide at the hands of his mother who then committed suicide. Among other system shortcomings, the report highlighted the need for improvements to case planning with a focus on the child as the primary client.

Following the release of the Turner report, the Department of Health and Community Services (DHCS) commissioned an operational and organizational review that was completed in 2007 by Deloitte Inc. [3] The review focused on roles and responsibilities, the relationship between the Regional Health Authorities (RHAs) and the DHCS and the tools and processes that support child, youth and family services. Recommendations were made in the areas of: [4]

- Strategy and standards: a clearly articulated vision supported by suitable practice standards
- Structure and accountability: clear lines of accountability including an integrated work plan and adequate resources to ensure follow-through
- Organizational culture: a provincial strategy focused on child well-being and protection and supported by all levels
- Staff, with access to support, clinical supervision, management and ongoing training.

In response to these findings, in the 2007 provincial budget the Government invested additional resources in the child welfare system in the areas of human resources ($2.5 million), foundational resources including training, professional development and monitoring and evaluation ($2.7 million), as well as funds for one time initiatives ($1.3 million).

The *Clinical Services Review* initiative has been designed to provide both baseline information regarding the clinical practice across the province as well as recommendations regarding the design and management of a provincial quality improvement program.

[3] Organizational and Operational Review of Child, Youth and Family Services: Deloitte Consulting Inc., March 2007

[4] This is a summary of themes that were described in the Deloitte Report. For full text please refer to the full report

### 2.1.1 QUALITY INITIATIVES IN CHILD WELFARE

As with other public and social services, significant changes have occurred over the past decade in the level of awareness of consumers and citizens regarding the overall quality of available services. This increased attentiveness and demand for quality has been seen in response to a range of publicly funded or regulated services from health care to the quality of drinking water to student achievement in education. Overall there is evidence of more active participation of consumers in service selection and evaluation with service provision of all types now more clearly aimed at satisfying the customer.

As part of the focus on quality, value for dollar has also become the mantra of organizations, businesses and services whether regulated, funded or delivered by government. The public wants to be assured that their tax dollars are being spent to maximum benefit. More and more there is a public demand that service response is effective and efficient. In general, a business approach is being brought to bear on the delivery of social services.

These factors have had a profound influence on the expectations of the public and of funders. In the Canadian context, there have been various levels of setting standards, identifying favorable outcomes and developing funding parameters within which they are to be delivered. In many instances, the increased focus on quality has been driven not just by good business practices but by identified and sometimes publicly scrutinized service deficiencies. Recent examples include the Goudge Inquiry in Ontario which has been looking into the operation of the Coroner's Office in the province and the Nunn inquiry in Nova Scotia which examined the youth corrections system.

#### *Quality and Child Protection*

The child protection system has been subject to similar inquiries some examples of which are described briefly below:

- In British Columbia in 1997 a toddler, a client of the BC Department of Child and Youth Services was killed while in the care of his mother while under the supervision of the child welfare department. The events leading up to his death were the focus of a judicial review.

- In the United Kingdom a series of inquiries into the deaths or injury of children named to the child protection register were conducted. These inquiries shed light on the factors that contributed to the deaths and made recommendations regarding how they could be avoided in the future.

- In Ontario between 1998 and 2000 a series of inquests into the deaths of children receiving child protection services shone a harsh but necessary light on the shortcomings of the system.

The findings from these inquiries focused, in general, on the need for changes in the following areas:

- Legislation and regulation to better provide an accountability framework for the provision of service and the protection of the public.

- Defining or redefining preferred or acceptable practices.

- Education and/or training to ensure that day to day practice is meeting an identified standard.

- Monitoring and control to provide a mechanism for giving feedback on the extent to which newly established standards, regulations and legislation are being achieved.

- Strategies to facilitate and enable collaboration between and among sectors.

- Increased resources, both financial and human.

- Public education to inform the public of new findings, practices, laws, and accountability measures.

- Systems through which data regarding outcomes and outputs can be routinely collected in order that changes in practice can be identified.

Following as it does on the *Turner Review and Investigation*, the current clinical review will provide direction regarding the development of a service quality system for Newfoundland and Labrador that will support the provision of the best possible interventions to children, youth and their families.

# 3.0 PURPOSE AND METHODOLOGY

## 3.1 PROJECT DESCRIPTION AND MODEL

This project has been undertaken in response to a request for proposals (RFP) tendered by the Department of Health and Community Services in August, 2007. The purpose of the project was to undertake an analysis of clinical social work and management practices in the CYFS Programs. The following programs were examined – Protective Intervention, Family Services, Child Welfare Allowance, Children in Care and Custody, Caregiver Homes and Youth Services (residential and non residential). The analysis included a random sample case file review with cases drawn from all four RHAs. It was anticipated that the findings would build a process to enhance clinical practice, identify training and development requirements, support decision making and planning in complex cases, identify program and policy requirements and lead to the development of a quality improvement framework.

## 3.2 SUPPORTS TO THE PROJECT

The *Clinical Services Review* commenced in April of 2008. The structure for the project consisted of the following:

- Three external consultants who were retained under contract as a result of the RFP process. They worked with the project manager assigned by the department.

- An Advisory Committee (Appendix 1) composed of senior staff from each of the four RHAs, the Provincial Director of Children and Youth Services, the Assistant Deputy Minister of Public Health, Wellness and Children and Youth Services (Chair), and community representatives with an interest in child protection practice and research. The role of this committee was to provide advice to the DHCS, to assist in the completion of the clinical review of the CYFS programs and practice in the four RHAs.

- A Working Group (Appendix 2) chaired by the project manager and composed of directors and management representatives from each of the four RHAs with consultants from DHCS. They participated in consultation with the three external consultants and assisted with the development of the data collection tools, the analysis of the results and the development of recommendations.

- File reviewers (Appendix 3) consisted of four DHCS consultants and five RHA managers as well as the external project consultants. This team, which varied in size daily from seven to twelve individuals, reviewed the files utilizing the data collection tools that had been developed. (See Supplementary Appendices.)

## 3.3 SAMPLING

A total of 9630 cases were determined to have been active during the fiscal year 2007/08 (April 1, 2007 to March 31, 2008) across seven service areas. This period was chosen as it represented a timeframe that was current and where up-to-date policies were in place. The numbers were retrieved from Client Referral Management System (CRMS), the provincial database for all program areas, in the month of April 2008 with the exception of Caregiver Home files which were collected manually. Based on the total number of active cases, as seen in figure 1, a sample was drawn. The sample size of 370 achieves a 95% confidence level for the province within a plus or minus 5% range. The distribution by program type is shown in figure 2.

All regions were provided with a complete list of the files that had been chosen for the file review. The list identified one extra file per program per region in the event that one file could not be reviewed from the sample. This resulted in a total sample size of 400 files.

**Figure 1: Total Number of Cases Active from April 1, 2007 to March 31, 2008**
**Source: (CRMS)**

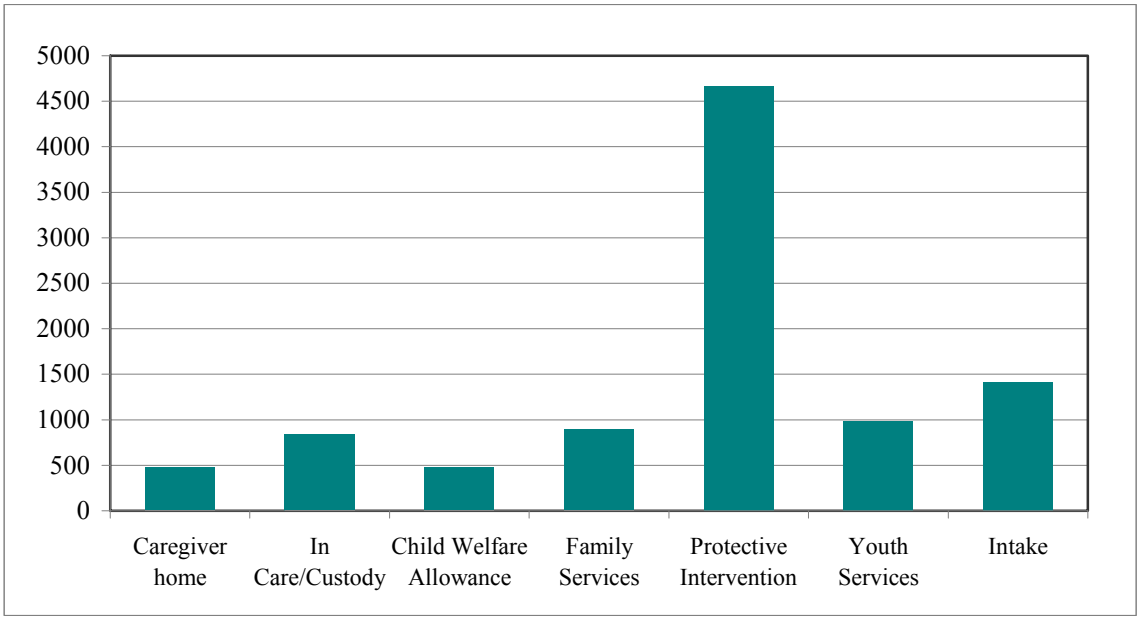
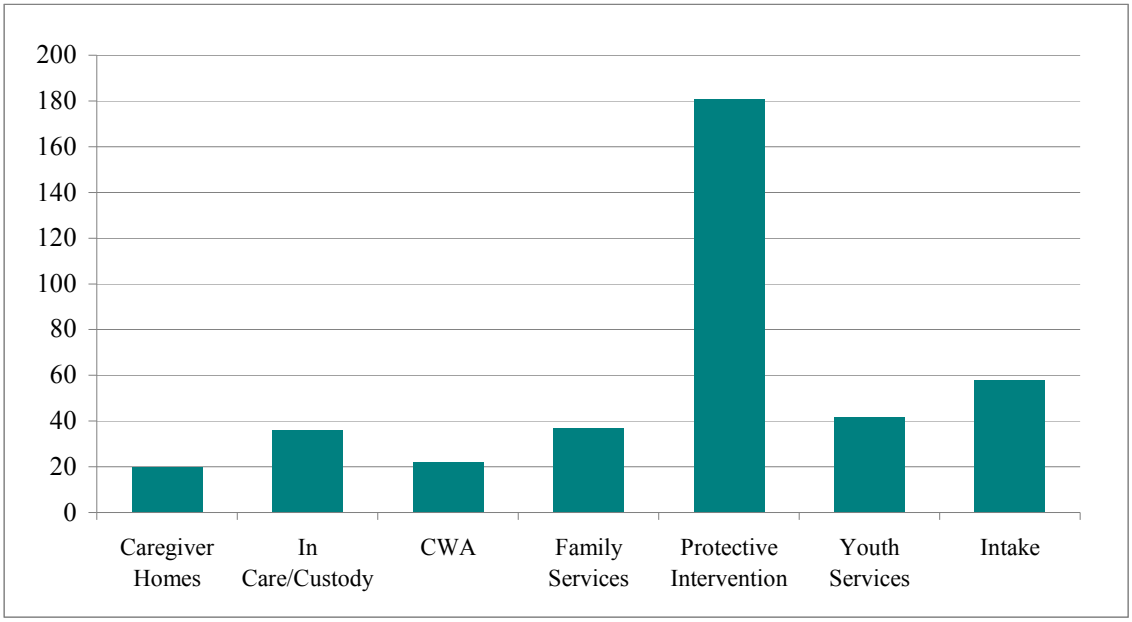


**Figure 2: File Distribution by Program Type**

Source: (CRMS)




## 3.4 DATA INSTRUMENTS

### 3.4.1 DEVELOPMENT OF DATA COLLECTION TOOLS

The *Clinical Services Review* included the following: Family Services; Protection Intervention Program; Child Welfare Allowance; Children in Care and Custody; Youth Services (residential and non residential); and Caregiver Services. Data collection tools were developed by the external consultants for each of these programs. Data fields were identified based on written CYFS practice standards and preferred clinical practices across the child welfare field. An additional data tool was developed in order to analyze the referrals that were 'screened out for service'.

### 3.4.2 TESTING OF THE DATA TOOLS

Limited testing of the data collection tools occurred in May of 2008 with selected members of the review team testing the tools on a small sample of twelve files. Pre-testing of the tools for the Family Services files and the Child Welfare Allowance files did not occur as sample files were unavailable. Input regarding the data collection tools was elicited from the members of the Advisory Committee and the Working Group. From the pilot testing and the feedback, minor modifications were made to the data fields and consensus was achieved regarding the application of certain data fields.

## 3.5 FILE REVIEW PROCESS

### 3.5.1 ORIENTATION

The file review began on June 19, 2008, with an orientation for all reviewers. The orientation provided reviewers with a context for the project including background information regarding Quality Improvement practices in child welfare. In addition, it provided reviewers with an opportunity to acquaint themselves with one another, the external project consultants, the tools and the expectations for the project. The review of the files began on June 20 and was concluded on July 2, 2008, a total of nine working days. A range of seven to twelve individuals participated daily in the review of files. The reviewers were supported by the Department's Consultant for Quality Improvement who ensured file management and security. This was achieved through the careful monitoring of a master list which tracked the progress of files through the review process.

### 3.5.2 CONFLICT OF INTEREST

In order to avoid conflict of interest, criteria for file selection for each reviewer were developed. The criteria provided that:

- Reviewers would not review files where they had any involvement in the direct service provision or supervision of the case
- Reviewers would not review a file where either the worker or the client/family member was a friend, relative, neighbor or person with a close association
- Reviewers would generally not review a file from their region of the province. If the reviewer must review a file from his/her region because no other file was available for review, it would not be a file from his/her office or a file involving a staff member in their work area.

### 3.5.3 FILE MANAGEMENT

In total the review team examined clinical practices as evidenced by 396 files drawn from all service areas. All files were delivered by secure means to a central location within the Confederation Building, St. John's. Steps were taken to ensure that the room in which the review was conducted was secure. Careful tracking of the files occurred with a sign in and out system for each file. Once the review of the files was completed they were returned to the appropriate Regional Health Authority via secure delivery.

### 3.5.4 FILE REVIEW AND DOCUMENTATION

Files were reviewed one program type at a time using the corresponding data collection tools. This enabled the team members to consult with one another regarding the interpretation of case practices and clarification of data requirements. A log format was used to track observations and issues arising on each file. In each program area an extra file was requested for review in the event that another file was unsuitable for review. In the

end 396 of the 400 files that had been requested were reviewed resulting in a total number of files reviewed that was 26 above the target number of 370.

## 3.6 DISCUSSION AND CONFIRMATION OF OBSERVATIONS

When all of the files in a specific program area were reviewed, a facilitated discussion took place regarding themes that had emerged. All of the themes and observations were noted and were compared with the quantitative data results.

### 3.6.1 DEBRIEFING OF THE FILE REVIEW PROCESS

Following the completion of the full review of all of the files, the reviewers participated in a half day session to discuss and confirm the overall themes and issues that emerged. The purpose was to provide feedback on all aspects of the file review process and to gain consensus on the findings which are system wide. The reviewers also shared learning from participating in the process that will support future activities in implementing quality improvement programs.

## 3.7 RESULTS FOLLOWING THE REVIEW PROCESS

### 3.7.1 AVAILABILITY OF FILES FOR REVIEW

Of the original 400 files requested, 6.5% or 25 files could not be forwarded for inclusion in the project. When this occurred, the region was requested to provide an explanation and the next random file number was provided. This process was utilized until the required sample number was provided and the complete list of active case files had been reached.

**Table 1: Files not Available for Review**

| Reason for Exclusion | Percentage |
|---|---|
| Inaccuracies/errors in CRMS | 2.50 (10 files) |
| No involvement/files required closure | 1.50 (7 files) |
| Not found | 1.25 (5 files) |
| Case records required for court | 0.25 (1 file) |
| Wrong file sent | 0.25 (1 file) |
| File in Storage | 0.25 (1 file) |
| **Total** | **25** |

#### 3.7.1.1 Commentary

Although the number of unavailable files did not deter the review, it indicates issues for the system that will require addressing in the future. The most concerning reason in terms

of quality improvement are the files not found, those awaiting closing and the number of errors in CRMS.

### 3.7.2 RETURNED CASES

The reviewers identified sixty eight (68) cases in which there was a concern about clinical work on the file that could potentially affect the well-being of a child. A format was developed for forwarding these concerns to the attention of the Director in each region. These cases were returned, along with a description of the specific concern, for attention and follow-up.

**Table 2: Files Reviewed with Concerns by Issue and Type**

| Type of Issue | Number | Percentage |
|---|---|---|
| Incomplete investigation of allegation of mistreatment of a child in a foster home. | 1 | 1.5 |
| Incomplete assessment/intervention to sexual molestation /risk of sexual molestation of children by a third party (child or adult) | 3 | 4.4 |
| Lengthy gaps in documentation and/or service | 22 | 32.4 |
| Incomplete investigation | 10 | 14.7 |
| Insufficient contact, follow-up or planning | 15 | 22.1 |
| Case requires reassessment regarding service status Classification (active? Needs further assessment? Should be closed or transferred?) | 12 | 17.6 |
| Serious complaint not investigated | 5 | 7.4 |
| **Total** | **68** | **100** |

#### 3.7.2.1 Commentary

The number of files returned with concerns for managerial review represents 17% of the total number of files seen by the reviewers. These identified concerns have implications for the protection of children and the accurate assessment of the scope of work being done by the system. Both conditions – inactive cases and service quality deficiencies - are liabilities. To better understand the implications of this finding, it should be viewed with the foregoing table (*Table 1)* which illustrates files that were selected but not available for review (6.5%). The results together suggest that there are issues related to service quality, organization and work completion in approximately one in four case files. This preliminary observation has been further examined in conjunction with the data results described more thoroughly in Section 5 of this report. It was clear, however, after this phase of the project that there is currently no way of accurately determining which cases are active and form a legitimate part of the workload for staff.

## 3.8 DATA INPUT

As the data collection forms were completed they were gathered by program type and forwarded to individuals with expertise in data entry and analysis who were retained by the

external project consultants. The analysis was completed using Excel and *Statistical Program for Social Services* (SPSS) software. All data was handled in a secure fashion so as to ensure confidentiality and protection of information. In order to ensure anonymity for clients and staff no identifying information was collected.

## 3.9 HUMAN RESOURCES

Table 5 represents the human resources input that was required to perform the file review phase of the project.

**Table 3: File Review Inputs**

| | |
|---|---|
| # of files reviewed | 396 |
| # of programs | 7 |
| Total # of working days | 84 |
| # of files reviewed per reviewer/per day (avg.) | 4.75 |

### 3.9.1 COMMENTARY

Information provided by the external consultants, based on past experience, suggested a production rate of approximately four files reviewed per day. In fact the Protective Intervention Program files were completed at a rate of 4.25 per day. In the program discussions it was suggested that the time required for review would have been longer if the documentation in the files had been more complete.

# 4.0 FINDINGS AND CONCLUSIONS

## 4.1 INTRODUCTION

This section of the report details the findings, observations and conclusions that have been drawn from the file review. The actual results from the data have been the basis for what is presented as follows. The findings will lead to the recommendations in the following chapter.

## 4.2 REFERRAL SCREENED OUT OF SERVICE

- Records of referrals are being made. Information regarding the referral is clear and the family identified. Required documentation by social workers is completed but timeliness needs some improvement.

- Record checks are being done. The type of past record is not always apparent on the files.

- A significant proportion of referrals are determined to be ineligible for service despite existing previous records and regardless of fairly recent file closures or referrals.

- Managers are being consulted about the decision of eligibility for service but managers are not always authorizing the social worker's documentation and the disposition of a referral within required timeframes. Managers are also backdating sign off on files.

- Child protection investigations, in full or in part, are occurring on some screened out referrals coded "S16" but should have been re-coded to "S 14".

- There is no standard format across regions for calls/referrals received after hours.

## 4.3 PROTECTIVE INTERVENTION PROGRAM

- When investigating complaints of child maltreatment, a systematic approach for the collection of information and the documentation of information from investigative interviews, observations etc. is not evident in the case files.

- While a model for risk management in child protection matters has been introduced by CYFS and some steps taken towards implementation, there is much work needed to fully implement the model and ensure compliance with standards and tools involved.

1. Social workers' compliance with documentation requirements upon the initial receipt of the referral is good but declines following the initial response to the referral and declines further once the assessment and investigation concludes that the child/ren require protective intervention services.
2. Adherence to timeframes for documentation showed lower levels of compliance with the standards than the actual completion as seen in the files.
3. Most cases requiring long-term protective intervention do not have a completed assessment of the risks for the children.
4. Service planning is almost non-existent.
5. Standards for supervisory input, review and monitoring of documentation are not highlighted for all steps in the risk management model and supervisory involvement fluctuates in different risk decisions.

- Face-to-face contact with the family and child/ren in many long-term protective intervention cases is not sufficient to ensure the child/ren are receiving appropriate care or to develop the relationships to effect the needed changes to protect children.

- There is no evidence of consistent practices to assess and investigate referrals received on cases already open.

- There is a significant proportion of cases (as high as 18%) that appear not to be receiving services but are open for protective intervention services.

- Turnover of the social workers assigned to cases is at a level that affects client-worker relationships and case progress. Lack of conferences among the departing worker, arriving worker and family as well incomplete documentation and the absence of case plans further accentuates the problems created by staff turnover.

- Court intervention is sought for custody orders in only a small percentage of cases. There is no evidence that supervision orders are being requested by CYFS or ordered by the court.

## 4.4 FAMILY SERVICES

- Records of referral are being made and completed by the workers in a timely manner.

- Record checks are being completed. A significant number of the cases had been open previously in the Protective Intervention Program. This raises the issue whether risk assessment and past history are being used to determine the appropriate service for children and families.

- Managers are being consulted about eligibility for service although not always in a timely manner.

- The program is being used to respond to referrals related to following up 3rd Party Assault cases.

- Evidence of service agreements with families and or community service providers was low.

- A quarter of the files did not indicate contact and/or an assessment.

- The program responds to a wide range of supports to families and children.

- Given that the main service was connecting families to community services; it is concerning that there was little indication that they were notified at the point of closure.

## 4.5 CHILD WELFARE ALLOWANCE

- Financial approvals for the child welfare allowance and special additional expenses are carried out.

- A standardized assessment and approval process to evaluate a placement prior to placing a child with a relative or significant other person is not incorporated into practice.

- There is good placement stability for the children receiving child welfare allowance.

- The level of face-to-face contact with the child and the family providing care is not sufficient to ensure the child is receiving appropriate care and that the child's needs are being met by the placement.

- Service planning is not satisfactory as "Individual Support Service Plans" and reviews of case plans are not routinely occurring.

## 4.6 CHILDREN IN CARE AND CUSTODY

- Plans for the child were in place in two-thirds of the files reviewed.

- ISSPs are generally being prepared where plans of care are in place.

- Basic information required by standards regarding the child was not routinely available in the files. It was not clear whether this basic information is being collected and shared with caregivers.

- It was not possible to determine from the records whether the required information regarding the child's placement was being shared with parents.

- It was also not possible to determine from the files whether the information necessary for placement matching was being collected and shared with caregivers.

- Supervisory input was evident in two-thirds of the files reviewed.

- Services required by the child during the time in care (vision, dental, medical) are not being consistently obtained and /or documented.

- Contact with the child was at the required level in just over half of the cases.

## 4.7 CAREGIVER HOMES

- The number of relative/significant other files in the sample was small and as a result does not lend itself to drawing general conclusions regarding reliability.

- The policy manual provides clear guidance to staff on the completion of the annual caregiver reviews.

- There are serious deficiencies in the level of annual caregiver reviews being completed.

- There are deficiencies in documentation and assessments with key information often missing.

- The files do not contain a list of placements making it difficult to determine the number of children who have been in the home. Among other things, this could make tracking of serious occurrences affecting children (for example, complaints about the standard of care in the home) very difficult. The absence of this information also raises questions as to how other social workers assess the suitability of placements for children if there is such little written record of caregiver home activity.

- The low frequency of contact with the caregivers is of concern as support is crucial to sustaining caregiver homes and ensuring the safety and stability of the placement for the child.

## 4.8 YOUTH SERVICES

- The program provides good supports to vulnerable youth not previously in care as well as youth previously in care.
- The risks that are identified are similar to those which are investigated in the Protective Intervention Program.

- There is evidence of involvement of parents and others in the planning. Youth participate in setting their goals.

- The youth are relatively stable in their residence. Over 60% are in school or an education program.

- Contact with the social worker is most likely on a quarterly basis.

- ISSPs are being completed in few cases. When they were used the follow-up and support was more comprehensive.

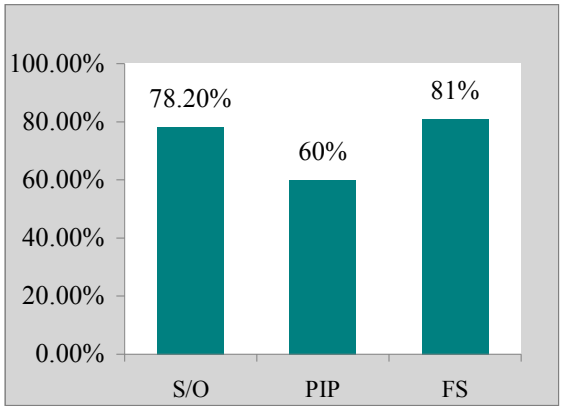
- The number of files with missing information, failure to complete the Youth Services Agreement, Youth Risk Screening Tool and other documentation; significantly impact the data results.

## 4.9 OVERALL FINDINGS

The following charts show key findings in relation to the delivery of services across all of the programs. These factors were selected as they are often considered to be proxy indicators of service quality. In addition, they are directly linked to Department policies and form a key part of any child protection risk management system. In short, they are foundational activities in any child protection system.

### 4.9.1 PREVIOUS RECORDS

**Figure OF 1: Previous CYFS Records**

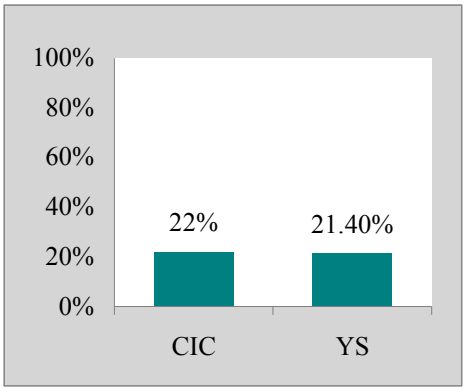



In the above program areas staff members are required to check provincial and regional records in order to determine if the child and/or family has had previous contact or involvement with CYFS. This is important background information used to assist social workers in assessing risk and making suitable plans for the child and /or family.

- In 81% of *Family Service* cases the family had previous CYFS contact
- In almost 80% of *screened out* cases the family had had previous CYFS contact
- Sixty percent of P*rotection Intervention* cases had a prior record of CYFS involvement
- The high level of prior CYFS involvement of families raises the question of whether the larger picture of child maltreatment is being fully considered in the decision about the appropriate the child protection intervention. In particular where a decision is made to offer no protection investigation.

## 4.9.2 PREVIOUS ADMISSIONS

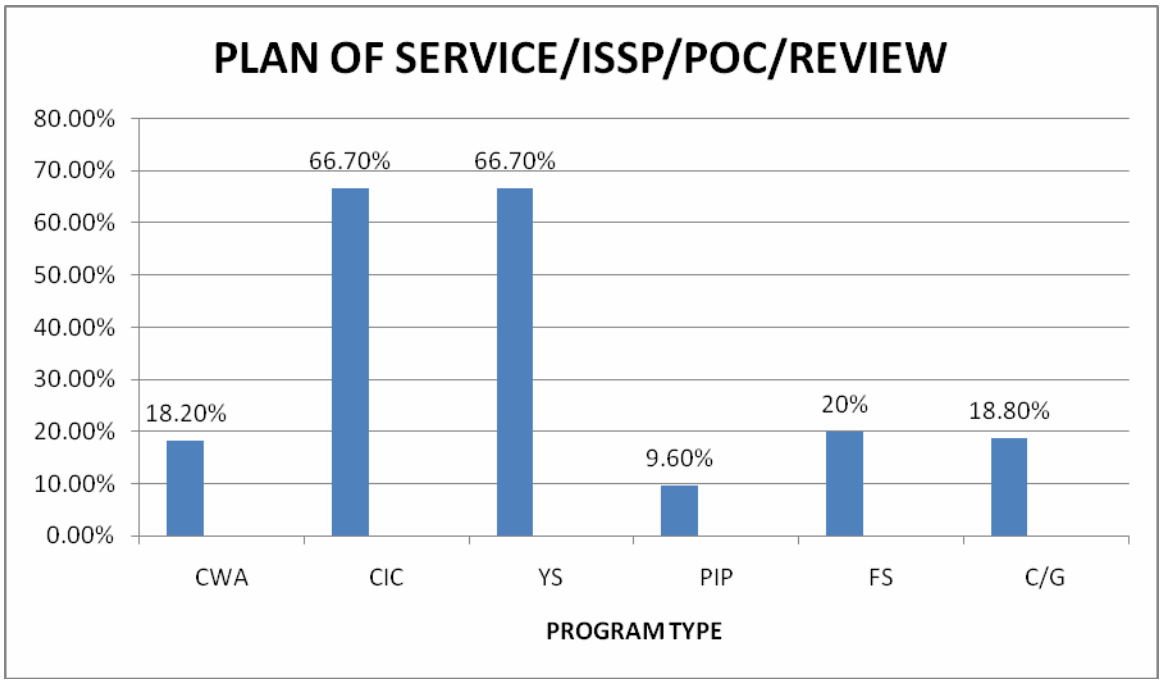
**Figure OF 2: Previous Admissions**




Records revealed that 22% of *children in care* and just over 21% of *youth* had been in the care of the child welfare system previously. This is suggestive of a degree of instability for children and youth in the residential care system, especially when considered together with the frequency of placement change. Examining the barriers to achieving greater placement stability and permanence for children and youth in the system should be the focus of further scrutiny.

## 4.9.3 PLANS OF SERVICE

**Figure OF 3: Plan of Service / ISSP / POC / Review**



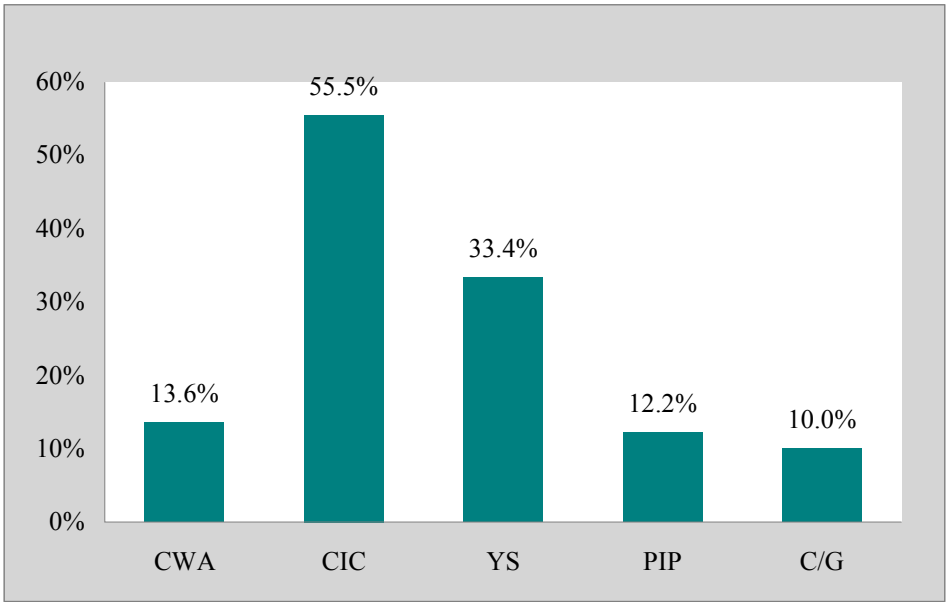

The above graphs illustrate the extent to which the required planning documents had been prepared as required by policy across the various program areas. Family centred action plans, individual support services plans, plans of care and annual reviews are all basic tools

employed to ensure an agreed upon quality of service is being pursued. While the nature of the document varies, they all serve a similar purpose which is to outline goals and progress towards achieving them as well as describing how the goals are to be attained and who is responsible for which aspect of the plan.

- The programs C*hildren in Care and Custody* and Y*outh Services* achieved the highest rate of compliance with 66.7% of the files reviewed – or two out of three – containing a Plan of Care
- Twenty percent of the *Family Service* sample – one in five files – had an ISSP
- Approximately 1 in 5 cases in the C*hild Welfare Allowance and Caregiver* programs contained service plans (CWA) or annual reviews (C/G)
- Fewer than 10% of the P*rotection Intervention Program* files contained a family-centred action plan

### 4.9.4 WORKER CONTACT

**Figure OF 4: Face-Face Contact Monthly or More**



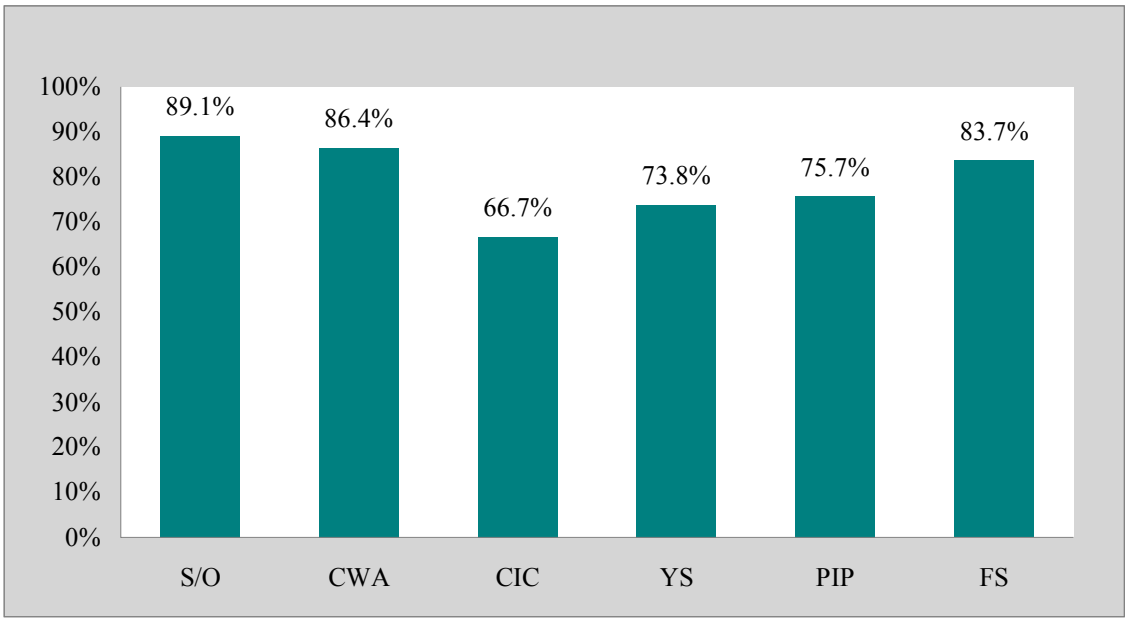

Face to face contact with the parents, children and caregivers receiving child protection services is a critical component of building a relationship that will promote good parenting practices and child development. A minimum standard of one face-to-face contact per month is described in practice standards. This information was collected from all service areas.

- Just over 50% of *Children in Care and Custody* – one in two children – had a minimum of monthly contact or more with their social worker
- One- third of *Youth Services* clients – 33% of the sample- had a minimum of one contact or more per month with their social worker
- Almost 14% of the *Child Welfare Allowance* recipients received the required level of contact
- *Protective Intervention Clients* received a monthly contact or more with their social worker in just over 12% cases

- *Caregivers* received monthly contact or more 10% of the time
- Where social workers indicated that they were providing supportive counseling with clients or monitoring families, the question arises as to how effectively this is occurring given the infrequent contact.

### 4.9.5 MANAGER INPUT

**Figure OF 5: Supervisory Input**




One of the strengths of the child protection system is the teamwork model in which critical decisions are made jointly between the social worker and the manager/supervisor. The above table describes the extent to which this is occurring as documented in the file sample.

- Rates of supervisory/manager input are occurring as required in over 80% of cases in the *screened out, Child Welfare Allowance and Family Service* programs
- In about three quarters of *Protection Intervention and Youth Services* cases, supervisory input is occurring as required
- The *Children in Care* cases receive supervisory/management input 66.7% of the time

# 5.0 RECOMMENDATIONS

The following section begins with an overarching recommendation which will provide structure and direction to the various proposed changes. Next are recommendations designed to address broad systems issues that arose from data and the qualitative input. The final series of recommendations are program-specific based on the results of the file review. In order to achieve results that build on this baseline and the recommendations of other reports a different approach to the delivery of child protection services will be required.

## 5.2 GOVERNANCE / MODEL OF MANAGEMENT

Based on previous reports and recommendations and the results of the file review from this project, it is clear that clinical services require direction and support from a system that is competent. The *Clinical Services Review* provides both data results and qualitative feedback that point to a child protection system that requires comprehensive development and evaluation if it is to achieve the quality that will adequately protect children and support families.

The scope of changes that need to be made cannot be fully effective with the current structure between the Department and the Regions. The system requires standardization, compliance and the availability of resources and tools to adequately perform the work. Relationships based on collegiality, informal systems and local interpretations are not strong enough to achieve this. Therefore a centralized mandate for change is proposed.

**It is recommended that the Department of Child, Youth and Family Services structure and resource a leadership team that is mandated to implement the agenda for change. The purpose of the leadership team is to plan and bring together, in a focused and time limited manner, the elements that will support systemic improvements over a number of years.**

**Features of the leadership structure should include:**

- **Appointment of an individual in the leadership position who has demonstrated experience in system development and change management as well as knowledge of clinical practice in child welfare.**

- **A reporting relationship and accountability that is directly to the Deputy Minister as well as to the Provincial Director of Child Youth and Family Services.**

- **A Steering Committee made up of senior members of the Department and the Regional Health Authorities at the Vice President level.**

- **Authority to develop and implement changes with expectations for compliance where necessary.**

- **Both human and financial resources to bring together the team and to develop a comprehensive plan for the system with both long and short term strategies.**

- **Regular reporting to both the Minister and the RHAs on achievements to meet goals.**

- **A budget that is realistic for the scope of the work and supports the use of advisors etc. for specialized projects such as Workload Measurement, Information Systems, Human Resources and Training, Quality Improvement and potentially system design. The budget should include supports to the RHAs as required, especially for staff participation, development and/or implementation.**

In order to be effective, the system requires agreed to goals around which strategies and plans can be developed and implemented. This means that current initiatives require rationalization as to where they fit with the overall goals and priorities. Unless priorities are clearly communicated and connected to goals for quality improvement, there will be limited benefit for staff and for the community.

**It is recommended that CYFS be provided with the resources to develop a Strategic Plan for the Department that includes:**

- **A statement of the vision and mission that is built on the legislation and linked to the overall strategic plan for the Ministry.**

- **Support to the leadership team to produce the short and long term strategy and work plan.**

- **An agreement with the Regional Health Authorities on the goals and priorities over the next 3 to 5 years.**

- **An inventory of current initiatives and projects.**

- **A process to rationalize all projects and initiatives in relation to the long term goals to ensure the best opportunities for sustained improvements rather than "quick fixes".**

## 5.3 SYSTEMS RECOMMENDATIONS

### 5.3.1 LEGISLATION REFORM

The review determined that there was little usage being made of the legislation to motivate client change via supervision orders. Only 4% of the protection intervention cases reviewed had court involvement in the previous year despite the anecdotal evidence that court consumes a considerable amount of worker time.

There is limited accountability of the child protection system to the court with temporary care orders being permitted to expire rather that reviewed for evidence of progress and suitable intervention.

There are situations where the child protection mandate does not extend to children potentially at risk such as cases of third party abuse (section 16), youth at risk (section 24) and children potentially at risk being served through section 10.

**It is recommended that the legislation undergo review with the goal of making amendments that will ensure a more child-focused judicial and service response and ensure greater system accountability to the court.**

### 5.3.2 HUMAN RESOURCES

There is an urgent need to stabilize the workforce in the child protection service. The review found that one quarter of all cases in the investigation and assessment phase of protection intervention had a change of worker. One half of the protection intervention cases had experienced a change of worker in the past year, as had more than one third of children in care and custody.

The frequency of contact with clients and caregivers also appears to be linked to staffing shortages and rapid turnover necessitating constant reprioritizing of the work to be done. Vacancy rates across the province are high and staff is being promoted to management positions with very little practice experience.

Some cases, especially in protective intervention, are left ‘floating’ in the system with no intervention being provided. Long periods of time elapsed during which children are not being seen by the protection system. There is little formal planning being done regarding service to children and supporting families. Service gaps are evident with incomplete or absent assessments regarding the risk to children and interventions that will address that risk.

Investigations and assessments are not being completed in a timely manner and service documentation declines dramatically once there is a decision that a child needs continued protective intervention services. Qualitative feedback during this project suggests that staff

are juggling the need for an immediate response to new child protection referrals with the ongoing demands of long-term protection intervention cases. New referrals require a speedy response, a comprehensive assessment and a quick determination of whether children are safe. By contrast, long-term protective intervention cases require planning and prescheduled and reliable follow-through. If other areas of service are also part of the social worker's caseload, the demands on that individual's time, scope of knowledge and skills increases.

**It is recommended that the Department, together with the RHAs, develop a provincial recruitment and retention strategy that will address both the short and long-term staffing needs of the child protection system. This should include and not be limited to:**

- **Recruiting teams of people who can be deployed over a three to six month period to work in areas with critical needs**

- **Exploring the utilization of staff with areas of specialty training complimentary to social work to provide services differentially and to increase the pool of individuals from which staff are drawn**

- **Providing financial and other incentives to recruit and retain child protection workers in recognition of the high degree of complexity and liability involved in the work**

- **Considering structural staffing changes to accommodate areas of service specialization to increase expertise and efficiency in service delivery**

- **Ensuring worker safety when developing a staff recruitment and retention strategy and making structural changes**

- **Developing a system-wide, emergency after-hours service that does not rely solely on the services of the social workers who provide services during regular office hours. Consideration should a given to the development of a call centre that will respond to and dispatch calls after regular office hours. Follow-up would be done by designated staff in the regions.**

### 5.3.3 TRAINING AND DEVELOPMENT

Although it is understood that staff hired to perform frontline service and management functions are professionally trained in social work, there is the need to develop skills germane to the job of child protection. The file review revealed a system, particularly in Protective Intervention, that responds mainly to crisis. There appears to be little focus on activities beyond crisis response such as comprehensive assessment, client engagement, planning and risk assessment which are essential to the creation of an effective child protection system.

The level of services that were observed in the file review supports the need for the above training prior to the introduction of any enhanced or higher level service strategies.

Training needs to be implemented through a program that includes both mandatory and optional sessions. In order to support staff, there should be a requirement that specific training is required and mandatory related to the type of service delivered.

**In order to improve the quality of the clinical services and to support staff at all levels it is recommended that the Department, in collaboration with the RHAs, develop and resource training and development programs that are both mandatory and specialized. Such programs should be focused on core competencies to deliver clinical services.**

**Core training is a key component to increasing knowledge and skills and should include but not limited to:**

- **Comprehensive risk investigation and assessment**
- **Understanding of family history and patterns of parenting**
- **Case planning and follow-up**
- **Client engagement, particularly in service planning**
- **Regular assessments and reviews**
- **Documentation and use of the case record as a clinical tool**
- **Clinical supervision**

**Features of the training and development program should be:**

- **Orientation and basic training for all staff new to CYFS.**

- **Review and refresher opportunities for current staff on the basic competencies which have been identified in the *Clinical Services Review*.**

- **Opportunities on a regular basis to learn and develop knowledge and skills related to best practices, research and developments in the field of child welfare.**

- **Given the geography and population of Newfoundland and Labrador, there currently are a range of models of service delivery from specialized caseloads to generic caseloads. Training should be available that supports these differences. Further, the methodology for any training needs to be adaptable to include both face to face and online.**

The file review demonstrated that the most frequent form of manager input was sign off of records. In the qualitative discussions the Working Group provided the observation that the majority of current managers had no training or development beyond their often limited frontline experience. This is a system weakness. The lack of support for staff working in a system that is seriously under resourced constitutes a systemic shortcoming that is likely to contribute to increased risk to children and social worker burn out. Training for managers needs to be given the same support and resources as for frontline staff if the system is to make improvements in quality. Therefore; the following is recommended:

- **Development of managers and directors is an essential investment to achieve system improvements. A variety of training and development opportunities based on their needs to be made available. Training and development should be enhanced by coaching and mentoring.**

- **Similar to the training needs for new frontline staff, new managers should have a supervisory training program that is required and includes mentoring.**

- **As part of the training, managers require information regarding how to complete effective and timely performance appraisals of staff that include goals and achievements and training needs**.

### 5.3.4 QUALITY IMPROVEMENT

The current system is working under a conflicting array of purposes and a vision in which child protection is virtually invisible. As a set of high-risk activities, child protection services require a concerted and sustained focus on key activities, risk indicators, service targets and client feedback. The profile of the child protection service needs to be heightened and more systematic attention paid to indicators of quality at all levels of the system.

A quality improvement approach should include monitoring and analysis of serious occurrences, child fatalities, and client complaints. These client indicators should be supplemented with ongoing information regarding workload levels, staff turnover, the capacity of the alternative care system and other relevant system's issues. Other indicators such as school achievement and permanence for all children receiving protection intervention service should be included.

**The overall system objective should strive to achieve the following features:**

- **The child is seen as the client with the focus on his/her protection.**
- **Cases are received, recorded, interpreted and dealt with according to policies and preferred practices**
- **Information is used to assess risk, understand triggers and interpret accumulating evidence**
- **The system moves from data collection and sharing to strategic discussions and clear planning**
- **Comprehensive assessments are completed, including the histories of family members**
- **There is a high degree of interagency collaboration and service integration with a coordinated response across professionals and agencies**
- **There is timely, open and effective communication among service providers**
- **There is evidence of shared decision-making regarding case planning and problem-solving**

**Therefore it is recommended that the Department, in conjunction with the RHAs, develop a system-wide quality improvement program with the following features:**

- **A clearly articulated organizational purpose, vision and mission specific to the delivery of child protection services**
- **An organizational culture that embraces the articulated purpose, vision and mission and supports efforts to improve service quality**
- **A systematic approach to identifying areas to be reviewed and outcome indicators consistent with the overall mission, purpose and vision of the organization**
- **Methods for providing feedback to stakeholders regarding service quality, areas for improvement and strategies for attaining change**

### 5.3.5 MANAGEMENT OF COMPLEX OR CONTENTIOUS CASES

At present, there is a lack of routine, systematic and comprehensive approaches to dealing with complex and contentious cases in a consistent manner across the province. The approaches described below are likely to require training and development of key staff in order to ensure a shared understanding of the purposes of the reviews and how the information arising can be utilized to protect children and make further service improvements.

**The development of a Quality Improvement Program as described above should support both the identification and prevention of many contentious issues. In addition, a response protocol and problem-solving strategy is required. Such an approach should include:**

- **A definition of and routine protocol for identifying and responding to serious occurrences such as serious injuries of children in care, high risk families who go missing.**

- **A system for the routine review using a multidisciplinary approach of all child protection cases in which there is the death of a child by any means. The results of these reviews should be summarized and recommendations that arise should be used to improve service provision. The information obtained via the review should also inform future services to the families of the deceased child with a particular focus on protecting other children in the family.**

- **The regular use of collaborative case conferencing as a tool for planning and decision-making in complex or contentions cases.**

## 5.3.6 POLICIES AND PROCEDURES

Although some previous work was undertaken in 2007 to develop the current *Child, Youth and Family Services Policy and Standards Manual*, further work and revision is required to ensure that social workers and supervisors have clear expectations and requirements in all program areas. The Department had already identified prior to the *Clinical Services Review* that the Family Services Program needed policies and standards.

**As a result of the *Clinical Services Review*, it is recommended that the following be addressed in further developing the *Child, Youth and Family Services Policy and Standards Manual*:**

- **All compulsory requirements of social workers and supervisors need to be outlined in standards for each program.**
- **There are some directions contained in the existing procedures that are mandatory and should be integrated into the standards.**
- **Standards regarding the frequency of client contact need to be developed for all programs.**
- **Standards regarding record checks and the integration of family history need to be developed for all programs.**
- **Service planning tools should be reviewed to determine if they could be combined to simplify planning and aid in completion.**
- **An investigation format for the collection of information in the investigation and assessment of child maltreatment reports needs to be developed.**
- **Standards for the investigation of new referrals on open protective intervention cases needs to be developed.**
- **Standards for the assessment of homes offering to provide care to children in the child welfare allowance program need to be established.**
- **Standardized assessment formats need to be developed and used throughout the province to support the consistent application of standards for caregiver homes and documentation of compliance with the standards.**
- **Procedures need to be developed for the response to the alleged sexual abuse of children by persons who are not defined legally as parents.**

**In order for staff to be knowledgeable about the content of the manual, methods need to be developed to familiarize staff with the expected practices through ongoing training and supervision.**

**A system for ongoing review, updating and communication of changes to the manual must be implemented.**

### 5.3.7 ASSESSMENT OF WORKLOAD

In the process of selecting and reviewing files for the *Clinical Services Review*, a significant number of protection intervention cases were identified that appeared to require closure and/or that had not received direct contact for a lengthy period of time.

**It is recommended that the Department in conjunction with the RHAs take steps to assess the actual workload in the protection intervention program in order to ensure that children in need of protection are receiving service and that inactive cases are closed. This would of necessity include determining the date of last contact with protection intervention families and the number of cases that are inactive. From there, steps should be taken to update the risk assessment where necessary or take the appropriate steps to close the case**.

There is no system in place at present for determining what constitutes a realistic workload for social workers (the number and type of cases for which the worker is responsible) or for managers (the number of staff reporting to the manager). The scope of the work must be better defined. The development of a workload measurement system can serve as the ongoing platform on which staffing decisions and allocations can be made.

**It is further recommended that the Department in conjunction with the RHAs take steps to develop a system that will permit an accurate assessment of the tasks involved in providing services in the various programs and an estimate of the time that is required to complete those tasks. The tasks should include such factors as supports available to social workers, training, time spent in court, experience level of the social worker, travel, meetings and supervision as well as the tasks required to serve the child and family. Once this is completed it should be utilized to set staffing and caseload benchmarks.**

### 5.3.8 DOCUMENTATION

During the course of the file review it became immediately evident that the documentation was consistently not formatted in a manner that allowed the reviewer to easily find key information. Further the documentation was often not timely or provided in an organized manner. This presents a serious liability for clinical services as missing information and or unclear documentation affect decisions made about services to children at risk. In addition, this situation reduces the effectiveness of the case file as a clinical tool.

In every program there were files not available. The file reviews consistently noted data not found or missing including risk assessments, family centered action plans, ISSPs etc. The liability issue for the system has many aspects, not merely the need for better attention to documentation. The formats need development with realistic expectations set for timeliness of completion. The staff requires training on gathering family history and use of the record to make decisions about risk to children. This implies the need for a major change of culture in the system from one that is embedded with under valuing documentation to a system that uses the client record as a clinical tool.

- **It is recommended that the Department, in collaboration with the RHAs, identify and focus on the issues with documentation that impede effective clinical service.**

- **The improvements to documentation require the development of consistent formats, a model of file organization, setting of expectations for timeliness and content of recording, and policies and procedures.**

- **Mandatory standards and expectations for documentation need to be implemented across the system for all programs.**

- **Training is required for both frontline staff and managers on the clinical use of the case file when making decisions about risk to children. This is particularly important in understanding parenting capacity and the effect of family history.**

### 5.3.9 INFORMATION TECHNOLOGY

The review determined that there were protective intervention cases that had been awaiting closure for considerable periods of time. A variety of reasons were provided including issues related to the functionality of Client Referral and Management System (CRMS). In various programs that were reviewed, completion of required documentation was an identified problem. In all service areas, the need for more focused monitoring of service activity was identified. This raises the question of whether frontline staff and supervisors are receiving automatically timely and applicable reports from the information system to assist with the organization of work, timeliness of documentation, and appropriate reviews and authorizations. It appears that the system relies heavily on informal information transmitted from one individual to another.

CMRS could not distinguish for the reviewers cases in the assessment and investigation phase of the protective intervention service from cases receiving long-term protective intervention services. The reviewers only determined this information by reading the files. This lack of information would seriously impact a manager's ability to manage the flow of work and staffing requirements in the protective intervention program. There appeared to be no data output about case status, cases awaiting closure, document completion, and documents needing supervisory review. There was no overall picture of the scope or cost of the child protection system. Basic information needs to be readily available to managers and accessible as tools for guiding the system. Without information, it is not possible for managers and directors to be responsible for their work and that of their staff.

In protective intervention cases, the review found rates for the completion of the risk assessment tool and family centered action plan to be lower than other components of the Risk Management System. For this reason it might be worthwhile to determine if CRMS presents any impediments to the completion process or whether any aspects of the electronic tools can be streamlined in order to improve completion.

Because frontline staff are expected to travel to clients and are often at a distance from their office and supervisor, they could benefit from technology to support worker safety, communication with the supervisor and completion of documentation from locations.

**It is recommended that the Client Referral and Management System (CRMS) be examined to determine how the system can be resourced and enhanced to further support the work of frontline staff and supervisors.**

**CRMS has not been directly examined in this review: however, a number of issues related to its impact on frontline clinical practice was consistently identified. It should ensure the following in order to support timely documentation on cases and supervisory review:**

- **Determine if CRMS presents any barriers to the completion of the risk assessment tool and family centered action plan and if so, implement changes to streamline completion these documents.**

- **Prompt turnaround and resolution of identified problems for workers and supervisors navigating a case through CRMS or closing a file.**

- **Provision of readily available, case-specific information on a daily basis for workers and supervisors including documentation due, overdue and completed according to standards. Frontline staff and supervisors need to be aware of pending deadlines and the status of cases in terms of compliance with standards.**

- **Prompts for supervisors for the review of documents that have been completed by their frontline workers and are requiring supervisory review, signature and possibly editing before finalization. The status of the flow documents between the worker and supervisor should be apparent to both.**

- **Direct access by covering workers and supervisors to files that they are covering so that case notes and documents can be completed and added to the record in a worker's absence.**

- **Remote access to CRMS and case documentation forms so that documents can be electronically completed away from the office and documents requiring client participation may be completed with the client.**

**Further it is recommended that management data reports be provided to managers on a monthly basis immediately. The reports should be designed to provide the level of information needed by the manager to understand and perform his or her responsibilities. These reports must supply managers with information about the number and status of cases in the system, the number of children in care and custody, the number of caregiver homes and placements, expenditures to date and what the status of those expenditures is as compared with the approved budget for the year.**

**Training should be provided for all management staff in order that they develop expertise in interpreting management data reports, and using the reports to assign work, monitor service activities, and integrate the information into the supervision of their staff. This training needs to be provided to existing managers as well as to new**

**managers following their appointment. The manager's understanding of the data information provided should be enhanced by expecting managers to report on some regular basis regarding the activities and status of their unit's work and to set goals regarding their ongoing management activities.**

**Tools such as laptop computers and cell phones should be regarded as tools that are essential to the efficient completion of the work.**

## 5.4 PROGRAM RECOMMENDATIONS

The following recommendations are specific to each program that was reviewed and informed the systems recommendations.

### 5.4.1 REFERRALS SCREENED OUT OF SERVICE

- Revise the provincial initial intake form so that the documentation of a past record check includes the file numbers and the type of past records.
- Train social workers and managers to consider a referral in the context and knowledge of past records and referrals.
- Define in policy the use of "S16" coding for referrals or eliminate the coding altogether.
- Improve timeliness of documentation and the supervisory review of documentation.
- Develop a policy that requires at least monthly management review of a defined percentage of referrals that were received but deemed ineligible for service, as a quality improvement measure.
- Develop a provincial standardized format for "after hour" calls or referrals.

### 5.4.2 PROTECTIVE INTERVENTION PROGRAM

- Obtain a better knowledge of the actual workload by completing an audit of all protective prevention cases on workers' caseloads to be sure that their cases are matching with the electronic information system (CRMS) and identify cases that should be closed. Develop a structured and time-limited plan to ensure that cases that should be closed are closed.
- Code or label protective intervention cases that are at the assessment and investigative stage differently from cases requiring ongoing /long-term child protective intervention. This would assist in assessing overall provincial workload, the caseloads of individual social workers and impediments to service flow. It might also assist in ensuring more timely completion of investigations and determinations of the need for long-term child protective services.
- Establish standards regarding face-to-face contact with families and children and develop a system to track the frequency of contact.

- Develop a human resource plan that undertakes issues such as staff recruitment, retention, and structure to address the need for greater continuity in service delivery in protective intervention cases.

- Review and revise the current risk management system giving consideration to:
    - An outline for the collection of information in child protection investigations.
    - An extension of the timeline for the completion of an investigation under specific circumstances and with particular documentation.
    - The development of standards regarding record checks.
    - The streamlining of the risk assessment tool and the family centered action plan and/or the associated electronic processes to facilitate improvements in completion of required documentation.
    - Combining the family centered action plan and the individual support service plan into one service plan that is child centered and focused on the reduction of risk of harm to children.
    - The development of standards and procedures for new referrals on open cases.
    - Expressing in standards all essential requirements for social workers and supervisors pertaining to risk decisions in the risk management model.

- Develop a plan for enhanced implementation of the risk management system through revised policies and procedures, staff training, and monitoring adherence to the standards and requirements of the model.

- Develop a system for tracking documentation timelines and documentation completion for all cases, producing online current notifications and reports for staff and supervisors on pending, completed and overdue documentation on assigned cases. Clarify expectations of supervisors with respect to staff's completion of documentation as well as supervisory input and review.

### 5.4.3 FAMILY SERVICES

- Develop policies and procedures to guide the service.

- Provide clarity to workers and managers on eligibility for the Family Services Program.

- Define Family Services in terms of risk assessment and its' connection to Protective Intervention.

- If Family Services is to be used for 3rd Party Assault referrals it needs standards written to address the service response to children and families.

A sample of files needs to be audited on a regular basis to ensure that the program is not being used to manage cases where there are risks to a child that require protective intervention.

### 5.4.4 CHILD WELFARE ALLOWANCE

- Direct more rigorous attention to the services to children and families so this program is not treated solely as a financial allowance.

- Implement standardized assessment procedures and approval processes with families offering to provide placements for children under the child welfare allowance program.

- Develop standards regarding contact with the child and with the family who is providing care.

- Improve service planning for the children in this program together with systems to support supervisory input and review of plans.

### 5.4.5 CHILDREN IN CARE AND CUSTODY

- A strategy is required to ensure that all children in care have a plan developed that addresses their developmental needs. This will likely require that managers and social workers establish targets for the completion of plans and that managers monitor progress towards the targets. Once the plans are in place the managers will need to receive data on a monthly basis that accurately describes the status of the plans for children to ensure that they are updated as required. With plans in place on a more routine schedule, the requirement of reviewing them on a monthly basis should be reconsidered. A review of the plan on a quarterly basis (for children under five) and every six months (for children five and over) might be considered.

- Almost 60% of the children in the sample had one worker over the previous year. However, almost one-third of the sample had 2 or 3 workers over the previous 12 months and another child had had four workers. This points to a concerning lack of stability in relationships for children and for caregivers. Efforts are urgently required to ensure that children in care receive stable, continuous services.

- A province-wide system of file organization should be developed. Such a system should provide a template for documenting required information regarding the child and his/her placement. Basic information about the child such as health, education, dental and vision care, location and type of placement should be readily available across the system.

- While there is extensive use of family based care (caregiver homes), almost one in five placements was described as an individual or alternative living arrangement. This is indicative of the challenging needs of the children and the shortage of suitable substitute living arrangements. A focused plan for the recruitment, training and support of caregiver homes and the development of a range of placement alternatives within the province is urgently required.

### 5.4.6 CAREGIVER HOMES

- Standard formats require development across the province to the support consistent application of standards for caregiver homes and to streamline the location of key data.

- Utilizing reliable monthly data reports, managers must track the approval and review processes for caregiver homes to ensure that timeframes are being met, key documents are being reviewed and that annual reviews of caregiver homes are occurring as required.

- Consideration should be given to assigning certain tasks in the caregiver approval process to support staff (e.g. The gathering of medicals, reference letters, record checks and criminal checks, safety inspections of the home, etc.) as a way of addressing some of the workload and recruitment challenges being experienced.

- Using the data derived from the Children in Care portion of this review, a needs assessment for children in alternative/individual living arrangements should be completed. This information should be utilized to develop an overall plan for the recruitment and retention of caregiver homes and other residential resources such as special treatment foster care.

### 5.4.7 YOUTH SERVICES

- Although the program appears successful, meeting standards for completion of the Youth Services Agreement, Youth Risk Screening Tool, ISSP and the Cancellation Form need to be improved.

- Regular and ongoing review of goals is essential for youth to move through the transition to adulthood. Therefore it is recommended that programs be developed to support training for independence.

- There does not appear to be a centralized model for planning for special needs youth. This should be designed and implemented with participation from both the children's and adult sectors. The goal would be early identification (e.g. age 14) and a team approach to long term planning.

- Future review of the *Child, Youth and Family Services Act*, should give consideration to reinstating continuous care status to age 18 years. In terms of support to youth who have experienced trauma and loss in their early years; the current young age of 16 for termination may feel like a significant loss of support from the system.

# 6.0 SUMMARY

Given the province's desire to make appropriate investments to improve the quality of the child protection system, the 'Clinical Services Review' was pursued in order to develop recommendations that would assist in directing the planning and implementation of any needed additions or changes in policies, programs, standards, practices and methods of service delivery. This was achieved through the following process:

- A review of recent reports and materials including the Turner Report (October 2006) and the *Deloitte Organizational and Operational Review* (March 2007)
- The design of data collection instruments for all service areas (family services; protective intervention including cases screened out of service; children in care and custody; child welfare allowance; caregiver homes; youth services, both residential and non residential)
- The completion of data collection from 400 case files
- The collation and analysis of the collected data in conjunction with both a Working Group and an Advisory Committee
- The development of observations, findings, conclusions and recommendations regarding the current state of clinical services

The final report includes recommendation for policies and procedures; service models and tools; training and development; quality improvement practices and programs; and structural reform and leadership.

The review found that the achievement of an acceptable standard of clinical services is being undermined by the following systemic barriers:

- **Workforce instability** that results in service discontinuity that is compromising the welfare of children. This is seen in casework where there are repeated worker changes; contacts with clients that are significantly below what is necessary for maintaining a clinical relationship and supporting client change; lack of planning with clients; incomplete or missing client records; low levels of compliance with current service standards.

- **Sufficient leadership and management** that is focused on a realistic set of goals and tasks related to a clear vision of child protection.

- **Lack of training and development** at all levels of the system to support a professional and competent service response.

- **Legislation, policies and procedures** that fail to adequately position the safety, protection and well-being of the child as paramount.

- **Lack of timely and accurate data** about the work being done and how information about that work can be used to plan for services to children.

Recommendations from the review are focused on the following areas:

- **Leadership:** The need for a mandated leadership team with sufficient resources and time within which to undertake the necessary reform of the child protection system.

- **Legislative Reform:** The current legislation requires review and updating in several areas in order to achieve greater clarity of purpose with a more child-centered focus.

- **Stabilization of the Workforce:** There is an urgent need to stabilize the province's workforce through the development of a coordinated, province-wide recruitment and retention program. Such a program will recognize the risks inherent in child protection work as the most difficult form of social work practice. Workforce stabilization will require incentives, both financial and other, in order to attract, support and keep people on the job.

- **Training and Development:** The workforce at all levels requires a training and development program that is both mandatory for orientation and basic training as well as the development of core competencies. The program will be effective with support provided through mentoring and coaching.

- **Quality Improvement:** Development of a quality improvement program that will utilize the baseline data extracted from this project and develops strategies for improving on the results. Accurate and timely information regarding casework and flow, human resources and financial resources is essential to the development of such a program.

- **Management of Complex Cases:** A system for the management of complex cases is needed. This should include the routine review of certain types of cases according to an agreed-upon format. Findings and recommendations coming out of these reviews should be aggregated and utilized to make service improvements.

- **Policies and Procedures:** In order to ensure consistent direction to staff for the performance of the work, current policies and procedures are required that are clearly described for each program. The policies need to be based on the intent of the legislation as well as standards and best practices.

- **Workload:** An accurate picture of the workload and the current work must be ascertained. From this, workload benchmarks must be developed and implemented to direct staff recruitment and management and case assignment.

- **Documentation:** In addition to the need for standardized formats for documentation and organization; the case file needs to be used as a tool for decision making. This will require training for both frontline and managerial staff.

- **Infrastructure and Information Technology:** Accurate, timely information and training on how it is to be utilized to set targets, monitor and evaluate service goals. This will promote a system view and reduce the reliance on often faulty anecdotal information.

The priorities listed above will require a concerted and sustained focus of strong leadership over several years in order to achieve the improvement of the child protection system that is urgently required. It will not be an easy task, however the challenge is an opportunity to build an effective child protection system on behalf of the children and families of Newfoundland and Labrador.

# APPENDICES

## Appendix 1 ADVISORY COMMITTEE MEMBERS

**Jennifer Jeans**, Assistant Deputy Minister of Public Health & Wellness and Children & Youth Services (Chair)
**Ivy Burt**, Director, Children, Youth and Family Services
**Rosemarie Goodyear**, Vice President, Community Health & Primary Health Care, Central Health Authority
**Michelle House**, Vice President, Population Health, Western Health Authority
**Glenys Walsh**, Quality and Clinical Safety Leader, Eastern Health Authority
**Delia Connell**, Vice President Community Services and Aboriginal Affairs Labrador - Grenfell Health Authority
**Michelle Shallow**, Manager, Child, Youth & Family Services
**Lynnette West**, Consultant Quality Improvement, Child, Youth & Family Services
**Cathie Barker-Pinsent**, Director, Child, Youth & Family Services, Eastern Health Authority
**Heather Jacobs**, Assistant Deputy Minister, Department of Justice
**Dr. Rob Morris**, Janeway Child Protection Program
**Lisa Crockwell**, Executive Director & Registrar, Newfoundland & Labrador Association of Social Workers
**Dr. Dennis Kimberley**, School of Social Work, Memorial University of Newfoundland
**Charlene Dodd**, Policy & Planning Evaluation Consultant, Department of Health and Community Services

## Appendix 2 WORKING GROUP MEMBERS

**Michelle Shallow**, Manager, CYFS
**Lynnette West**, Consultant, Quality Improvement
**Genny Corbin**, Director, CYFS, Labrador Grenfell Health Authority
**Lyla Andrew**, Director, CYFS, Labrador Grenfell Health Authority
**Cathie Barker-Pinsent**, Director, CYFS, Eastern Health Authority
**Joan Davis Whalen**, Senior Project Manager, Eastern Health Authority
**Cora Collins**, Director, CYFS, Western Regional Health Authority
**Jana Gosse**, Quality and Strategic Directions Manager, Western Regional Health Authority
**Dorothy Dormondy**, Director, CYFS, Central Regional Health Authority
**Vanessa Mercer Oldford**, Manager Program Planning, Central Regional Health Authority

## Appendix 3 FILE REVIEW TEAM

**Michelle Shallow**, Manager, Child, Youth & Family Services
**Lynnette West**, Consultant Quality Improvement, Child, Youth & Family Services
**Susan Walsh**, Manager, Strengthening the Child, Youth & Family Services System
**Helen MacDonald**, Program Consultant, Protective Intervention
**Mabel Anderson**, Program Consultant, In Care / Custody
**Joan Davis Whalen**, Senior Project Manager, Eastern Regional Health Authority
**Jana Gosse**, Quality and Strategic Directions Manager, Western Regional Health Authority
**Vanessa Mercer Oldford**, Manager, Program Planning, Central Health Authority
**Sheila Fitzgerald**, Program Manager (Clinical), Labrador Grenfell Health Authority
**Amanda Winsor**, Program Manager (Clinical), Labrador Grenfell Health Authority
**Susan Abell**, External Consultant
**Judith van Leeuwen**, External Consultant
**Sandy Moshenko**, External Consultant

# Appendix 4 DATA AND ANALYSIS FROM FILE REVIEW

# Appendix 4.1 REFERRALS SCREENED OUT OF SERVICE

## Table of Contents



## List of Tables

## Appendix 4.1.1 PROGRAM DESCRIPTION

Child, Youth and Family Services provide an intake service to receive reports about child maltreatment and requests for services from the community and to assess eligibility for its services.

Standards have been interpreted based on the wording in the Child, Youth and Family Services Policy and Standards Manual and the Risk Management System. This includes any mandatory directions to staff, which appear as part of the procedures narrative.

## Appendix 4.1.2 DATA RESULTS AND ANALYSIS

### Appendix 4.1.2.1 Sample Size

A sample of 58 cases that were determined to be ineligible for service was drawn for the file review. Three files (1 from each of the Eastern, Western and Central Regional Offices) were eliminated as these referrals were not actually screened out and did not meet the criteria for the sample. Thus the file review included 55 files from the four regions. The sample of referrals, which were screened out of service, related to the period between April 1, 2007 and March 31, 2008. 60% of the files pertained to referrals received in 2007 and 29% of the files pertained to referrals in 2008. There were 6 cases where the reviewers did not indicate which year the referral was received.

### Appendix 4.1.2.2 Referral Source

Parents were the greatest source of referral (18.2%). Only three of the 10 files, in which a parent made the referral to Child, Family and Youth Services, was the parent identified by the reviewers as a non-custodial parent. Other frequent referral sources were community professionals, police, health professionals, and school personnel. A fairly large number of the referral sources wished to remain anonymous.

### Table SO 1: Source of Referral

| Referral Source | Number Of Files | Percentage |
|---|---|---|
| Parent | 10 | 18.2 |
| Child | 2 | 3.6 |
| Other Family Member | 2 | 3.6 |
| Police | 7 | 12.7 |
| Health Professional | 7 | 12.7 |
| School | 6 | 10.9 |
| Other Professional | 9 | 16.4 |
| Neighbour | 3 | 5.5 |
| Anonymous | 7 | 12.7 |
| Other: Babysitter | 1 | 1.8 |
| Reviewer Did Not Complete Data | 1 | 1.8 |
| **Total** | **55** | **100** |

## Appendix 4.1.2.3 Reason for Referral

Reasons for referral are outlined below in Table SO.2. The categories outlined are not mutually exclusive as reviewers in five cases chose two or more reasons for referral. When the reviewers indicated the reason for service as "other" the notations included: the behaviour of the care provider, failure to maintain physical safety, funding for daycare, harassing phone calls, lack of school attendance, people in the home arguing, or watching pornographic material.

The highest proportion of screened out referrals pertained to physical abuse, inadequate supervision and family violence.

### Table SO 2: Reason for Referral

| Reason * | Number Of Files Where Reason Noted | Percentage Of Sample Reason Noted | Reason for Referral* | Number Of Files Where Reason Noted | Percentage Of Sample Where Reason Noted |
|---|---|---|---|---|---|
| Physical Abuse | 7 | 12.7 | Parental Substance Abuse | 3 | 5.5 |
| Risk of Physical Abuse | 2 | 3.6 | Parental Mental Health | 2 | 3.6 |
| Sexual Abuse or Sexual Exploitation | 2 | 3.6 | Parental Physical Health | 0 | 0.0 |
| Risk of Sexual Abuse or Sexual Exploitation | 1 | 1.8 | Parental Incarceration | 0 | 0.0 |
| Emotional Abuse | 5 | 9.1 | Inadequate Care giving/ Parenting Skills | 3 | 5.5 |
| Failure to Meet Developmental Needs | 0 | 0.0 | Marital/Partner Problem | 2 | 3.6 |
| Failure to Meet Physical Needs | 3 | 5.5 | Birth Planning | 1 | 1.8 |
| Failure to Meet Medical Needs | 0 | 0.0 | Assistance with Special Needs Child | 0 | 0.0 |
| Inadequate Supervision | 7 | 12.7 | Respite | 1 | 1.8 |
| Abandonment | 0 | 0.0 | Financial Support To Care For a Child | 1 | 1.8 |
| Child Behaviour | 4 | 7.3 | Voluntary Request For Short-term Child Placement | 0 | 0.0 |
| Parent-Child Conflict | 0 | 0.0 | Transportation Costs | 0 | 0.0 |
| Family Violence | 7 | 12.7 | Other | 10 | 18.2 |
| **Total** | | | | **61** | **100** |

* Not mutually exclusive. Reviewers in 5 cases chose more than 1 reason for service; thus 61 notations of the reason for service on the 55 files.

## Appendix 4.1.2.4 Documentation of Referrals

All files had written documentation regarding the referral. The initial intake report was also completed for all referrals. As shown in Table SO.3, 64 % of the referrals were documented within 24 hours as required by CYFS' standards. The intake report was completed in 49.1% of the files within the required time period of 24 hours as shown in Table SO.4.

### Table SO 3: Documentation of Referral Information

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 24 hours | 35 | 63.6 |
| 25 hours- 3 days | 4 | 7.2 |
| 4-7 days | 6 | 10.9 |
| More Than 7 days | 10 | 18.2 |
| **Total** | **55** | **100** |

### Table SO 4: Completion of Intake Report

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 24 hours | 27 | 49.1 |
| 25 hours- 3 days | 7 | 12.7 |
| 4-7 days | 7 | 12.7 |
| More Than 7 days | 11 | 20.0 |
| Reviewer Did Not Complete Data | 3 | 5.5 |
| **Total** | **55** | **100** |

It was determined that in 53 of the 55 files or 96.4 % of the referrals, there was sufficient information collected to understand the concern and/or the circumstances that prompted the referral. In 54 of the 55 files or 98.2% of the referrals, there was sufficient information collected to identify the child/ren and the family.

## Appendix 4.1.2.5 Record Checks

Record checks were completed in 53 of the 55 files or in 96.4 % of the referrals as required by CYFS' procedures. Previous child protective intervention files existed for 43 files or 78.2 % of the referrals that were screened out. In 30.2 % of the referrals that had a previously existing protective intervention file, it had been less than 3 months since case closure or since a previous referral had been made as shown in Table SO.5.

### Table SO 5: Time Since Closed From Protective Intervention Program or Since a Previous Referral Was Made

| Time Since Closed Or Previous Referral | Number Of Referrals With Previous Protective Intervention Files | Percentage |
|---|---|---|
| Currently Active Protective Intervention Case | 1 | 2.3 |
| Less Than 3 Months | 13 | 30.2 |
| 3-6 Months | 4 | 9.3 |
| 7-12 Months | 6 | 13.9 |
| More Than One Year | 12 | 27.9 |
| Cannot Determine Time Frame | 7 | 16.3 |
| **Total** | **43** | **100** |

Families of origin files are records on the parents' parents or records on the parents when they were children. The reviewers were able to determine whether a family of origin record existed or not, in less than half of the cases. There is not a designated space to indicate this information on the intake report. There were only 5 files, or 9.1% of the sample, where the existence of a family of origin record was evident.

## Appendix 4.1.2.6 Managerial Consultation and Authorization

The managers were consulted regarding the decision whether to accept the referral or not in 49 or 89.1% of the files. In 79.9% of the cases, this consultation occurred, as required by CYFS procedures, within 24 hours from the time of referral. See Table SO.6.

### Table SO 6: Managerial Consultation about the Referral

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 24 hours | 39 | 70.9 |
| 25 hours- 7 days | 4 | 7.3 |
| 7-14 days | 2 | 3.6 |
| More Than 14 days | 7 | 12.7 |
| Cannot Determine Time Frame | 3 | 5.5 |
| **Total** | **55** | **100** |

A manager authorized the social worker's documentation and the disposition of the referral within 7 days, as required by CYFS' standards, in 34 files or 61.8% of the referrals as shown in Table SO.7. The existence of a manager's approval could not be determined in 16.4% of the cases. In 17 files or 30.9 % of the files, the social worker wrote that the approval by the manager was given verbally without the manager reviewing the documentation and making the approval in writing.

### Table SO 7: Managerial Authorization of Social Worker's Documentation and Disposition of Referral

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 7 days | 34 | 61.8 |
| 8-14 days | 3 | 5.5 |
| 15-30 days | 5 | 9.1 |
| More Than One Month | 4 | 7.3 |
| Cannot Determine Time Frame | 9 | 16.4 |
| **Total** | **55** | **100** |

## Appendix 4.1.2.7 Reason That Referral Was Screened Out

41.8% of the referrals were screened out after a decision was made that the referral did not meet the criteria for protective intervention. It is important to note that at least 13 of the 55 cases or 23.6% of the files had an investigation completed in part or in full prior to screening out the referral. These referrals were processed outside of the required risk management system although some steps may have been applied. These referrals should have been coded as protective intervention.

### Table SO 8: Reason That Referral Was Screened Out

| Reason | Number Of Files | Percentage |
|---|---|---|
| Report Does Not Meet Definition Of A Child In Need Of Protective Intervention | 23 | 41.8 |
| Insufficient Information To Initiate An Investigation | 3 | 5.5 |
| Referral Source Lacks Credibility/ Report is Malicious Or False | 3 | 5.5 |
| Report Has Been Received Previously And Assessed | 1 | 1.8 |
| Other:<br>Child Recanted<br>Assessment and/or Investigation Initiated/Completed And Then Screened Out (Coded S 16)<br>Investigated And Closed (Coded S 14)<br>Issue Requires Jurisdiction Of School Attendance Act<br>Services Declined<br>Reason Not Documented By Social Worker | <br>1<br>12<br>1<br>1<br>1<br>4 | 36.4 |
| Data Not Completed By Reviewer | 5 | 9.1 |
| **Total** | **55** | **100** |

At the time of screening out the referrals, it was noted that 7 families were referred to specific services. One case received the protective intervention program due to another referral, one was offered family services, one remained receiving family services, one was referred for daycare subsidy, one was referred to the police (RCMP) and in two cases the specific community service was not reported by the reviewer.

## Appendix 4.1.2.8 Summary

- Good records of all referrals are being made but documentation is not meeting the required timeframe.
- The initial intake reports are being completed for all referrals but documentation is not being completed within the required timeframe.
- Record checks are being completed but the intake form does not require documentation of the file name, number and the type of record.
- A significant proportion of the screened out referrals are from parents requesting service. This might benefit from further investigation to determine what services are being sought by parents but cannot be provided.
- Over three quarters of the screened out referrals had previous child protective intervention files. For one third of the referrals with these previous records, a previous referral or file closing had been less than three months. This may suggest a referral is being assessed in isolation rather than in the context of past history and previous referrals.
- Managers are being consulted about the decision of eligibility for service but managers are not always authorizing the social worker's documentation and the disposition of the referral within the required timeframe.
- There is an apparent lack of understanding of the referral coding "S16" because referrals coded as such are involving at least partial investigations (including interviews) of a child's need for protective intervention.
- There are no standardized documentation requirements for after-hours calls across the regions.

# Appendix 4.2 PROTECTIVE INTERVENTION PROGRAM

## Table of Contents

## List of Tables

## Appendix 4.2.1 PROGRAM DESCRIPTION

In collaboration with the community, Child Youth and Family Services (CYFS) is charged with the responsibility of protecting children under the age of sixteen who have suffered or are at risk of suffering harm or maltreatment. The Protective Intervention Program is mandated under the Child Youth And Family Services Act to intervene, assess and secure the safety, health and well-being of children in accordance the legislation. Circumstances for intervention are limited by the definition of a child in need of protective intervention under section 14 of the Child Youth And Family Services Act. The provision of services is guided by the philosophy and principles set out in the Act as well as CYFS' standards and procedures.

Standards have been interpreted based on the wording in the Child, Youth and Family Services Policy and Standards Manual and the Risk Management System. This includes any mandatory directions to staff, which appear as part of the procedures narrative.

## Appendix 4.2.2 DATA RESULTS AND ANALYSIS

### Appendix 4.2.2.1 Sample

A sample of 180 cases was drawn for the file review. The file review included files from the four regions. All cases in the sample were open and receiving service for part or all of the period between April 1, 2007 and March 31, 2008.

65 files in the sample or 36.1% received assessment and investigation services only while the other 115 files or 63.9% received long-term protective intervention services following the initial assessment and investigation.

### Appendix 4.2.2.2 Length of Service since Case Opening

Only 7 files or 4.1 % of the total selected sample of 180 files were open as result of a referral prior to 2001. There were 93 protective intervention files or 51.7% of the total sample that were open longer than one year.
As shown in Table PI.1, 41.5 % of the 65 protective intervention files that received only assessment and investigation services were open for less than 3 months. 35.3% of the assessment and investigation files were open over 7 months. It is apparent that these files are staying open for assessment and investigation much longer than the prescribed standard of 30 days.

**Table PI 1: Length of Service since Case Opening For Cases Receiving Only Assessment And Investigation Services**

| Length Of Service Since Opening | Number Of Assessment/Investigation Only PI* Files | Percentage |
|---|---|---|
| Less Than 3 Months | 27 | 41.5 |
| 3-6 Months | 11 | 16.9 |
| 7-11 Months | 9 | 13.8 |
| 1-2 Years | 9 | 13.8 |
| More Than 2 Years | 5 | 7.7 |
| Reviewer Did Not Complete Data | 4 | 6.2 |
| **Total** | **65** | **100** |

* PI=Protective Intervention

As shown in Table PI.2, 25.2% of the long-term protective intervention files were open 1-2 years, and 43.5% were open more than 2 years; therefore, 68.7% were open longer than 1 year.

**Table PI 2: Length of Service since Case Opening For Cases Receiving Long-Term Protective Intervention**

| Length Of Service Since Opening | Number Of Long-Term PI Files | Percentage |
|---|---|---|
| Less Than 3 Months | 5 | 4.3 |
| 3-6 Months | 8 | 7.0 |
| 7-11 Months | 18 | 15.7 |
| 1-2 Years | 29 | 25.2 |
| More Than 2 Years | 50 | 43.5 |
| Reviewer Did Not Complete Data | 5 | 4.3 |
| **Total** | **115** | **100** |

* PI=Protective Intervention

# PART A: ASSESSMENT AND INVESTIGATION STAGE

Assessment and investigation services were provided to the 180 cases in the sample.

## Appendix 4.2.2.3 Referral Source

As shown in Table PI.3, police were the most frequent source of referral and made 21.7% of the referrals. Other frequent referral sources were parents, community professionals, health professionals, and school personnel. When referrals from professional sources (e.g. police, health professionals, educators, and other professionals) of referral are considered together, they represent about 57% of the total referrals.

Taken as a whole, parents made 12.8% of the referrals. Only 6 of the 23 files in which a parent made a referral to Child, Family and Youth Services, was the parent identified by the reviewers as a non-custodial parent; thus, a non-custodial parent made 26.1% of the referrals that were made by parents or 3.3% of the initial referrals overall.

**Table PI 3: Source of Referral for All Cases In The Sample**

| Referral Source | Number Of Files | Percentage | |
|---|---|---|---|
| Parent | 23 | 12.8 | |
| Child | 2 | 1.1 | |
| Other Family Member | 15 | 8.3 | |
| Police | 39 | 21.7 | 57% |
| Health Professional | 22 | 12.2 | |
| School | 18 | 10.0 | |
| Other Professional | 23 | 12.8 | |
| Neighbour | 16 | 8.9 | |
| Anonymous | 7 | 3.9 | |
| Other:<br>Community Member<br>Foster Parent/Caregiver<br>Friend Of Family<br>Unknown<br>Witness | 13<br>(6)<br>(1)<br>(4)<br>(1)<br>(1) | 7.2 | |
| Reviewer Did Not Complete Data | 2 | 1.1 | |
| **Total** | **180** | **100** | |

## Appendix 4.2.2.4 Reason for Referral

Reasons for referral for the 180 cases in the sample, as determined by reviewers from the recorded referral information, are outlined in Table PI.4. The categories outlined are not mutually exclusive as reviewers could choose more than one reason for referral. The most frequent reasons for service were physical abuse, emotional abuse, family violence and inadequate supervision.

**Table PI 4: Reason for Referral As Determined By Reviewers from the Information Recorded About the Initial Call**

| Reason for Referral* | Number Of Files Where Reason noted | Percentage Of Sample | | Reason for Referral* | Number Of Files Where Reason noted | Percentage Of Sample |
|---|---|---|---|---|---|---|
| Physical Abuse | 58 | 32.2 | | Child Behaviour | 13 | 7.2 |
| Risk of Physical Abuse | 15 | 8.3 | | Parent-Child Conflict | 3 | 1.7 |
| Sexual Abuse or Sexual Exploitation | 3 | 1.7 | | Family Violence | 50 | 27.8 |
| Risk of Sexual Abuse or Sexual Exploitation | 8 | 4.4 | | Parental Substance Abuse | 14 | 7.8 |
| Emotional Abuse | 55 | 30.6 | | Parental Mental Health | 5 | 2.8 |
| Failure to Meet Developmental Needs | 2 | 1.1 | | Parental Physical Health | 1 | .6 |
| Failure to Meet Physical Needs | 5 | 1.1 | | Parental Incarceration | 0 | 0 |
| Failure to Meet Medical Needs | 2 | 1.1 | | Inadequate Care giving/ Parenting Skills | 12 | 6.7 |
| Supervision | 25 | 13.9 | | Other: (Custody Access Issues; Mental Health) | 2 | 1.1 |
| Abandonment | 2 | 1.1 | | **Total** | **275** | **100** |

* Not mutually exclusive. Reviewers could choose more than 1 reason for service; thus the 275 notations for the180 files in the sample.

## Appendix 4.2.2.5 Documentation of Referrals

### *Child Protection Report*

177 of 180 files or 98.3% had written documentation of the information regarding the referral on the Child Protection Report form. As displayed in Table PI.5, about two thirds of the referrals were documented within the CYFS' standard that requires the documentation to be completed no later than 24 hours from the time of the referral.

**Table PI 5: Timeframe for Documentation of Referral Information**

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 24 hours | 120 | 66.7 |
| 25 hours- 3 days | 15 | 8.3 |
| 4-7 days | 11 | 6.1 |
| More Than 7 days | 18 | 10.0 |
| Reviewer Cannot Determine | 7 | 3.9 |
| Reviewer Did Not Complete Data | 9 | 5.0 |
| **Total** | **180** | **100** |

### *Initial Intake Report*

The initial intake report was completed by the social worker for 165 or 91.7% of the 180 cases in the sample. As shown in Table PI.6, the timeframe for completion of the report could only be determined for 162 of these files. The intake report was completed in 51.1% of the files within the established standard time period of 24 hours.

**Table PI 6: Timeframe for Completion of Initial Intake Report**

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 24 hours | 92 | 51.1 |
| 25 hours- 3 days | 22 | 12.2 |
| 4-7 days | 16 | 8.9 |
| More Than 7 days | 32 | 17.8 |
| Never Completed | 2 | 1.1 |
| **Sub-Total** | **162** | |
| Reviewer Cannot Determine Timeframe | 5 | 2.8 |
| Not Applicable (e.g. 1998 Referral) | 5 | 2.8 |
| Reviewer Did Not Complete Data | 6 | 3.3 |
| **Total** | **180** | **100** |

## Appendix 4.2.2.6 Legislative Reason for Protective Intervention

When the documented legislative reason for the case opening was examined, it was again confirmed that the greatest proportion of cases pertained to physical abuse, emotional abuse, family violence and inadequate supervision. Reviewers made a similar finding when reading the file information about the call from the referral source.

**Table PI 7: Legislative Reason for Protective Intervention upon Receipt of Referral**

| Legislative Reason* | Number Of Files Where Reason Noted | Percentage Of Sample |
|---|---|---|
| Physically Harmed Or Risk Of Being Physical Harm By Parental Action Or Lack Of Action | 75 | 31.3 |
| Sexual Abused Or Exploited Or Risk Of Being Sexual Abused Or Sexual Exploited By A Parent | 3 | 1.3 |
| Emotionally Harmed By Parent's Conduct | 55 | 22.9 |
| Risk Of Being Physically Harmed By A Person And Parent Does Not Protect | 7 | 2.9 |
| Risk Of Being Sexually Abused Or Exploited By A Person And Parent Does Not Protect | 7 | 2.9 |
| Risk Of Being Emotionally Harmed By A Person And Parent Does Not Protect | 6 | 2.5 |
| Parent Refuses Or Fails To Obtained Treatment Recommended By Qualified Health Practitioner | 1 | 0.4 |
| Abandoned | 3 | 1.3 |
| Parent Unavailable To Care Or Not Made Adequate Provisions For Care | 11 | 4.6 |
| Living In A Situation Where There Is Violence | 47 | 19.6 |
| Under 12 Yrs/ Inadequate Supervision | 21 | 8.8 |
| Under 12 Yrs/ Killed Or Seriously Injured Person Or Caused Serious Damage to Property | 1 | 0.4 |
| Under 12 Yrs/ More Than Once Injured Or Threatened To Injure Person Or Living Thing And With Parental Encouragement Or Inadequate Parental Response | 0 | 0.0 |
| C/D Open Prior To Current Legislation | 3 | 1.3 |
| **Total Notations** | **240** | **100** |

* Not mutually exclusive. More than 1 reason could be noted per file; thus the 240 notations on 180 files.

## Appendix 4.2.2.7 Record Checks

It could be determined that there was a previous record with CYFS for 108 files or 60% of the total sample of files, as outlined in Table PI.8. Information collected indicated that 76 or 70.4% of these 108 cases, with previous records, had records that pertained to protective intervention and this represents 42.2% of the total sample of 180 cases. Also 13 of the 108 cases with previous records had records that pertained to services other than protective intervention and the type of record in the remaining 19 files could not be determined. Although there is not a designated space to indicate the existence of family of origin files on the initial intake report, reviewers were able to identify 27 cases where CYFS had a family of origin file associated with the family referred.

**Table PI 8: Does CYFS Have A Previous Record Of The Family Referred?**

| Existing Past Records (Any Type)? | Number Of Files | Percentage |
|---|---|---|
| Yes | 108 | 60.0 |
| No | 63 | 35.0 |
| Cannot Determine | 9 | 5.0 |
| **Total** | **180** | **100** |

## *Cases with Previous Protective Intervention Record*

As shown in Table PI.9, 53.9 % of the 76 cases, that were known to have previous protective intervention records, had had 2 or more protective intervention openings.

**Table PI 9: Number Of Previous Protective Intervention Case Openings for Those Cases in the Sample That Had a Previous Protective Intervention Record**

| Number Of Previous Protective Intervention Openings | Number Of Files | Percentage | |
|---|---|---|---|
| 1 Previous Protective Intervention Opening | 35 | 46.1 | |
| 2-3 Previous Protective Intervention Openings | 22 | 28.9 | 53.9% |
| More Than 3 Previous Protective Intervention Openings | 19 | 25.0 | |
| **Total** | **76** | **100** | |

Table PI.10 shows the length of time since CYFS' previous case opening to the protective intervention program for the 76 cases with a previous protective intervention record. There were 23 cases or almost one third, which had been closed less than six months prior to the case opening, which was part of this review. There were 36 cases or 47.4% where the case had been closed for over one year prior to the case opening, which was being reviewed.

**Table PI 10: Length of Time since Previous Protective Intervention Case Opening**

| Time Since Previous Opening | Number Of Files | Percentage | |
|---|---|---|---|
| Less Than 3 Months | 14 | 18.4 | 30.2% |
| 3-6 Months | 9 | 11.8 | |
| 7-12 Months | 11 | 14.5 | |
| Over 1 Year | 36 | 47.4 | |
| Cannot Determine | 2 | 2.6 | |
| Reviewer Did Not Complete Data | 4 | 5.3 | |
| **Total** | **76** | **100** | |

### *Review of Previous CYFS' Records*

As shown in Table PI.11, the reviewers could not determine whether past records were actually reviewed by the social worker in 34.3% of the 108 cases with past records. Where there was evidence on file regarding whether past records were reviewed or not, it was determined that the previous records were reviewed in 61.8% of the cases.

**Table PI 11: Were Past Records Reviewed When They Existed?**

| Past Record Reviewed? | Number Of Files | Percentage | Valid Percentage |
|---|---|---|---|
| Yes | 34 | 31.5 | 61.8 |
| No | 21 | 19.4 | 38.2 |
| **Sub-Total** | **55** | | **100** |
| Cannot Determine | 37 | 34.3 | |
| Not Applicable | 9 | 8.3 | |
| Reviewer Did Not Complete Data | 7 | 6.5 | |
| **Total** | **108** | **100** | |

## Appendix 4.2.2.8 Managerial Consultation and Authorization

### *Referral*

The managers were consulted regarding the decision whether to accept the referral or not in 152 or 84.4% of the 180 cases in the sample. See Table PI.12.

**Table PI 12: Did Managerial Consultation Occur Regarding Whether To Accept The Referral?**

| Did Managerial Consultation Occur? | Number Of Files | Percentage |
|---|---|---|
| Yes | 152 | 84.4 |
| No | 19 | 10.6 |
| Cannot Determine | 8 | 4.4 |
| Not Applicable (1998 Referral) | 1 | 0.6 |
| **Total** | **180** | **100** |

In 115 or 63.9% of the sample, this consultation about whether to accept the referral occurred within 24 hours from the time of referral, as CYFS' procedures require. See Table PI.13 for the timeframes in which the consultation with a manager occurred.

**Table PI 13: Timeframe of Managerial Consultation Regarding Acceptance of the Referral**

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 24 hours | 115 | 63.9 |
| 25 hours- 7 days | 23 | 12.8 |
| 7-14 days | 3 | 1.7 |
| More Than 14 days | 8 | 4.4 |
| Never Occurred | 5 | 2.8 |
| Cannot Determine Time Frame | 17 | 9.4 |
| Not Applicable (1998 Referral) | 3 | 1.7 |
| Reviewer Did Not Complete Data | 6 | 3.3 |
| **Total** | **180** | **100** |

## *Documentation and Disposition of Referral*

In accordance with CYFS' standards, a manager must also authorize the social worker's documentation and the disposition of the referral within 7 days. Table PI.14 shows that in 99 files or 55% of the referrals, the manager authorized the documentation and the disposition of the referral within the required period of 7 days. The existence of a manager's approval could not be determined in 15% of the sample.

**Table PI 14: Timeframe of Managerial Authorization of Social Worker's Documentation and Disposition of Referral**

| Timeframe | Number Of Files | Percentage |
|---|---|---|
| Within 7 days | 99 | 55.0 |
| 8-14 days | 8 | 4.4 |
| 15-30 days | 6 | 3.3 |
| More Than One Month | 16 | 8.9 |
| Never Done | 9 | 5.0 |
| **Sub-Total** | **138** | |
| Cannot Determine Time Frame | 27 | 15.0 |
| Not Applicable (1998 Referral) | 1 | .6 |
| Reviewer Did Not Complete Data | 14 | 7.8 |
| **Total** | **180** | **100** |

From other data collected in the review, it was determined that in 70 files or 38.9 % of the files where the manager authorized the documentation, the social worker wrote that the approval by the manager was given verbally without the manager reviewing the documentation and making the approval in writing.

## Appendix 4.2.2.9 Response Time

Standards require that the child alleged to have been maltreated be seen as soon as possible and no later than 72 hours after the receipt of the report. Table PI.15 indicates the response time to the initial referral for cases in the sample. Approximately one third of the referrals received a response within 12 hours and about three quarters had a response within 3 days (72 hours) of the referral. About 5 % had a response time of over two weeks and 1 % was never followed up at all.

**Table PI 15: Response Time to Referral**

| Timeframe | Number Of Files | Percentage | |
|---|---|---|---|
| 12 Hours Or Less | 62 | 34.4 | 74.4% |
| 13 hours- 3 Days | 72 | 40.0 | |
| 4-7 Days | 22 | 12.2 | |
| 8-14 Days | 7 | 3.9 | |
| Over 2 Weeks | 9 | 5.0 | |
| Not At All | 2 | 1.1 | |
| Cannot Determine | 6 | 3.3 | |
| **Total** | **180** | **100** | |

### *Reviewers' Assessment of Response Times to Referrals*

The case review also collected information about the reviewers' opinions about the response times to the referrals. The reviewers agreed with the response time in 138 cases or slightly over three quarters of the cases but did not agree with the response time in 36 or 20% of the cases. For the remaining 6 cases in the sample, the reviewers could not make an assessment based on the information available.

The reviewers did not support the response time in all of the 18 cases where the response to the referral was longer than a week or did not occur at all. Also, they did not support the response time in 4 of the 72 cases that had a response time between 13 hours to 3 days and in 14 of the 22 cases that had a response time of 4-7 days.

In two thirds of the cases where the reviewers did not agree with the response time, the reasons documented included the vulnerability of the child due to age or developmental issues (16 cases), the nature of the injury to the child (3 cases), the child's proximity to the abuser (4 cases) and inadequate supervision of the child pending investigation (1 case). Reasons listed for the other third of the cases where the reviewer did not agree with the response time related to such reasons as excessive delay, outside standards of practice, and no response to the referral.

# Appendix 4.2.2.10 Assessment and Investigative Interviews

## *Interviews Conducted*

Any report of maltreatment of a child needs to be completed as thoroughly and as objectively as possible. The following Table PI.16 outlines the number of cases where various people were interviewed as part of the assessment and investigation into the referral or report that a child was in need of protective intervention. Some of the people might not need to be interviewed in particular cases depending on the seriousness of the report and the range of the information they might provide; therefore, reviewers noted when someone would not be applicable for an interview in a case.

**Table PI 16: Interviews as Part of the Assessment and Investigation Process**

| Persons Interviewed | Yes # Files | No # Files | Cannot Determine # Files | Not Applicable # Files | Total # Files |
|---|---|---|---|---|---|
| Referral Source | 82 | 71 | 13 | 14 | 180 |
| Victim/Child | 115 | 28 | 6 | 31 | 180 |
| Siblings | 64 | 40 | 6 | 70 | 180 |
| Mother | 155 | 16 | 7 | 2 | 180 |
| Father | 81 | 68 | 14 | 17 | 180 |
| Other Parental Figure/s | 24 | 56 | 9 | 91 | 180 |
| Witnesses | 10 | 68 | 12 | 90 | 180 |
| Relatives | 38 | 64 | 10 | 68 | 180 |
| Other Caregivers | 13 | 54 | 11 | 102 | 180 |
| Professionals Involved | 61 | 56 | 11 | 52 | 180 |
| Other Jurisdictions Involved | 4 | 49 | 9 | 118 | 180 |
| Other (Police, Former Foster Parent, Family Friend, Resident In Home, Collateral Reference Etc.) | 6 | 44 | 7 | 123 | 180 |

From the data, it appears that interviews with the mother of the child/ren were occurring fairly regularly or in 87.1% of the applicable cases (in 155 of 178 cases) but fathers were being excluded in 41.7% of the applicable cases (in 68 of 163 cases). The child victim or subject of the report was interviewed in 115 or 77.2% of the 149 cases where such was deemed to be appropriate by the reviewer. It is also apparent that in 40 or 36.4% of the 110 cases involving siblings, siblings were not interviewed.

In the 115 cases where the child/ren was interviewed during the investigation, the reviewer could determine in 101 of these cases some information about the structure of the interview with the child/ren. In 91 or 90.1% of these 101 cases, the interviews with children were conducted with some independence from the parents

In about half of the cases where other professionals or service providers were involved, these individuals were being contacted as part of the investigation; however, there were an almost equal number of cases where their input was not sought. The data would also

suggest that third party information could be sought more frequently from other involved witnesses, other parental or caregiver figures and relatives to more thoroughly determine the credibility of the reported concern for a child. When applicable to a case, 69.2% of other caregivers, 77% of witnesses, and 57.1% of relatives were not being interviewed as part of the investigation.

## *Omitting To Interview an Important Person*

In the course of data collection, the reviewers identified 62 cases or 34.4% of the sample of 180 cases where one or more important persons were not interviewed but should have been, as part of the assessment and investigation process. When considering these 62 cases, there were, on average, two people that should have been interviewed per case but were not.

Table PI.17 identifies the number of cases where the reviewers thought that a particular person should have been interviewed as part of the assessment and investigation of the referral but the person was not contacted. It is valuable to note that in 13.3% of the sample, it was determined that the father was not interviewed but should have been. Also in a significant number of cases, the reviewers thought that an interview with the child and communication with other involved professionals should have occurred.

**Table PI 17: Persons That Should Have Been Interviewed As Part of Assessment and Investigation but Were Not Interviewed**

| Person | Number Of Files | Percentage Of The Sample Of 180 Cases |
|---|---|---|
| Referral Source | 12 | 6.7 |
| Victim/Child | 16 | 8.9 |
| Siblings | 14 | 7.8 |
| Mother | 6 | 3.3 |
| Father | 24 | 13.3 |
| Other Parental Figure/s | 7 | 3.8 |
| Witnesses | 6 | 3.3 |
| Relatives | 14 | 7.8 |
| Other Caregivers | 3 | 1.7 |
| Professionals Involved | 16 | 8.9 |
| Other Jurisdictions Involved | 1 | 0.6 |

## *Cancelled Interviews*

There were only 5 cases where a parent or the worker missed or cancelled an arranged interview during the assessment and investigation stage. In all cases, another interview was set up by the social worker. In 4 of the 5 cases, the social worker re-scheduled the interview within two days and in the fifth case, it was re-scheduled at a time longer than a week.

## *Clinical Observations*

It is part of the investigative process to visit the family's home and make observations of the home environment relevant to the nature of the referral (adequacy of food, safety,

cleanliness, existence of hazards for children etc). If a child has been injured, it is imperative to observe the injury to the child as well as the location and physical situation where the injury occurred. As well, observations of the interaction between the parent and children provide vital information in assessing the quality of parenting or care giving being provided to the children and the priority given by a parent to the children's needs. Some attention is being given to these kinds of observations as part of the collection of information for assessment but not on a consistent basis. In cases where the reviewer could determine that an injury to a child occurred, the social worker documented observations of the injury in half of the cases and in more than half of the cases did not explore the location or situation where the injury occurred. Information about the home's physical environment was collected and parent- child interaction observed less than half of the time. The data is shown in Table PI.18.

**Table PI 18: Observations as Part of Assessment and Investigation**

| Observations | Yes | | No | | Cannot Determine | | Not Applicable | | Data Missing | | Total Files | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| Home Environment | 54 | 30.0 | 82 | 45.6 | 36 | 20.0 | 3 | 1.7 | 5 | 2.8 | 180 | 100 |
| Injury | 14 | 7.8 | 14 | 7.8 | 20 | 11.1 | 126 | 70.0 | 6 | 3.3 | 180 | 100 |
| Location And Situation Were Injury Or Harm Occurred | 17 | 9.4 | 22 | 12.2 | 19 | 10.6 | 116 | 64.4 | 6 | 3.3 | 180 | 100 |
| Care Giving And Parenting | 58 | 32.2 | 79 | 43.9 | 29 | 16.1 | 9 | 5.0 | 5 | 2.8 | 180 | 100 |

## Appendix 4.2.2.11 Medical Examination as Part of the Investigation

In 5% of the cases, a medical examination formed part of the investigative process. Only in 5 or 6.1% of the 82 cases where a medical did not occur, did a reviewer think that a medical opinion could have assisted in the investigation.

## Appendix 4.2.2.12 Police Involvement

As shown in Table PI.19, there were 33 cases where Child, Youth and Family Services (CYFS) staff made referrals to the police and 43 cases where the police made referrals to CYFS. In the 59 cases where a referral was not made to the police by CYFS, 7 cases or 11.9% were identified where the reviewer thought a referral should have been made to the police.

A joint police and CYFS investigation occurred in 19 or 25% of the 76 cases when a referral occurred between CYFS and police. In 6 of these 19 cases the police referred to CYFS and in the other 13 cases CYFS, referred to the police.

### Table PI 19: Referrals between Police and CYFS

| Referral | Number Of Files | Percentage |
|---|---|---|
| Yes, CYFS Made A Referral To Police | 33 | 18.3 |
| No, CYFS Did Not Make A Referral To Police | 59 | 32.8 |
| Police Made Referral To CYFS* | 43 | 23.9 |
| Cannot Determine | 5 | 2.8 |
| Not Applicable | 40 | 22.2 |

* 39 of the 43 referrals made by the police pertained to an initial referral and 4 referrals occurred at different points in a case

## Appendix 4.2.2.13 Identification of Additional Child Protection Concerns While Open For Assessment and Investigation

There were 15 or 8.3% of the sample where additional protection concerns were identified by the worker or referred by others while the case was open for assessment and investigation into the initial referral.

There were 2 of the 15 cases where the reviewer did not provide information about the new child protection concern. Among the remaining 13 cases, there were 20 reasons identified for protective intervention. Physical harm or risk of physical harm to the child and living in a situation of family violence were the most frequently identified concerns.

## Appendix 4.2.2.14 Safety Assessment

### *Completion of Safety Assessment Tool*

A safety assessment was completed in 73.3 % of the investigations or in 132 files as shown in Table PI.20. In over one quarter of the investigations, a safety assessment was not done.

In all but 1 case, the child identified on the referral was included in the safety assessment. There were 6 or 4.5% of the 132 files where all children under 16 years were not included in the completed safety assessment.

### Table PI 20: Completion of Safety Assessment

| Safety Assessment | Number Of Files | Percentage |
|---|---|---|
| Completed | 132 | 73.3 |
| Not Completed | 47 | 26.1 |
| Not Applicable (Children Already In Care) | 1 | 0.6 |
| **Total** | **180** | **100** |

### *Timeframe for Completion of Safety Assessment*

Where the safety assessment was completed, it was done within the required timeframe (24 hours of the child/ren being seen) in 80 cases or 60.6 % of the time as shown in Table

PI.21. Compliance with this CYFS' standard for the entire sample of 180 cases overall is 44.4%.

**Table PI 21: Was the Safety Assessment Completed Within 24 Hours of Child/ren Being Seen?**

| Completed Within 24 Hours? | Number Of Files | Percentage |
|---|---|---|
| Yes | 80 | 60.6 |
| No | 48 | 36.4 |
| Cannot Determine | 4 | 3.0 |
| **Total** | **132** | **100** |

## *Information Included In Safety Assessment*

Past history and former record information when existing and applicable, was included in completed safety assessments 49% of the time. The current and presenting situation was outlined in 88% of the completed safety assessments. In 118 or 89% of the 132 cases where a safety assessment was done, the safety assessment was congruent with the information received or collected.

Where information could be sought from third parties to form an assessment of safety, this was done 39% of the time in those cases with completed safety assessments as shown in Table PI.22.

**Table PI 22: Did The Safety Assessment Include Information From Third Parties?**

| Information From Third Parties? | Number Of Files | Percentage |
|---|---|---|
| Yes | 45 | 38.5 |
| No | 72 | 61.5 |
| **Sub-Total** | **117** | **100** |
| Cannot Determine | 4 | |
| Not Applicable | 11 | |
| **Total** | **132** | |

## *Safety Plan*

If a child is deemed safe while the investigation is undertaken, a safety plan is not required. Of the 132 files where a safety assessment was done, there were 58 files where a safety plan was required and reviewers found that a plan for the child's safety was developed in 51 or 88 % of these cases.

## Appendix 4.2.2.15 Verification Decision Regarding Child Protection Allegations /Concerns

A documented decision regarding the validity of the child protection report was apparent in 121 of the 180 cases in the sample or 67.2 % of the cases.

In the 121 files where the verification decision was documented, the verification decision was congruent with the information collected or reported in 109 or 90.1% of the cases and the written documentation of the verification decision adequately explained the rationale for the decision in 89 or 73.6 % of the cases.

### *Timeframe of Verification Decision*

According to CYFS' standards, the social worker must determine if the allegations in the child protection report are verified within 30 days after the report is received. As shown in Table PI.23, the worker made a decision about the validity of the child protection concern or allegation within 30 days of the referral in 82 cases. This represents 67.8 % of the cases where documentation was completed or 45.6% of the overall sample of 180 cases. In 13.2% of the cases where documentation was completed, the verification decision was made and documented after 3 months.

**Table PI 23: Timeframe for Completion of Verification Process**

| Time Frame | Number Of Files | Percentage |
|---|---|---|
| Within 30 Days | 82 | 67.8 |
| 31-60 Days | 9 | 7.4 |
| 2-3 Months | 5 | 4.1 |
| Over 3 Months | 16 | 13.2 |
| Cannot Determine | 5 | 4.1 |
| Reviewer Did Not Complete Data | 4 | 3.3 |
| **Total** | **121** | **100** |

### *Managerial Approval of Verification Decision*

Approval of the verification decision by the manager could be found in 79 or 65.3% of the 121 cases where the worker completed and documented the verification process. This represents 43.9% of the overall sample of 180 cases. The manager's approval of the verification decision occurred within 30 days of referral in 50 cases, in 31-60 days in 8 cases, in 2-3 months in 3 cases and over three months' time in 18 cases.

## Appendix 4.2.2.16 Documentation of the Decision Whether A Child Requires Protective Intervention Following the Investigation

Within 30 days after the child protection report is received, CFYS standards require the social worker to determine if continued protective intervention is required. The supervisor must approve the documented decision.

In 114 or 63.3% of the 180 cases, the case record showed that a decision had been made and documented regarding the child/ren's need for protection following the completion of the assessment and investigation. See Table PI.24.

### Table PI 24: Was a Decision Made and Documented Regarding the Child/ren's Need for Protective Intervention?

| Decision Made? | Number Of Files | Percentage |
|---|---|---|
| Yes | 114 | 63.3 |
| No | 54 | 30.0 |
| Cannot Determine | 12 | 6.7 |
| **Total** | **180** | **100** |

The completion of this documentation within 30 days occurred in 72 cases or 40% of the overall sample of 180 cases. The supervisor's approval of this documentation occurred in 85 cases or 47.2% of the sample.

In the 114 cases where the decision regarding the child/ren's need for protective intervention was documented:

- The decision reflected the information collected by and reported to CYFS in 106 or 93% of the cases.
- The decision was documented within 30 days in 72 or almost two thirds of the cases.
- A manager approved the decision in 85 or three quarters of the cases.

## Appendix 4.2.2.17 Closure Following Assessment and Investigation

There were 56 cases or 31.1% of the sample of protective intervention cases closed after the assessment and investigation of the referral was completed.

Table PI.25 shows the reasons for these case closures. In half of the cases that closed following investigation, the child protection concerns were not substantiated. Child protection concerns were confirmed in about one third of the closed cases and the child protection concerns were addressed prior to closure.

### Table PI 25: Reason for Case Closure Following Assessment and Investigation

| Reason | Number Of Files | Percentage |
|---|---|---|
| Protection Concerns Not Substantiated | 28 | 50.0 |
| Protection Concerns Substantiated But Addressed Prior To Closure | 19 | 33.9 |
| Referral To Another Child Welfare Authority On Closing | 2 | 3.6 |
| Transferred To Family Services (S10) | | |
| Other<br>Child Turned 16<br>Family Declined Services And Services Promised Were Not Provided<br>Undetermined | 3<br>(1)<br>(1)<br>(1) | 5.4 |
| Reviewer Did Not Complete Data | 1 | 1.8 |
| **Total** | **56** | **100** |

The reviewer determined that contact with the referral source would be appropriate upon closure in 39 of the 56 closures; however, the referral source was contacted in 12 or about one third of these 39 identified cases. There were 51 of the 56 cases where it could be determined if discussion occurred with the family about the closure of the case and it appeared that families were consulted in 37 or almost three quarters of the cases. Upon closure of the investigation, contact with other service providers to the family was thought by the reviewers to be appropriate in 37 of the 56 cases; however, community service providers were contacted about the case plan for closure in 11 of the 37 identified cases or about 30% of the time.

### *Manager Consultation Regarding Closure*

Managers were consulted in 50 of these 56 closures or 89 % of the time about case closure following assessment and investigation as required by CYFS' standards. The data collected would suggest that case closure decisions are processed more consistently through managers than referral eligibility, intake documentation, safety plans, and verification decisions pertaining to child protection reports.

## Appendix 4.2.2.18 Number of Assigned Workers during the Initial Investigative Period

To the extent that the number of assigned social workers could be determined, 69.4% of the sample had only 1 worker assigned during the investigative stage; however, 49 cases or 27.2% had a change of worker during the process, which can potentially compromise an investigation. It is concerning that at least 13 cases had 3 or more workers involved in the completion of the investigation into the referral.

**Table PI 26: Number of Workers Assigned During Assessment and Investigation Period**

| Number Of Workers | Number Of Files | Percentage |
|---|---|---|
| 1 | 125 | 69.4 |
| 2 | 36 | 20.0 |
| 3 | 8 | 4.4 |
| 4 | 3 | 1.7 |
| 5 | 2 | 1.1 |
| 6 or more | 0 | 0.0 |
| **Sub-Total** | **174** | |
| Cannot Determine | 5 | 2.8 |
| Reviewer Did Not Complete Data | 1 | 0.6 |
| **Total** | **180** | **100** |

## Appendix 4.2.2.19 Case Disposition Following Assessment and Investigation

As indicated previously, 56 cases, or 31.1% of the sample of 180 protective intervention cases, closed following the investigation of the referral. This left 124 cases in the sample that did not close following assessment and investigation as shown in Table PI.27.

**Table PI 27: Did The Case Close Following Assessment And Investigation?**

| Closed? | Number Of Files | Percentage |
|---|---|---|
| Yes | 56 | 31.1 |
| No | 124 | 68.9 |
| **Total** | **180** | **100** |

There were only 115 cases or 63.9 % of the sample of 180 cases where there was evidence of protective intervention services following the investigation and where reviewers were able to document ongoing case activity. There remained 9 cases or 5% of the sample where the cases were never closed following the investigative phase but they also did not appear to receive any further child protective intervention services. In these latter 9 cases, the investigative process was never brought to a clear conclusion and no long-term protective intervention services were provided.

Some information about these 9 cases is provided below in Table PI.28. Seven of the 9 cases had been open for more than 1 year.

**Table PI 28: Length of Time Cases, That Were Not Closed Following Investigation and Did Not Receive Long-Term Protective Intervention, Were Open**

| Length Of Time Open | Number Of Files | Percentage |
|---|---|---|
| 3-6 Months | 1 | 11.1 |
| 7-11 Months | 1 | 11.1 |
| 1-2 Years | 2 | 22.2 |
| More Than Two Years<br>Opened 2006<br>Opened 2004<br>Opened 2003<br>Opened 1996 | 5<br>(2)<br>(1)<br>(1)<br>(1) | 55.6 |
| **Total** | **9** | **100** |

# PART B: CONTINUED PROVISION OF CHILD PROTECTIVE INTERVENTION FOLLOWING COMPLETION OF ASSESSMENT AND INVESTIGATION

This section pertains to 115 cases where further protective intervention services were provided following assessment and investigation.

## Appendix 4.2.2.20 Reason for Long-Term Protective Intervention

The reasons for keeping the file open for protective intervention services following investigation showed a similar trend to the initial reasons for referral. More than one legislative reason (according to the definition of a child who needs protective intervention under the CYFS Act) could pertain to a file; in fact, an average 1.3 reasons were cited per case. From the review of the 115 cases receiving long-term protective intervention services, the five most frequent reasons for a case to stay open were:

- Physical harm or risk of physical harm by parental action or lack of action (Cited in 49 cases or 42.6% of the sample)
- Living in a situation where there is violence (Cited in 32 cases or 27.8% of the sample)
- Emotionally harmed by the parent's conduct (Cited in 30 cases or 26.1% of the sample)
- Child is under 12 years of age and has been left without adequate supervision (Cited in 14 cases or 12.2% of the sample)
- Parent is unavailable to provide care or did not make adequate provisions for care (Cited in 8 cases or 12.2 % of the sample)

## Appendix 4.2.2.21 Case Transfer

Not all regions have a model of service where cases, that require long-term protective intervention services, are transferred to a different worker after the completion of the assessment and investigation of the child protection report. The reviewers were able to determine that a case transfer to another worker occurred following the conclusion of the investigation in 35 or 30.4% of the 115 cases that remained open for long-term protective intervention. In over half of the cases where a transfer occurred, the transfer between workers took over 1 month to transpire.

**Table PI.29: Time between Decision to Keep Case Open and the Transfer**

| Time Period | Number Of Files | Percentage |
|---|---|---|
| 1 Week | 8 | 22.9 |
| 8-30 Days | 8 | 22.9 |
| More Than One Month | 18 | 51.4 |
| Cannot Determine | 1 | 2.9 |
| **Total** | **35** | **100** |

## Appendix 4.2.2.22 Risk Assessment

### *Completion of Initial Risk Assessment*

Once there was a decision made for a case to remain open for long-term child protective intervention, an initial risk assessment was completed on the prescribed format in 30 or 26.1% of the cases- about one quarter of the 115 cases. Also as shown in Table PI.30, the completion of the risk assessment instrument was not applicable for at least 5 cases as the tool was not in use at the time that the decision was made to provide long-term child protective intervention services.

### Table PI 30: Was An Initial Risk Assessment Completed?

| Completed? | Number Of Files | Percentage |
|---|---|---|
| Yes | 30 | 26.1 |
| No | 78 | 67.8 |
| **Sub-Total** | **108** | |
| Cannot Determine | 2 | 1.7 |
| Not Applicable | 5 | 4.3 |
| **Total** | **115** | **100** |

## *Timeframe for Completion of Initial Risk Assessment*

According to CYFS' standards, an initial risk assessment is to be completed within 30 days of receiving a child protection report if the investigation determines that a child needs continued child protective intervention. In half of the cases where a risk assessment was completed, the assessment was done within 30 days of the referral as required. Thus requirements were met in 15 of 115 cases or 13% of the overall sample.

### Table PI 31: Time Frame for Completion of Initial Risk Assessment

| Time Frame | Number Of Files | Percentage |
|---|---|---|
| Within 30 Days | 15 | 50.0 |
| 31- 60 Days | 1 | 3.3 |
| 2-3 Months | 5 | 16.7 |
| More Than 3 Months | 8 | 26.7 |
| Cannot Determine | 1 | 3.3 |
| **Total** | **30** | **100** |

## *Information Pertaining To Initial Risk Assessments*

In the 30 cases where the initial risk assessment was completed, the assessment was found to be consistent with the information collected and reported in 28 or 93.3% of the cases. It was difficult for reviewers to determine from the files whether the risk assessment was discussed with the family; however, in 12 of the 30 cases where the initial risk assessment was completed, there was information to confirm that the assessment was discussed with the family.

## *Review of Risk Assessments*

Generally, the development of the initial or subsequent risk assessments, the review of risk assessments at critical points in a case and the updating of existing assessments every three months are not occurring except in a small proportion of cases. There were 10 cases or 16.1% the 62 cases with subsequent child maltreatment reports, where the risk assessment was reviewed when a new child protection report was received. There was only 1 case in the sample of 115 cases where the risk assessment was updated regularly and approximately every three months.

There were 23 cases or 20% of the 115 long-term protective intervention cases where there was evidence of a manager approving a risk assessment irrespective of whether the risk assessment was the initial or a subsequent assessment.

## Appendix 4.2.2.23 Service Planning

Case plans are intended to outline the goals of the services to be provided, the tasks involved; individual responsible for particular tasks, timelines, and expected outcomes. The review of plans is to evaluate progress and readjust services as required. Participation of involved parties in the development of the plans is important to identify strategies that will increase safety and well-being for the child, build on client strengths and achieve commitment to plans. This review has shown that very little formal planning of the intervention is occurring which suggests that long-term child protective intervention services may be fairly reactive.

### *Completion of the Initial Family Centered Action Plan*

Service planning for a case must be completed on the Family Centered Action Plan form. The initial Family Centered Action Plan was completed in 11 cases or 9.6 % of the sample of 115 cases as shown in Table PI.32.

**Table PI 32: Was An Initial Family Centered Action Plan Developed?**

| Developed? | Number Of Files | Percentage |
|---|---|---|
| Yes | 11 | 9.6 |
| No | 100 | 87.0 |
| Cannot Determine | 3 | 2.6 |
| Not Applicable | 1 | 0.9 |
| **Total** | **115** | **100** |

### *Timeframe for Completion of the Initial Family Centered Action Plan and Family Involvement in Planning*

According to CYFS' standards, an initial family centered action plan must be completed within 30 days of receiving the child protection report if the case is to remain open. Compliance with this standard for the sample of 115 cases was 4.4%. In 5 of the 11 cases where an initial action plan was developed, the plan was done within 30 days of the referral. In 7 of the cases, the children were seen at the time of developing the plan. Where initial family centered action plans were developed as shown in Table PI.33, the action plans were developed with the family and reflected the family's input in almost half of the cases whereas in the remaining cases, the plan was developed independent of the family or discussed with the family after the plan was drafted by the worker.

**Table PI 33: Involvement of Family in Initial Action Plan**

| Level Of Involvement | Number Of Files | Percentage Of The 11 Files With Plans |
|---|---|---|
| Plan Developed Independent Of Family | 1 | 9.1 |
| Plan Discussed With Family After Drafted | 3 | 27.3 |
| Drafted With Client And Reflects Input | 5 | 45.5 |
| Cannot Determine | 2 | 18.2 |
| **Total** | **11** | **100** |

### *Individual Support Service Plan*

An Individual Support Service Plan is to be developed for a child where the child influence section of the risk assessment tool identifies a risk factor requiring intervention on an ongoing basis. In only one case was an Individual Support Service Plan developed for a child to address identified risk factors under "Child Influence" in the risk assessment tool.

### *Content and Review of Family Centered Action Plans*

CYFS' standards require that a family centered action plan be reviewed at least every 90 days. There were no cases where action plans were reviewed every three months. There were 4 cases where planning was reviewed within a period of 6-12months and 4 cases where the review of the plan occurred in a period greater than 1 year. So few plans were completed that to draw any conclusions from the data about the services provided, assignment of responsibility for tasks, time frames for completion of tasks, outcome of plans, review of plans with parties, and the involvement of managers in reviewing plans is of limited value.

## Appendix 4.2.2.24 Frequency and Nature of the Social Worker's Direct Face-To Face Contact

The social worker's relationship and contacts with family members is the basis for setting and evaluating goals and is the conduit for strengthening family members to improve functioning and make needed changes.

### *Worker Face-To-Face Contact in Last Year of Service*

As shown in Table PI.34, there were 12.2% of the families in the long-term protective intervention sample of 115 cases that were receiving an interview at least once a month; however, 75.6% that were receiving personal contact quarterly or less. There is no CYFS' standard with respect to frequency of direct contacts with clients.

### Table PI 34: Face-To-Face Contact with Family on Average in Last Year of Service

| Frequency Of Contact | Number Of Files | Percentage | |
|---|---|---|---|
| 2 Or More Contacts Per Month | 4 | 3.5 | 12.2% |
| 1 Contact Per Month | 10 | 8.7 | |
| Less Than One Contact A Month But At Least Bi-Monthly | 10 | 8.7 | |
| Quarterly Or Less | 84 | 73.0 | 75.6% |
| No Contact | 3 | 2.6 | |
| Reviewer Cannot Determine Contact | 4 | 3.5 | |
| **Total** | **115** | **100.0** | |

Similarly and as presented in Table PI.35, 12.2% of the children in long-term protective intervention cases were receiving an interview at least once a month and 78.3% were receiving personal contact quarterly or less. . There is no CYFS' standard with respect to frequency of direct contacts with children.

### Table PI 35: Face-To-Face Contact with Child on Average in Last Year of Service

| Frequency Of Contact | Number Of Files | Percentage | |
|---|---|---|---|
| 2 Or More Contacts Per Month | 3 | 2.6 | 12.2% |
| 1 Contact Per Month | 11 | 9.6 | |
| Less Than One Contact A Month But At Least Bi-Monthly | 5 | 4.3 | |
| Quarterly Or Less | 87 | 75.7 | 78.3% |
| No Contact | 3 | 2.6 | |
| Reviewer Cannot Determine Contact | 6 | 5.2 | |
| **Total** | **115** | **100.0** | |

As part of the data collection, reviewers were also asked to determine if children were interviewed privately at least every three months. The reviewers identified 15 cases where children were interviewed privately on a quarterly basis.

## *Worker Face-To-Face Contact with a Family Member in Last Three Months of Service*

As shown in Table PI.36, there were 80 files or over two thirds of the cases where the worker had not had face-to-face contact with a family member in the last three months of service.

**Table PI 36: Face- To- Face Contact with a Family Member in the Last Three Months of the Case Being Open**

| Contact In Last Three Months? | Number Of Files | Percentage |
|---|---|---|
| Yes | 33 | 28.7 |
| No | 80 | 69.6 |
| Reviewer Cannot Determine Contact | 1 | 0.9 |
| Not Applicable | 1 | 0.9 |
| **Total** | **115** | **100.0** |

In 24 or 30% of the 80 cases that had not had contact in the last three months of service, the reviewers indicated that the lack of contact was related to delays in case closure as shown in Table PI.37.

**Table PI 37: Lack of Contact in the Last Three Months and Delay in Case Closure**

| Is Lack Of Contact Related To Delay In Case Closure? | Number Of Files | Percentage |
|---|---|---|
| Yes | 24 | 30.0 |
| No | 42 | 52.5 |
| Reviewer Cannot Determine Contact | 10 | 12.5 |
| Reviewer Did Not complete Data | 4 | 5.0 |
| **Total** | **80** | **100.0** |

## *Observing Children Under 5 Years of Age with A Parent In Their Home Environment*

In cases where it was determined that there was a child under the age of 5 years, it was evident that approximately half of these children were being observed with their parents during contacts. See Table PI.38.

**Table PI 38: Are Children Under 5 Years Being Observed In Their Home Environment With The Parent?**

| Observed With Parent? | Number Of Files | Percentage |
|---|---|---|
| Yes | 21 | 48.8 |
| No | 22 | 51.2 |
| **Sub-Total** | **43** | **100.0** |
| Reviewer Cannot Determine Contact | 11 | |
| Not Applicable | 60 | |
| Reviewer Did Not complete Data | 1 | |
| **Total** | **115** | |

## *Nature of Social Worker's Contact*

Reviewers were asked to determine the nature of the social worker's contact and intervention with the family. As outlined in Table PI.39, the contact in 67% of the cases was found to have little or no direct service with the expectation that the family take action

under some direction from the worker. Reviewers' comments in some cases indicated that there was a very low level of monitoring by the social worker. In 27% of the cases, the worker was perceived to be providing case management through such activities as providing information, making referrals, coordinating services and monitoring the family situation. As evidenced by an active counselling role, providing concrete help and case managing, 3.5% of the cases were seen to be receiving clinical intervention from the worker. In the 4 cases where a clinical intervention was being provided to the family, 2 cases involved work with the parents and child together and 2 involved work primarily with the parents.

**Table PI 39: Intervention Provided By Social Worker**

| Type Of Intervention | Number Of Files | Percentage |
|---|---|---|
| Monitoring: Little or no direct service. Family expected to take action under direction of worker | 77 | 67.0 |
| Case Management: Provides information, referrals, coordinates services and monitors family situation | 31 | 27.0 |
| Clinical Intervention: Assumes active counselling role, advocates for services, provides concrete help and case manages. | 4 | 3.5 |
| Reviewer Cannot Determine Nature Of Contact | 3 | 2.6 |
| **Total** | **115** | **100.0** |

## Appendix 4.2.2.25 Number Of Assigned Social Workers in the Last Year That the Case Was Open

There was 1 assigned social worker in the past year for 56.5% of the cases; however, 13.9% had 3 or more workers. Frequent turnover of workers can compromise case progress.

**Table PI 40: Number of Assigned Workers in the Last Year of the Case Being Open**

| Number Of Workers | Number Of Files | Percentage |
|---|---|---|
| 1 | 65 | 56.5 |
| 2 | 32 | 27.8 |
| 3 | 9 | 7.8 |
| 4 | 5 | 4.3 |
| 5 | 1 | 0.9 |
| 6 or more | 1 | 0.9 |
| Cannot Determine | 2 | 1.7 |
| **Total** | **115** | **100.0** |

### *Case Transfers When Worker Change Occurs*

There were 3 cases identified where there was a case conference or discussion between the departing worker and the newly assigned worker. There were 2 cases identified where these two workers had a joint meeting with the family. Evidence of notifying other service providers of a change in the assigned worker was evidenced in 1 case. Of the 48 cases

where a change of worker occurred, there was information on file to confirm that the family was notified of the change of worker in 15 or 31.3% of these cases.

### Appendix 4.2.2.26 Assigned Community Support Worker

The reviewers identified five cases having an assigned community service worker. For 2 cases, the direct contact with the family was two or more times per month and for 1 case the contact was quarterly or less. Contact in the other 2 cases could not be determined.

### Appendix 4.2.2.27 Family Support Services

There were 9 of the 115 cases or 7.8% receiving family support services. Contracts were in place and tasks outlined in 4 of the cases or almost one half of the cases. The goals of family support were met fully in 1 case and partially met in 2 cases. Goals of family support were not being met in the majority of cases but the reasons were not collected in this study. Communication did not appear to be happening on a regular basis between the social worker and the family support worker as shown in Table PI.41 and this may relate to case progress to some degree.

**Table PI 41: Frequency of Communication Between Social Worker and Family Support Worker**

| Frequency Of Communication | Number Of Files | Percentage |
|---|---|---|
| At least Monthly | 3 | 33.3 |
| At Least Quarterly | 2 | 22.2 |
| Little Evidence Of Communication | 4 | 44.4 |
| **Total** | **9** | **100.0** |

### Appendix 4.2.2.28 Court Involvement

There were 5 cases or 4.3% of the long-term protection intervention cases that clearly had court involvement under the Child, Youth and Family Services Act in the last year. No cases received an order under CYFS Act s 34(2) for the child to reside with the parent under the supervision of the Director with or without terms under CYFS Act s 34(3). There were 8 cases or 7% of the 115 families in the sample who had children in the care and custody of the Director and in 2 cases or one quarter of these 8 files, the children were placed with relatives or neighbours.

### Appendix 4.2.2.29 Conferences and Communication with Other Service Providers

In almost a quarter of the files, the reviewers documented that there was some communication or conference with other service providers in the case. Family members participated in about two thirds of the cases where reviewers could determine that conferences occurred.

## Appendix 4.2.2.30 New Child Protection Report/ Referral on an Active Long-Term Protective Intervention Case

There were 62 files or 53.9% of the cases where further child protection reports were received while the case was open for protective intervention services.

### Table PI 42: Referrals on Active Long-term Protective Intervention Cases

| New Referral/s Received? | Number Of Files | Percentage |
|---|---|---|
| Yes | 62 | 53.9 |
| No | 48 | 41.7 |
| Reviewer Cannot Determine | 4 | 3.5 |
| Reviewer Did Not Complete Data | 1 | 0.9 |
| **Total** | **115** | **100.0** |

Table PI.43 indicates that in 77.4% of the cases with subsequent child protection reports, the referral or information was either not followed up or not investigated thoroughly to a conclusion.

### Table PI.43: Quality of Investigation of Referrals on Active Long-term Protective Intervention Cases

| Quality Of Investigations | Number Of Files | Percentage | |
|---|---|---|---|
| Investigative Steps Initiated, Review Of Risks, Decisions Regarding Verification, Adjustments In Action Plan | 12 | 19.4 | |
| Documentation, Some Collection Of Information, Child Safety Assessed But Investigation Not Brought To A Full Conclusion | 32 | 51.6 | 77.4% |
| Documentation Of Concern But Required Investigative Follow-Up Did Not Occur | 16 | 25.8 | |
| Reviewer Did Not Complete Data | 2 | 3.2 | |
| **Total** | **62** | **100.0** | |

## Appendix 4.2.2.31 Manager Approvals and Supervisory Consultation

Overall the involvement of the manager was evident in 87 or 75.7% of the long-term protective intervention cases. For 72.4% of the files where supervisory involvement was apparent, signatures on records was the most frequent notation. Consultation notes and worker's case notes were the other sources of information about supervisory involvement.

### Table PI 44: How Supervisory Input Was Documented

| Evidence Of Supervisory Input | Number Of Files | | Percentage Of The 87 Cases Where There was Evidence Of Supervisory Input |
|---|---|---|---|
| Conference Notes | Yes | 8 | 9.2 |
| Consultation Notes | Yes | 39 | 44.8 |
| Meeting With Clients | Yes | 1 | 1.0 |
| Signature Sign Offs On Records | Yes | 63 | 72.4 |
| Other<br>Worker's Case Notes<br>Verbal Final Approvals | Yes | 13<br>(12)<br>(1) | 15.9 |

## Appendix 4.2.2.32 Case Closure

Of the 115 long-term protective intervention files, 20 cases or 17.4 % were closed. A manager approved 85% of these closed cases as required by CYFS' standards. The review of risk assessments or family action plans is not occurring prior to case closure primarily as their use is not integrated into social work practices. There was very little evidence of seeing children and discussing plans prior to closure or informing other service providers of closure plans.

### Table PI 45: Occurrence of Closure Activities

| Closure Activity | Number Of Files | | Percentage Of The 20 Closed Cases |
|---|---|---|---|
| The Risk Assessment Reviewed Within 30 Days Of Closure? | Yes | 3 | 15.0 |
| Family Centred Action Plan Reviewed Within 30 Days Of Closure? | Yes | 0 | 0.0 |
| Children Seen Prior To Closure? | Yes | 4 | 20.0 |
| Closure Discussed With Family? | Yes | 8 | 40.0 |
| Closure Discussed With Child/ren? | Yes | 0 | 0.0 |
| Other Service Providers Advised Of Closure? | Yes | 1 | 5.0 |
| Closure Approved By Manager? | Yes | 17 | 85.0 |
| Family Referred To Other Services:<br>Child Care (1); Family services (1);<br>Respite For Developmentally Delayed (1) | Yes | 3 | 15.0 |

## Appendix 4.2.2.33 Summary

- About 36% of the protective intervention cases involve only assessment and investigation.
- Over half of the referrals are from professional sources such as police educators, health practitioners and other professionals.
- Physical abuse, emotional abuse, family violence and inadequate supervision are the most frequent reasons for service.
- Referral information is being documented consistently. The Child Protection Report is completed within 24 hours as required in about two thirds of the cases.
- Managers are consulted regarding acceptance of the referral in at least 4 of every 5 cases and this consultation occurs within the 24-hour requirement for about two thirds of the cases.
- Record checks on new referrals are being completed. About 60% of referred families have a previous record with CYFS.
- Reviewers agreed with the response times to referrals in slightly over three quarters of the cases. Three quarters of the cases are responded to within three-days as required.
- The initial intake report is completed consistently. About one half are completed within 24 hours of the referral as required.
- Managers are authorizing the worker's intake documentation and the disposition of the referral within the 7-day requirement in slightly more than half of the cases.
- The safety assessment is being completed in about three quarters of the referrals. Documentation of the safety assessment is to be completed within 24 hours of seeing the children and the compliance rate was 44%. Where a safety assessment is completed, a safety plan for the child/ren, determined to be at risk while CYFS investigates an allegation of child maltreatment, is regularly developed.
- The documentation of the verification decision regarding the report of child maltreatment is completed in about two thirds of the cases. The compliance rate for completing this documentation within 30 days from the date of referral as required is 46% overall. The manager's involvement in the approval of the verification decision is 44% for the overall sample.
- Documentation of the concluding decision about a child's ongoing need for protective services, following assessment and investigation of a referral, is completed in about two thirds of the cases. Completion of this process within the 30-day requirement occurs about 40% of the time. The manager's approval of the decision was evident in 47% of the sample.
- The assessment and investigative phase of protective intervention is taking much longer than the standard that requires the investigation to be concluded within 30 days.
- Once a case remains open for long-term protective intervention, an initial risk assessment is completed in about one quarter of the cases and the compliance rate

for completing this documentation within 30 days of the referral is 13% for the sample.

- There is very little evidence of case planning of services, which suggests that long-term child protective intervention services may be quite reactive. There is evidence of an initial Family Centered Action Plan in about 10% of the long- term protective intervention cases.
- For about three quarters of open long-term protective intervention cases with new child protection reports, the investigative follow up either does not occur or is not investigated thoroughly.
- Over one quarter of the cases had a change of worker over the investigative process and about one half of the cases receiving long-term child protective intervention services have a change of worker in a year.
- Three quarters of the long-term protective intervention cases are receiving personal contact from the assigned worker quarterly or less. A higher level of contact is required to provide an effective service and to ensure the children are receiving appropriate care. Two thirds of the cases are obtaining a very low level of monitoring and case management.
- It appears that in a year, about 4 % of the long-term protection intervention cases have court involvement under the Child, Youth and Family Services Act.
- The study suggests that about 8% of the cases are receiving family support services. Goals of the support service are well articulated in half of the cases. More coordination and communication between the social worker and the family support worker needs to occur.
- There are a significant proportion of cases, about 18% of the sample that appears to require case closure, as service is not being provided and reviewers indicated that delay in closure was a likely reason. Open cases with no service are a serious liability if harm occurs to a child.
- At various points where decisions need to be approved by a supervisor, there is evidence, on average, of supervisory input or approval in three quarters of the long-term protective intervention cases.
- While a model for risk management in the Protective Intervention Program has been introduced and steps taken for the implementation of the model, there is much work still needed to fully implement the model, to ensure compliance with the standards and to utilize the tools involved.

# Appendix 4.3 FAMILIY SERVICES

## Table of Contents



## List of Tables

## Appendix 4.3.1 PROGRAM DESCRIPTION

The Child, Youth and Family Services Act (Section 10) recognizes the need to support families in a variety of ways in order to support the health, safety and well-being of children. The Family Services program is designed to provide a continuum of direct and community services that are preventive, least intrusive and aimed at early intervention. Services are to be delivered using contracts with families and or community service providers. The child's best interests are paramount and the principles of the legislation shall apply.

## Appendix 4.3.2 DATA RESULTS AND ANALYSIS

### Appendix 4.3.2.1 Sample

Thirty seven files were randomly selected from the four Regions for the file review. All of the files were reviewed on June 27, 2008.
Each file was reviewed based on having been open for service within the timeframe of April 1, 2007 to March 31, 2008. In order to understand the reason for service, the file was examined from the date of the most recent opening. 30% of the files reviewed had been open prior to the previous year.

#### *Current Status*

As of the end of March 2008, 21 (56.8%) of the cases were closed and 15 (40.5%) remained open for services. The information on case status was missing in one file.

### Appendix 4.3.2.2 Length of Service

The following chart indicates that one quarter (24.3%) of the cases was recent and almost 40% had been open in excess of one year.

**Table FS 1: Length of Service**

| LENGTH OF SERVICE | NUMBER | PERCENTAGE |
|---|---|---|
| LESS THAN 3 MONTHS | 9 | 24.3 |
| 3-6 MONTHS | 6 | 16.2 |
| 7-11 MONTHS | 5 | 13.5 |
| 1-2 YEARS | 12 | 32.4 |
| MORE THAN 2 YEARS | 2 | 5.4 |
| MISSING/CAN'T DETERMINE | 3 | 8.1 |
| TOTAL | 37 | |

## Appendix 4.3.2.3 Source of the Referral

The goal of the Family Services program is to provide services to support children at risk and their families; therefore, it can be expected that almost half of the referrals (48.6%) were from parents. Further the other largest referral source is other professional in the community.

**Table FS 2: Referral Source**

| SOURCE | NUMBER | PERCENTAGE |
|---|---|---|
| PARENT (8 CUSTODIAL PARENTS) | 18 | 48.6 |
| ANOTHER FAMILY MEMBER | 1 | 2.7 |
| TRANSFERRED FROM PROTECTION | 2 | 5.4 |
| HEALTH PROFESSIONAL | 4 | 10.8 |
| OTHER:<br>- COMMUNITY PROFESSIONAL: 2<br>- NEIGHBOR/FRIEND: 2<br>- POLICE: 1<br>- SCHOOL: 6 | 11 | 29.7 |
| MISSING | 1 | 2.7 |
| TOTAL | 37 | |

## Appendix 4.3.2.4 Reason for the Referral

One third (35.1%) of the referrals were based issues related to the child's behavior. In the 37 cases the category of "other" reason for referral was identified most often. The following provides further detail with regard to the nature of the referrals.

### Table FS 3: Reason for the Referral

| Reason | Number | Percentage (of total sample of 37) |
|---|---|---|
| Substance abuse problem | 1 | 2.7 |
| Child behavior | 13 | 35.1 |
| Parent/child relationship | 1 | 2.7 |
| Birth planning | 1 | 2.7 |
| Child with Special needs | 4 | 10.8 |
| Respite | 3 | 8.1 |
| Financial Support to care for child | 4 | 10.8 |
| Other*<br>Child in care returned to non-custodial parent: 1<br>Children's mental health: 3<br>Custody/access 2<br>Domestic violence 1<br>Other province's child welfare case 1<br>Section 16 investigation 1<br>Third party sexual assault investigation 10<br>Sibling relationships 1<br>Supportive services 1 | | 56.8 |

A number of the reasons for referral appear to be ones that could fit with Protective Intervention, such as substance abuse, domestic violence and investigation of third party sexual assault (10 cases).
Some of the reasons for referral appear to overlap such as child behavior (35.1%), parent child relationship (2.7%) and children's mental health (8.1%). Although this program is not based on the need for protection, some of the foregoing reasons for referral may be linked to child abuse.
It should be noted that there were only 2 cases in the sample of 37 that were related to custody and access issues.

# PART A: ASSESSMENT

Standards have been interpreted as they appear in the Child, Youth and Family Services Policy and Standards Manual and the Risk Management System. This includes any mandatory directions to staff which appear as part of the procedures narrative.

## Appendix 4.3.2.5 Written report

In all of the 37 files the requirement for documenting the basic information about the referral (Child Protection Report) was completed.

### Table FS 4: Time to Complete Written Report of the Referral

| Timeframe | Number | Percentage |
|---|---|---|
| W/in 24 hours | 23 | 62.2 |
| 2-3 days | 2 | 5.4 |
| 4-7 days | 2 | 5.4 |
| Over 7 days | 6 | 16.2 |
| Can't determine or missing | 4 | 10.8 |
| **Total** | **37** | **100.0** |

This showed that approximately three quarters of the Child Protection Reports were written within seven days. 62.2% were completed in 24 hours from receiving the referral. The issue that was observed was that 10 files, one in four, were excessively delayed or the information was not available on the file.

## Appendix 4.3.2.6 Managerial Consultation

When a referral is received for Family Services, the manager provides consultation to the worker whether to accept the referral. The following emerged in the 37 files:

### Table FS 5: Consultation with Manager

| Manager Consultation | Number | Percentage |
|---|---|---|
| Yes | 31 | 83.8 |
| No | 5 | 13.5 |
| Missing/ can't determine | 1 | 2.7 |
| **Total** | **37** | **100.0** |
| **Within 24 Hours** | | |
| Yes | 24 | 64.9 |
| No | 12 | 32.4 |
| Missing/ can't determine | 1 | 2.7 |
| **Total** | **37** | **100.0** |

Of the 37 files, 31 documented that the manager was consulted and of those 24 were within 24 hours. (64.9%)

Review and approval of social worker's recommendation:
The manager is required to review and approve the worker's recommendation within 7 days.

### Table FS 6: Timeframe for Manager Approval of Worker Recommendation

| Within 7 Days | Number | Percentage |
|---|---|---|
| Yes | 25 | 67.6 |
| No | 10 | 27.0 |
| Missing/ can't determine | 2 | 5.4 |
| **Total** | **37** | **100.0** |

The completion of this part of the service process was satisfactory in two thirds of the files. For the remainder of the files (10) there was a significant delay and in 2 files managerial approval did not occur or wasn't documented.

## Appendix 4.3.2.7 Initial Intake Report Form (#14-696)

The form was documented for 35 of the 37 files. The timeframe for completion was:

**Table FS 7: Completion of Initial Intake Report**

| Timeframe | Number | Percentage |
|---|---|---|
| Within 24 hours | 23 | 65.7 |
| 2-3 days | 2 | 5.7 |
| 4-7 days | 5 | 14.3 |
| More than 7 days | 5 | 14.3 |
| **Total** | **35** | **100.0** |

## Appendix 4.3.2.8 Managerial Approval

Of the 35 Initial Intake Reports that were completed, all had managerial approval. The most frequent form of the approval was verbal (60%).

**Table FS 8: Form of Manager Approval**

| Form of Manager Approval | Number | Percentage |
|---|---|---|
| Written | 12 | 34.3 |
| Verbal | 21 | 60.0 |
| Not noted by reviewer | 2 | 5.7 |
| **Total** | **35** | **100.0** |

## Appendix 4.3.2.9 Record Checks

In all of the files (97.3%), except for one, a record check was completed. In 30 files (81.1%) it was determined that there were past records.

### Table FS 9: Type of Previous Record

| Type of Record | Number | Percentage |
|---|---|---|
| Family Services | 3 | 8.1 |
| Protective Intervention Program | 19 | 67.9 |
| Family of Origin | 1 | 2.7 |
| Other:<br>Child in Care & PIP: 1<br>Family Services & PIP: 2<br>PIP & Family of Origin: 1<br>Section 16: 1 | 5 | 13.5 |
| Not applicable | 7 | 18.9 |
| Can't determine | 2 | 5.4 |
| **Total** | **37** | **100.0** |

In over 80% of the cases the family was already known and had received services previously most often (67.9%) in the Protective Intervention Program.

## Appendix 4.3.2.10 First Contact

The worker established face to face contact with the family within 7 days in 62.2% of the cases.

### Table FS 10: Timeframe for Contact with Client

| Timeframe | Number | Percent |
|---|---|---|
| 7 days | 23 | 62.2 |
| 8-14 days | 3 | 8.1 |
| 15-30 days | 1 | 2.7 |
| Over one month | 4 | 10.8 |
| No contact | 5 | 13.5 |
| Missing | 1 | 2.7 |
| **Total** | **37** | **100.0** |

These results show that in one quarter of the cases the first contact was either longer than one month or not at all.

## Appendix 4.3.2.11 Assessment

The assessment is the initial clinical service provided to the family and determines the service to be provided. This includes the decision whether the case should receive services, be referred to another service or be closed.
The most used source of information on which the assessment was made was the current family situation (73%) and past history (56.8%). In one case no initial assessment was completed.

**Table FS 11: Type of Input to Assessment**

| Input to Assessment | Number | Percentage | N/A |
|---|---|---|---|
| Past history | 21 | 56.8 | 2 |
| Current presenting family situation | 27 | 73 | 1 |
| Information from relevant family members | 18 | 48.6 | 3 |
| Information from third parties | 15 | 40.5 | 7 |

## Appendix 4.3.2.12 Disposition following Assessment

Of the 37 cases reviewed, 21 remained open (56.8%) and 15 were closed (40.5%) following the initial assessment phase. In one file the disposition information was missing.

# Part B: SERVICE PLANNING

## Appendix 4.3.2.13 Service Agreement or Individual Support Services Plan (ISSP)

"Agreements with children, youth and families are usually entered into in the form of an Individual Support Services Plan."
In 3 files that were opened for service a written plan was on the file. The small number of plans in the files made it difficult to provide observations.

## Appendix 4.3.2.14 Type of Services

In the 37 files the reviewers identified that the following services were provided:

**Table FS 12: Type of Service**

| Service | Number | Percentage |
|---|---|---|
| Counseling/therapy | 4 | 10.8 |
| Family Support Service | 3 | 8.1 |
| Voluntary Care Agreement | 1 | 2.7 |
| Referral to a Community Service | 12 | 32.4 |
| Agreement w. another service provider | 3 | 8.1 |
| Advocacy for access to services | 4 | 10.8 |
| Other:<br>Assessment of referral – 2<br>Financial assistance – 4<br>Third party sexual assault – 6<br>Section 16 – 1<br>Referral to community resource – 2<br>Respite – 1<br>Support Services -2 | 18 | 48.6 |

The foregoing suggests that most of the service took the form of connecting families to the services that they required. Six cases of the original 10 referrals related to third party sexual assault.

## *Counseling Services*

In 4 (10.8%) files counseling services were provided. The frequency of contact between the worker and the family was:

**Table FS 13: Frequency of Counseling Contact**

| Contact with Family | Number |
|---|---|
| 4 times per month | 1 |
| 2 times per month | 1 |
| 1 time per month | 1 |
| No contact in previous 3 months | 1 |
| **Total** | **4** |

## *Family Support Services*

In 8.1% of the files family support services were provided. In all of the cases a contract was completed and there was monthly contact between the workers. 2 files clearly stated the goals and tasks and it could not be determined for the third contract. The goals were met in 2 of the cases.

## *Review of Initial Service Agreement*

The requirement to review the initial service plan occurred in 2 of the files. The plans were reviewed within 3 months and the family was involved. All tasks were completed in one case and most were completed in the second.

## Appendix 4.3.2.15 Response to New Information or a Referral

At any point in the provision of service new information or a referral can indicate the need to further assess the case. In the 21 cases that were open for service there were 11 instances where this occurred. The response was as follows:

**Table FS 14: New Information or Referral**

| New Information Received | Number |
|---|---|
| Investigation commenced | 2 |
| Not investigated | 8 |
| Could not be determined | 1 |
| **Total** | **11** |

## *Reports Not Investigated*

The reviewers observed that in the 11 cases, the following tasks were missing or not reported in the file in assessing risk to the child:

### Table FS 15: Tasks Missed in Follow-up to New Information or Referral

| Tasks Missed | Yes | N/A |
|---|---|---|
| Interviews with all children | 3 | 5 |
| Interviews with Parents/ Other Care Providers | 2 | 5 |
| Information from Third Parties | 1 | 1 |
| Referral to Police | | 5 |
| Medical Examination | | 5 |
| Physical Observations of the Child in the Home | 2 | 5 |
| Safety Assessment | 2 | 5 |
| Risk Assessment | 1 | 5 |
| Verification decision | 2 | 5 |
| Assessment of Child's Need For Protection | 2 | 5 |
| Initial intake to determine action | 1 | |

Although the numbers may be small, it is concerning that in 3 cases it was thought by the reviewer that all of the children were not interviewed.
In one case the file was transferred to Protective Intervention Program as a result of the investigation of the new information or referral.

## Appendix 4.3.2.16 Case Supervision

In three quarters of the files (73%) the input of the manager was documented; however in just under 10% of the files it could not be determined.
Evidence of managerial input was documented in the files as follows:

### Table FS 16: Evidence of Manager Input

| Supervisory input/ consultation | Number | Percentage |
|---|---|---|
| Yes | 27 | 73 |
| No | 6 | 16.2 |
| Not applicable | 1 | 2.7 |
| Cannot determine | 3 | 8.1 |
| **Total** | **37** | |

The most frequent form was signing off on the record (77.8%) and in a quarter (25.9%) of the files there were notes relating to consultation with the manager.

In the 27 files where there was documentation it took the form of:

### Table FS 17: Form of Manager Input on the File

| Indication of Supervision | Number | Percentage |
|---|---|---|
| Conference Notes | 1 | |
| Notes of supervision/ consultation | 7 | 25.9 |
| Meeting with clients | 0 | |
| Sign off on records | 21 | 77.8 |
| Approval of financial needs | 2 | |

## Appendix 4.3.2.17 Case Closure

When a case is to be closed it should indicate on the file who was involved in, or notified of, the decision.
For the sample of 37 files the case was closed in 21 (56.8%) of the total.
In some cases more than one response was given as there was consultation with more than one individual or group.

### Table FS 18: Consultation with Others Regarding Closure

| Consulted | Number | Percentage |
|---|---|---|
| Family | 12 | 57.1 |
| Children | 3 | 14.3 |
| Manager | 12 | 57.1 |
| Community services / professionals | 4 | 19.0 |

It should be noted the low number of times other community services (19%) were consulted in relation to the number of cases where this was part of the services provided.

### *Reason for Closure*

One quarter of the files (23.8%) closed as the service was no longer requested and almost half (42.9%) closed for a variety of "other" reasons.

For the 21 cases that were closed, the reasons were indicated as follows:

### Table FS 19: Reason for Case Closure

| Reason | Number | Percentage |
|---|---|---|
| Request for service withdrawn | 5 | 23.8 |
| Service not available | 1 | 4.8 |
| Referred to another service provider | 1 | 4.8 |
| Family not using services of CYFS | 2 | 9.5 |
| Transferred to PIP | 1 | 4.8 |
| Family moved | 1 | 4.8 |
| Other*<br>Caretaker took appropriate action: 1<br>Child turned 16: 2<br>Completed investigation & support: 1<br>Did not require S 10 or 14: 1<br>Funding not approved: 1<br>Investigation of sexual assault completed: 2<br>Unable to determine: 1 | 9 | 42.9 |
| Missing | 1 | 4.8 |
| **Total** | **21** | |

## Appendix 4.3.2.18 Summary

- 37 files were reviewed from the Family Services program. 30% of the cases had been open for service prior to April 1, 2007 and the remaining files received some form of service during April 1, 2007 to march 31, 2008.
- At the end of March 2008, 56.8% of the files in the sample were closed and the rest were still receiving services.
- In total 40% of the cases had been getting services for over one year with almost one third having been open for between 1 to 2 years.
- The largest number of referrals was from parents (48.6%).
- There were a variety of reasons for the referral, many having to do with child behavior, and issues related to children's mental health. 10 of the reasons for the referral were 3rd. party assault which is not covered under the legislation. (CYFS Act)
- The Child Protection report was completed in three quarters of the cases and in 24 hours in 62.2% of the files. The manager was consulted in 84% of the files. The manager approved the worker's recommendation within 7 days in two thirds of the cases.
- The documentation and managerial input is satisfactory overall in approximately two thirds of the files.
- The Initial Intake Report was completed within 24 hours in two thirds of the files and overall in 7 days for 85% of the cases.
- Managerial approval was most frequently (60%) verbal.
- Record checks were completed in almost all of the files. In 81.1% there was a previous record, 67.9% were in the Protective Intervention Program.

- Workers had face to face contact with the family in 7 days in 62.2% of the cases. For one quarter there the first contact was over a month and for some did not appear to have occurred at all.
- In assessing the need for service the current family situation (73%) and the past history (56.8%) were most often the basis for the decision. After the initial assessment 40.5% of the files closed.
- Only 3 files contained Service Agreements or ISSPs.
- The types of service provided most frequently was referral to another community service (32.4%) The category of "other" (48.6%) included 6 cases related to 3rd. party assault. Counseling service was provided by the worker in 4 cases and Family Support services were provided in 3 cases.
- In 11 files there was documentation about new information or a referral on the family. In 2 of the cases there was an investigation. The reviewers identified a number of tasks that should have been completed to identify whether there was risk to a child.
- Managerial input was evident in three quarters of the files, usually in the form of sign off.
- Of the files that closed (56.8%), the family and the manager were most often consulted (57.1%). In only 19% of the files the community service provider was included in the decision.
- Files closed for a variety of reasons, the most frequent being that the service was no longer requested (23.8%).
- Although there are few standards and policies for the program, it appears that the staff is responding similarly to the Protective Intervention Program in terms of response to the referral and documentation.
- There are a variety of issues evident in the files that potentially indicated risks to children; most obvious is 3rd. party assault referrals.

# Appendix 4.4 CHILD WELFARE ALLOWANCE

## Table of Contents



## List of Tables

## Appendix 4.4.1 PROGRAM DESCRIPTION

The Child Welfare Allowance Program is available to provide support and financial services to relatives or significant others who are willing and capable of providing care to a child who is in need of protective intervention and if relatives or significant others were not available; the child would have to be placed with a caregiver.

Standards have been interpreted based on the wording in the Child, Youth and Family Services Policy and Standards Manual and the Risk Management System. This includes any mandatory directions to staff, which appear as part of the procedures' narrative.

## Appendix 4.4.2 DATA RESULTS AND ANALYSIS

### Appendix 4.4.2.1 Sample Size

The file review included 22 files from the four regions. The sample of cases, that were reviewed, received service between April 1, 2007 and March 31, 2008; however, many cases had been opened much earlier. The actual years of case openings ranged from 1991 to 2008.

### Appendix 4.4.2.2 Ages of Children

When initiating the child welfare allowance, Child, Youth and Family Services are responding to a wide age range of children. At the time that the cases were opened for child welfare allowance, the children were of the following ages:

**Table CWA 1: Age of Child When CWA Initiated**

| Age | Number Of Files | Percentage |
|---|---|---|
| 0-1 Years | 3 | 13.6 |
| 2-6 Years | 5 | 22.7 |
| 7-11 Years | 5 | 22.7 |
| 12-15 Years | 5 | 22.7 |
| Reviewer Could Not Determine Age Of Child Or Date Of Case Opening | 4 | 18.2 |
| **Total** | **22** | **99.9** |

At the time of the file review, only 2 cases or 9 % were infants, there were no children between 2 and 6 years of age, 41% were between 12 and 15 years of age and 23% were 16 years of age or older.

**Table CWA 2: Age of Child or Youth at Time of Review**

| Age | Number Of Files | Percentage |
|---|---|---|
| 0-1 Years | 2 | 9.1 |
| 2-6 Years | 0 | 0.0 |
| 7-11 Years | 5 | 22.7 |
| 12-15 Years | 9 | 40.9 |
| 16-19 Years | 5 | 22.7 |
| Reviewer Did Not Determine Age | 1 | 4.5 |
| **Total** | **22** | **99.9** |

## Appendix 4.4.2.3 Length of Service in Child Welfare Allowance Program

Over half of the cases have received child welfare allowance services for more than 2 years. It appears that once a case is opened to the child welfare allowance program, the service continues for lengthy periods of time.

For the 12 cases that had been open for more than 2 years, half of these cases had been open 3-4 years, one quarter had been open 5-9 years, and the final quarter had been open for 12-16 years.

**Table CWA3: Length of Service in Child Welfare Allowance Program since Case Opening**

| Time In CWA Program | Number Of Files | Percentage |
|---|---|---|
| Less Than 3 Months | 1 | 4.5 |
| 3-6 Months | 0 | 0.0 |
| 7-11 Months | 5 | 22.7 |
| 1-2 Years | 3 | 13.6 |
| More Than 2 Years | 12 | 54.5 |
| Reviewer Did Not Determine Opening Date | 1 | 4.5 |
| **Total** | **22** | **99.8** |

## Appendix 4.4.2.4 Children's Families in Receipt of Other Programs

Reviewers were able to determine that 6 or 27.3% of the 22 children, who were receiving the child welfare allowance, were from families receiving services from the protective intervention program. They could not identify any cases where the children's families were open to the family services program.

## Appendix 4.4.2.5 Assessment of a Proposed Placement for a Child with a Relative/ Significant Other

An assessment of a proposed placement for the child occurred only in 13 of the 22 cases or in 59.1 % of the cases overall. This is a practice concern, as requirements for an assessment are not being met. Only 1 of the 7 cases, where an assessment was not done,

can be possibly explained by the move of the child and his placement family from another province to Newfoundland.

### Table CWA 4: Did Some Assessment Of The Placement Occur?

| Assessment Occurred? | Number Of Files | Percentage |
|---|---|---|
| Yes | 13 | 59.1 |
| No | 7 | 31.8 |
| Cannot Determine | 2 | 9.1 |
| **Total** | **22** | **100.0** |

When the 13 cases, where an assessment of the proposed placement was completed, there were inconsistencies in the components included in the assessment process. This would suggest that a standardized assessment practice is not occurring in assessing a placement prior to placing a child with a relative or significant other person under the Child Welfare Allowance Program.

### Table CWA 5: Assessment Activities

| Assessment Activity | Number Of Files Where Some Assessment Occurred | | Percentage Of The 13 Files Where Some Assessment Occurred | Percentage Of Overall Sample |
|---|---|---|---|---|
| Regional CYFS Record Checks | Yes | 3 | 23.1 | 13.6 |
| | No | 10 | 76.9 | |
| Provincial CYFS Record Checks | Yes | 4 | 30.8 | 18.2 |
| | No | 9 | 69.2 | |
| Police Record Checks | Yes | 6 | 46.2 | 27.3 |
| | No | 7 | 53.8 | |
| Personal Contact With Care Providers And Significant Others | Yes | 11 | 84.6 | 50.0 |
| | No | 2 | 15.4 | |
| Assessment Of Commitment To child | Yes | 8 | 61.5 | 36.4 |
| | No | 5 | 38.5 | |
| Determination of Ability To Protect The Child | Yes | 7 | 53.8 | 31.8 |
| | No | 6 | 46.2 | |
| Home Visit | Yes | 9 | 69.2 | 40.9 |
| | No | 4 | 30.8 | |
| Assessment Of Physical Space And Sleeping Arrangements | Yes | 5 | 38.5 | 22.7 |
| | No | 8 | 61.5 | |
| Other (Items Identified: Collateral Checks; References; Wishes Of Child & Interviewed Children Of CWA Family) | Yes | 3 | 21.1 | 13.6 |
| | No | 10 | 76.9 | |

When the practice of only the 10 cases that were opened for child welfare allowance in the most recent years of 2006, 2007, and 2008 was examined, some assessment of the proposed placement occurred in 70% of the cases. Although there may be some improvement in assessment practices in recent years, there is not sufficient compliance or consistency in assessment activities. Again it is apparent that a consistent and systematic assessment process is not occurring as the assessment activities vary for different cases.

**Table CWA 6: Assessment Activities for 10 Files Opened In 2006-8 Period**

| Assessment Activity | Number Of Files Where The Assessment Activity Occurred | Percentage |
|---|---|---|
| Regional CYFS Record Checks | 3 | 30.0 |
| Provincial CYFS Record Checks | 3 | 30.0 |
| Police Record Checks | 5 | 50.0 |
| Personal Contact With Care Providers And Significant Others | 6 | 60.0 |
| Assessment Of Commitment To child | 4 | 40.0 |
| Determination of Ability To Protect The Child | 3 | 30.0 |
| Home Visit | 5 | 50.0 |
| Assessment Of Physical Space And Sleeping Arrangements | 3 | 30.0 |

## Appendix 4.4.2.6 Individual Support Services Plan

In only 4 or 18.2 % of the cases, was an individual support services plan developed despite the requirement to do so in all cases.

## Appendix 4.4.2.7 Financial Support Agreement with Parent/s

In only 5 or 22.7 % of the cases, was a financial support agreement developed and signed by the parent/s.

## Appendix 4.4.2.8 Additional Allowances above the Regular Monthly Child Welfare Allowance Rate

There were 10 cases or 45.5% of the 22 cases that were provided an additional allowance. There was 1 case where the reviewer could not determine if an additional allowance was provided and the remaining cases had no additional allowance.

Only in 5 (50%) of the cases was it apparent to the reviewer that the relative or significant other, who was providing the placement for the child, was notified in writing regarding the amount that was approved and the length of the approval.
The manager's approval of the additional expenses, as required, occurred in 9 of the 10 cases or 90% of the time.

Health and medical expenses accounted for the most frequently approved expenses. This included such items as prescriptions, eyeglasses etc. Transportation to services or activities was the next most commonly approved expense. Reviewers that marked "other expenses" included such reasons for expenses as financial support for daycare, babysitting, recreational activities, respite, financial situation of placement family and two-days accommodation to receive needed services. The kinds of services provided in the 10 cases that received the additional allowances were as follows:

### Table CWA 7: Additional Allowances

| Services Requiring Additional Allowances | Number Of Files With Additional Allowance | | Percentage Of The 10 Cases With Additional Allowance | Percentage Of The Overall Sample |
|---|---|---|---|---|
| Health And Medical Services | Yes | 5 | 50.0 | 22.7 |
| | No | 5 | 50.0 | |
| Educational Expenses | Yes | 3 | 30.0 | 13.6 |
| | No | 7 | 70.0 | |
| Counselling | Yes | 2 | 20.0 | 9.1 |
| | No | 8 | 80.0 | |
| Transportation | Yes | 6 | 60.0 | 27.3 |
| | No | 4 | 40.0 | |
| Other (Items Included: daycare, babysitting, recreational activities, respite, financial situation of placement family and two-day accommodation) | Yes | 6 | 60.0 | 27.3 |
| | No | 4 | 40.0 | |

## Appendix 4.4.2.9 Review of Case Plan

The requirements to review the case plan at least every 6 months occurred in only 2 cases or 9.1% of the cases. There was only 1 case where a review of the plan was not applicable as the child had been in the program 6 months.

## Appendix 4.4.2.10 Face-To-Face Contact by the Assigned Social Worker in the Last Three Months

There were only 3 cases or 13.6% of the files where the child had personal contact with the social worker in the last three months prior to this case review or prior to case closing. In over half of the cases, the child had not had a face-to face contact with the social worker in three months.

### Table CWA 8: Social Worker's Face-To-Face Contact with Child

| Frequency Of Contact | Number Of Files | Percentage |
|---|---|---|
| 2 Or More Contacts Per Month | 0 | 0.0 |
| 1 Contact Per Month | 3 | 13.6 |
| Less Than One Contact Per Month But Some Contact | 6 | 27.3 |
| No Contact In The Last Three Months | 12 | 54.5 |
| Reviewer Cannot Determine Contact | 1 | 4.5 |
| **Total** | **22** | **99.9** |

Similarly, in over half of the cases, the family providing care to the child had not had a face-to face contact with the social worker in three months.

**Table CWA 9: Social Worker's Face-To-Face Contact with Placement Care Provider/s**

| Frequency Of Contact | Number Of Files | Percentage |
|---|---|---|
| 2 Or More Contacts Per Month | 0 | 0.0 |
| 1 Contact Per Month | 2 | 9.1 |
| Less Than One Contact Per Month But Some Contact | 7 | 31.8 |
| No Contact In The Last Three Months | 12 | 54.5 |
| Reviewer Cannot Determine Contact | 1 | 4.5 |
| **Total** | **22** | **99.9** |

## Appendix 4.4.2.11 Face-To-Face Contact with Child and/or Care Provider by an Assigned Community Service Worker/Contract Worker/ Family Support Worker in the Last Three Months

Only 3 cases, or 13% of the files, had a support worker assigned to the case. In all three cases, there was some personal contact with the child and/or the family providing care.

**Table CWA 10: Support Worker's Face-To-Face Contact with Family And /Or Child**

| Frequency Of Contact | Number Of Files | Percentage |
|---|---|---|
| 2 Or More Contacts Per Month | 1 | 33.3 |
| 1 Contact Per Month | 1 | 33.3 |
| Less Than One Contact Per Month But Some Contact | 1 | 33.3 |
| No Contact In The Last Three Months | 0 | 0.0 |
| Total | 3 | 99.9 |

## Appendix 4.4.2.12 Placement Stability

Only 3 of the 22 children or 13.6% experienced a placement change in the last year. These three children had two placements in the last year or one placement change. In only one case was the reviewer not able to determine the number of placements.

## Appendix 4.4.2.13 Manager Approvals and Supervisory Consultation

Overall the involvement of the manager was evident in 19 or 86.4% of the cases, mainly evidenced by signature of approval on the record.

### Table CWA 11: Evidence of Involvement of Manager

| Where Evidence Of Supervisory Input | Number Of Files | | Percentage Of The Overall Sample Of 22 Cases |
|---|---|---|---|
| Conference Notes | Yes | 2 | 9.1 |
| | No | 20 | 90.9 |
| Consultation Notes | Yes | 4 | 18.2 |
| | No | 18 | 81.8 |
| Meeting With Clients | Yes | 1 | 4.5 |
| | No | 21 | 95.5 |
| Signature Sign Offs On Records | Yes | 19 | 86.4 |
| | No | 3 | 13.6 |

The manager's approval of the financial arrangements with the placement occurred in 81.8% of the cases but the manager's approval of the placement occurred in only 50% of the cases. The manager's approval of the additional expenses over the regular child welfare allowance is required and approval occurred in 9 of the 10 cases where these additional expenses occurred or 90% of the time.

### Table CWA 12: Manager Approvals

| Decisions For Approval | Number Of Files | | Percentage |
|---|---|---|---|
| Financial Arrangement For CWA | Yes | 18 | 81.8 |
| | No | 4 | 18.2 |
| Placement Of Child | Yes | 11 | 50.0 |
| | No | 11 | 50.0 |
| Financial Support For Additional Services | Yes | 9 | 90.0 |
| | No | 1 | 10.0 |

## Appendix 4.4.2.14 Child Welfare Allowance Closure

Six of the 22 files or 27.3% were closed at the time of the review. In 4 of these 6 files, the child returned to the care of the parent/s. In two of the files, the service was terminated, as the child turned 18 years of age.

## Appendix 4.4.2.15 Summary

- It appears that once a case is opened to the child welfare allowance program, the service continues for lengthy periods of time.
- A standardized assessment practice is not occurring in assessing a placement prior to placing a child with a relative or significant other person.
- In over one half of the cases, the social worker had not had a face-to face contact with the child or the family providing care to the child in the three months prior to the review or case closure. A higher level of contact is required to provide an effective service and to ensure the child is receiving appropriate care. There are no standards related to the required contact by the assigned worker.
- A service plan is being developed in less than one fifth of the cases despite the expectation to do so in all cases. Where plans are developed, plans are seldom reviewed every 6 months as required.
- Placement stability appears to be fairly good but there is very little information to determine how well the child's needs are being met in the placement.
- Reviewers could determine that the families of only 27.3% of the children were receiving services and those families were receiving services from the protective intervention program.
- Overall the involvement of the manager was evident in 86.4% of the cases, mainly evidenced on the record by a signature of an approval. The manager's approval of the financial arrangements for the placement and any additional expenses over the basic allowance is occurring fairly regularly but the manager's approval of the placement is occurring only half of the time.

# Appendix 4.5 CHILDREN IN CARE AND CUSTODY

**Tables of Contents**

## List of Tables



## List of Charts

## Appendix 4.5.1 PROGRAM DESCRIPTION

This section refers to all forms of substitute care provided under the authority of the *Child, Youth and Family Services Act.* This includes children in care and custody under the terms of a voluntary agreement, an order of interim care, temporary custody orders and continuous custody orders. Children in care and custody have placements with approved caregivers, in group homes and in other specialized settings.

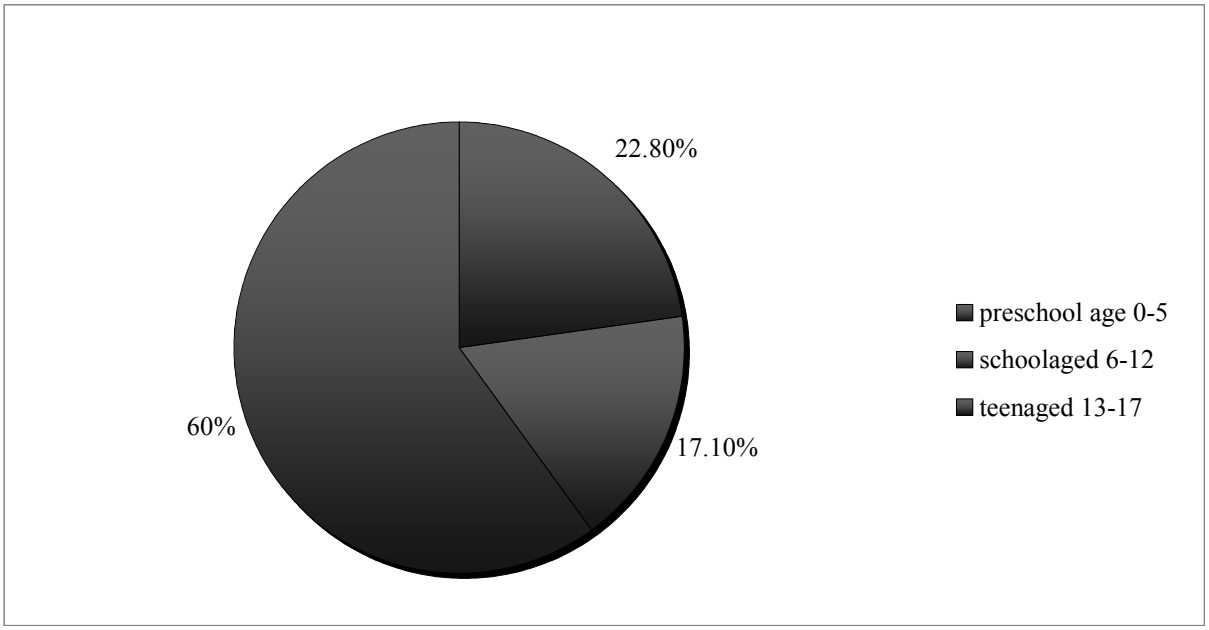
## Appendix 4.5.2 STANDARDS, POLICIES AND PREFERRED PRACTICES

Standards have been interpreted based on the wording in the *Child, Youth and Family Services Policy and Standards Manual* and the *Risk Management System.* This includes any mandatory directions to staff which appear as part of the procedures narrative. In addition, a small number of areas of preferred practice were included. These are identified as such where they occur.

## Appendix 4.5.3 DESCRIPTION OF CASES REVIEWED

For the purposes of the 'Clinical Services Review' 36 (thirty-six) files of children in care were randomly selected from across the province. Fourteen of the files were of girls (38.9%) and 22 files (61.1%) were those of boys. Sixty percent of the files (21 files) were for youth aged 12 or over. Six children (17.1%) were of school age (6-12); eight children (22.8%) were preschool (0-5). Data was unavailable for one child. Overall the children ranged in age from 17 years to one month at the time of the review.

**Figure CIC 1: Children in Care by Age**




## Appendix 4.5.5 LENGTH OF TIME IN CARE AT TIME OF THE REVIEW

At the time of the review eleven children (31.1%) had been in care for one year or less; another thirteen children ( 37.1%) had been in care for one to two years; the remainder (11 children; 31%)) had been in care for more than two years.

**Table CIC 1: Length of Time in Care**

| Length of Time in Care | Number | Percentage |
|---|---|---|
| Less than six months | 5 | 14.3 |
| Six to twelve months | 6 | 17.1 |
| One to two years | 13 | 37.1 |
| More than two years | 11 | 31.4 |
| **Total** | **35*** | **100** |

* Data not available for one file

## Appendix 4.5.6 LEGAL STATUS

At the time of the review seven children were in care on a voluntary agreement. Two children had an interim care order. Eleven children were in care on a temporary custody order. Fifteen children were in care on an order of continuous custody. One child was in care via a youth services agreement.

**Table CIC 2: Legal Status of Children in Care**

| Legal Status | Number | Percentage |
|---|---|---|
| Voluntary agreement | 7 | 19.4 |
| Interim care | 2 | 5.6 |
| Temporary custody order | 11 | 30.6 |
| Continuous custody order | 15 | 41.7 |
| Youth services | 1 | 2.8 |
| **TOTAL** | **36** | **100** |

## Appendix 4.5.7 PREVIOUS ADMISSIONS

Of the 36 children and youth whose files were part of the review, eight (22%) had experienced previous admissions to care. In four cases it could not be determined from the record if previous admissions had occurred. Of the children who had experienced previous admissions, five children had been in care on one prior occasion and three children had been in care two to four times previously.

## Appendix 4.5.8 CULTURAL OR ETHNIC AFFILIATION

In ten cases (27.8%) ethnic affiliation was found to be a relevant factor in planning for the child or youth. All identified cultural affiliation was first nations with 80% being Innu. The remainder was other first nations. In 25% of the cases ethnic or cultural affiliation could not be determined from the file review.

## Appendix 4.5.9 REASONS FOR ADMISSION

Reviewers were asked to indicate the reason or reasons for the child coming into care using a list derived from the legislative definition of a child in need of protection. In some instances the reviewers indicated more than one reason for the admission to care.

**Table CIC 3: Reason for Admission**

| Reason for Admission | Number of times Indicated | Percentage |
|---|---|---|
| Physical harm/risk of physical harm by parental action or lack of action | 21 | 67.7 |
| Sexually abused or exploited or risk of sexual abuse/exploitation by a parent | 1 | 3.2 |
| Emotionally harmed by parent's conduct | 14 | 45 |
| Risk Of Being Physically Harmed By A Person And Parent Does Not Protect | 2 | 6.5 |
| Risk Of Being Sexually Abused Or Exploited By A Person And Parent Does Not Protect | 1 | 3.2 |
| Risk Of Being Emotionally Harmed By A Person And Parent Does Not Protect | 2 | 6.5 |
| Parent Refuses Or Fails To Obtained Treatment Recommended By Qualified Health Practitioner | 1 | 3.2 |
| Abandoned | 4 | 12.9 |
| Parent Unavailable To Care Or Not Made Adequate Provisions For Care | 7 | 22.6 |
| Living in a Situation Where There Is Violence | 7 | 22.6 |
| under 12 and left without supervision | 3 | 9.7 |
| under 12 and has allegedly killed or seriously harmed another person under 12 and has seriously injured another person on more than one occasion | Not cited | Not cited |

The reasons most likely to be cited for children being admitted to care were physical harm or risk of physical harm by parental action or lack of action; parents unable to make adequate provisions for the care of the children; and/or children living in a situation where there is violence. There were five cases where the reason for admission could not be determined.

## Appendix 4.5.10 PLACEMENT TYPE

Of the 36 cases in the sample, the placement type was determined for 31, leaving 5 cases where placement type was not indicated. Over 44% of all placements were in caregiver homes (foster homes) at the time of the review. When relative/significant other placements are added to this almost 64% of all placements were in family based settings. Ten per cent of all placements were in out of province resources. Almost seventeen percent of placements were in individual or alternative living arrangements that are specifically tailored to meet the needs of the child or developed when other conventional placements were not available.

**Table CIC 4: Number of Cases in Each Placement Type**

| Placement Type | Caregiver Home | Relative/Significant Other | Group Home | Residential Service | Individual Living/Alternative Living |
|---|---|---|---|---|---|
| In Province | 16 | 7 | 5 | | 6 |
| Out of Province | | | 2 | 1 | |
| **Total** | **16** | **7** | **7** | **1** | **6** |
| **Percentage** | **44.4%** | **19.4%** | **19.5** | **2.8** | **16.7%** |

Reviewers were also asked to determine whether children and youth had experienced placement changes during the last year. Nineteen children (57.6%) had had no placement change in the twelve months prior to March 31, 2008. Nine children had experienced one placement change (27.3%) and four children (12.1%) had experienced 2-4 placement changes. One child had had more than four placement changes during the previous year.

## Appendix 4.5.11 PLACEMENT MATCHING

Provincial policies stipulate a number of factors that should be considered in selecting a suitable placement for a child being admitted to care. These factors are rooted in the principles of the *Child, Youth and Family Services Act* which promote:

> *"…the child's safety; developmental needs; cultural heritage; the child's views and wishes; continuity and stability in a child's care; the continuity of family and significant other relationships; the child's geographic and social environment; the child's supports outside the family." [Policy Manual Overview p.1]*

The policy manual goes on to direct staff that:

> *"When a child is placed in the care and custody of a director and it has been determined that a placement with relatives or a significant other is not available, every attempt shall be made to match the child's needs with a approved residential placement option. There are a number of factors that must be considered when selecting a placement for a child. These factors include:*
>
> - *an understanding of the child's views and wishes*
> - *the caregiver's ability to meet a particular child's needs*
> - *the ability to place siblings together if necessary*
> - *the proximity of the child's family, school and community*
> - *the caregiver's ability to support a child's religious and cultural background*
> - *the match between the child and other children already in the home being considered*
> - *the availability of a caregiver to be at home with a preschool child" [Policy Manual: Section 3, p 1]*

For the purposes of this review the presence of matching criteria was considered for *all* placements including any that were with relatives or significant others.

Overall it was difficult for the reviewers to determine whether or not the factors had been considered in placement selection. Depending on the factor, the number of situations in which *cannot determine* was indicated varied from a low of 24% (the ability to place siblings together) to a high of 61% (caregiver's ability to support the child's religion and culture). Of all the factors the one which was being considered most often was the caregiver's ability to meet the child's needs.

Among the other placement matching criteria was whether family members had been considered for the child. This was answered in the affirmative 61% of the time.

## Appendix 4.5.12 PREPARING FOR THE PLACEMENT

This section of the review assesses the extent to which relevant information regarding the child is collected and shared with the caregiver. It also looks at the extent to which the child (where developmentally appropriate) and the biological parents are informed of the placement and what it has to offer the child. As with the section above regarding placement matching, the reviewers were unable to determine in a significant number of cases whether basic information about the child, his needs and behaviour, was being gathered and shared with the caregiver. There is no standard form on which this information is contained and the reviewers were left to sift through case notes to find whether or not the information had been determined and shared.

### Table CIC 5: Preparing for the Placement

| Information Type | No | Yes | N/A | C/D Missing |
|---|---|---|---|---|
| Child's full name, date of birth and legal status | 2<br>*5.6%* | 21<br>*58.3%* | | 13<br>*36.1%* |
| Name of social worker and how (s)he can be reached | 3<br>*8.3%* | 19<br>*52.8%* | | 14<br>*38.9%* |
| MCP number, hospital cards, SIN | 5<br>*13.9%* | 13<br>*36.1%* | | 18<br>*50%* |
| Reasons for removal and relevant history | 3<br>*8.3%* | 18<br>*50%* | | 15<br>*41.7%* |
| Child's medical history | 4<br>*11.1%* | 15<br>*41.7%* | | 17<br>*47.2%* |
| Special needs of the child | 4<br>*11.1%* | 16<br>*44.4* | | 12<br>36.1% |
| Day-to-day routine (sleep, bedtime, food) | 4<br>*11.1%* | 13<br>*36.1%* | 2<br>*5.6%* | 17<br>*47.1%* |
| School information | 4<br>*11.1%* | 13<br>*36.1* | 11<br>*30.6%* | 8<br>*22.2%* |
| Child's personality and behaviour | 4<br>*11.1%* | 16<br>44.4% | 2<br>5.6% | 14<br>38.9% |
| History of abuse and maltreatment in previous placements | 2<br>*5.6%* | 8<br>*22.2%* | 17<br>*47.2%* | 9<br>*25%* |

## Appendix 4.5.13 SEEKING THE CHILD'S INPUT REGARDING LIFE DECISIONS

Reviewers were asked to look for evidence of whether or not the child (where it was developmentally appropriate) was being asked for his or her input into decisions in the child's life. They were also asked to list the sources of that information. In 50% of the sample (18 cases) there was evidence that the input of the child was being sought in planning and decision-making. In those cases input was evidenced by the content of the case notes (88.9%) and the participation of the child in the preparation of the plan of care (11.1%). In another 30.6% of cases (11 files) the child's age meant that his or her participation was not relevant. In the remainder of the cases, 7 cases or 19.5% of the sample, there was no evidence of the participation of the child or the child's involvement could not be determined.

## Appendix 4.5.14 POST PLACEMENT REQUIREMENTS AND MONITORING

Provincial practice standards and policies describe a number of minimum requirements for monitoring children and youth following their placements. These include:
visits by the social worker:

- the medical examination of the child following admission
- meeting with the child after placement
- completion of the Social/Medical History.

In addition to the above, data was collected on school participation as there was concern that children were experiencing lengthy delays in reentering school following a placement.

Once again it was difficult for reviewers to determine whether or not these requirements were met due to a lack of clear and standardized documentation. Some examples follow:

### Table CIC 6: Post Placement Requirements and Monitoring

| Requirement | % Compliance | Explanation |
|---|---|---|
| Child to be seen by the social worker within 7 days of the placement | 13 cases 36.1% | In 44% of cases the date of the post placement visit could not be determined. In four cases (11.1% of the sample) the post placement visit occurred more than 14 days following the placement. |
| Child receives a medical examination within 3 days of admission | 8 cases 22.2% | In 52.8% of the sample (19 cases) the reviewer could not determine when the post placement medical occurred. Three children (8.3%) had a medical within 4-7 days of admission; five children (13.9% of the sample) had a medical more than 14 days after admission. In two cases the reason given for the delay was that appointments were not readily available. |
| Attendance at school within 7 days of admission | 10 cases 38.5% | Twenty-six of the children in the sample were of school age. In 11 cases (42.3%) it could not be determined when the child resumed attending school. One child was not attending school for 14 days following placement. Two children were out of school for more than 30 days following placement. |
| Social/medical history completed within 30 days | 5 cases 13.9% | Seven cases had social and medical histories completed within 60 days (19.4%). In three cases the histories had not been completed. In 17 cases (47.2% of sample) it could not be determined when the histories had been completed. |

## Appendix 4.5.15 CONTACT WITH CHILDREN IN CARE

Critical to the monitoring of the care of the child is the expectation that the assigned social worker will meet regularly with the child/youth and the caregiver. Preferred practice stipulates that children are to be seen privately at least quarterly and younger children under five years of age are to be observed in the caregiver home with the caregiver. Provincial standards require that contact be maintained with the child a minimum of once monthly.

In 55.5% of the cases in the sample contact was maintained with the child once monthly or more. In 30.6% of the sample contact was less than once per month. In five cases (13.9%) the reviewer was unable to determine the frequency of the contact.

### Table CIC 7: Frequency of Direct Face-to-face Contact with Child over Five

| Frequency of Contact | Number | Percentage |
|---|---|---|
| Less than once per month | 11 | 30.6 |
| Once per month | 13 | 36.1 |
| 2 or more time per month | 7 | 19.4 |
| C/D | 5 | 13.9 |
| **Total** | **36** | **100.0** |

**Table CIC 8: Quarterly Private Interviews with Children**

| Quarterly private interview | Number | Percentage |
|---|---|---|
| No | 8 | 22.0 |
| Yes | 18 | 50.0 |
| N/A | 3 | 8.3 |
| C/D/ Missing | 7 | 19.5 |
| **Total** | **36** | **100.0** |

The number of children under five in the sample was very small (5 children). This means that drawing general conclusions about practice is not possible.

## Appendix 4.5.16 NUMBER OF ASSIGNED WORKERS IN THE PAST YEAR

One of the key factors in evaluating the quality of a child's experience in care is the provision of consistent case management by an assigned worker. Children who have graduated from the care system often cite a relationship with a key person such as their worker or caregiver as being significant in assisting them in achieving their goals. In this survey 21 children and youth (58.3%) had one assigned worker for the past year. Twelve (33.3%) children had 2 or 3 assigned workers during the past year. One child had more than four workers during the past year. The number of workers assigned could not be determined in 2 cases.

## Appendix 4.5.17 SUPERVISORY INPUT AND CONSULTATION

Joint decision-making and planning is an essential component of quality child welfare practice. The needs of children in care are often complex and benefit from the joint planning of a well-informed team. The project looked at whether there was evidence of supervisory input into the case and if so how this was noted on the records. Supervisory input or consultation was evident in 66.7% (24 cases) of the sample. In the remaining 12 cases (33.3%) there was no evidence of supervisory input or input could not be determined. The most often cited source of supervisory consultation or input was in supervision consultation notes (22 instances) and sign off on records (15 instances). Other less often cited sources were conference notes (8 instances) meetings with clients (2 instances), letters on file (1 instance), and emails (1 instance).

## Appendix 4.5.18 SHARING INFORMATION WITH THE PARENTS

Provincial standards require that the social worker shall ensure that the child and the child's parent(s) are provided with relevant information about the caregiver family unless it is not deemed in the child's best interest. This information was largely unavailable in the file. Such information as the name, address and telephone number of the caregiver; the rules in the caregiver home; the role of the caregiver; the cultural heritage of the family; and the religious affiliation of the caregiver family were unlikely to be shared with the

child's family. One exception was with regards to arrangements for contact or visiting between the child and the family where information was provided to the family in almost 60% of the sample.

## Appendix 4.5.19 PLANNING FOR THE CHILD

Each child in care is required to have a plan that will address his or her developmental needs. This constitutes a basic component of the child's stay in the care of the child welfare system. The Department has adopted the framework of developmental dimensions described in *Looking after Children* as the basis for the plan of care. Preferred practice stipulates that wherever possible the plan should be developed with the child, the caregiver and the child's family as well as other key individuals in the child's life. The reviewers were asked to enumerate the extent to which these practices were being observed. In two-thirds of the cases (24 files) a plan had been developed for the child. In one-third of the cases (12 files) there was either no evidence of a plan (11 files) or it could not be determined that a plan had been developed (1 file).

**Table CIC 9: Is There a Plan for the Child?**

| | Number | Percentage |
|---|---|---|
| No | 11 | 30.6 |
| Yes | 24 | 66.7 |
| C/D | 1 | 2.8 |
| **Total** | **36** | **100.0** |

### Appendix 4.5.19.1 Is the Plan Reviewed Monthly by the Social Worker?

The findings in this area are based on the 24 files where a plan had been developed for the child. In seven cases (29%) where plans had been prepared there was evidence of a monthly review. When taken as a percentage of the overall sample (36 cases) about one case in five (19.5%) had a plan of care that was subject to monthly review as stipulated in the standards.

### Appendix 4.5.19.2 Who participated in the Plan of Care for the Child?

Of the 24 cases where a plan was evident, the following is a list of the participants in the plan for the child. The numbers exceed the number of cases due to the fact of multiple participants in the preparation of the plan. The child participated in the preparation of the plan 50% of the time. In almost 60% of the files where a plan was in evidence the child's parents participated in its preparation. When taken as a percentage of the overall sample, parental participation occurred in just under four of every ten cases. Caregivers are cited as participants in fourteen instances or just under half of the cases where a plan was in place. This is slightly less than 40% of the overall sample of 36 cases.

### Table CIC 10: Who Participated in the Plan of Care?

| Participants | Number |
|---|---|
| Child | 12 |
| Parents | 14 |
| Significant others | 5 |
| Courts | 2 |
| Justice | 2 |
| Caregivers | 14 |
| Advocate for child | 1 |
| Worker | 19 |
| Community service providers | 8 |

A further requirement is that the plan be reviewed by the social worker monthly. In the 24 cases where a plan was evident, a monthly review could be confirmed in only 7 cases (29.2%). When compared with the overall sample of 36 cases, this means that the review of a plan occurred in one case in every five (20%).
In 23 of the 24 cases where a plan was evidenced, one of the following goals was indicated as required:

### Table CIC 11: Goals of Plan

| Goal | Frequency |
|---|---|
| Return of the child to the parent | 11 |
| Placement within his/her community | 1 |
| Adoption | 2 |
| Caregiver or residential care | 6 |
| Independence | 2 |
| No goals contained in plan/ C/D | 2 |
| **Total** | **24** |

## Appendix 4.5.19.4 Developmental Dimensions Addressed in the Plan

When the Plan of Care is developed for the child it is intended that a range of developmental dimensions will be addressed as outlined in *Looking After Children* and as described in the Policy Manual. Of the 24 cases where plans had been developed, the developmental dimensions were addressed as follows:

**Table CIC 12: Developmental Dimensions**

| Developmental Dimension | Number |
|---|---|
| Physical and sexual health | 15 |
| Education | 17 |
| Social presentation | 17 |
| Identity | 16 |
| Family and social relationships | 18 |
| Emotional and behavioral development | 17 |
| Self care skills | 16 |

In 50% of the cases where a plan had been prepared the reviewer answered 'yes' to the question of whether the child experienced a sense of security, stability, continuity of care and belonging. The child's view about the plan the pal was reflected in 58% of those cases with a plan. A copy of the plan had been provided to the parents in 25% of those cases (6 files) where a plan had been prepared.

## Appendix 4.5.19.5 Individual Support Services Plan (ISSP)

The ISSP is a tool which is used to coordinate the delivery of specialized services. Of the cases where plans of care had been prepared, 23 children were receiving services from one or more service provider. In 15 of the 23 cases (65% of cases with a plan) an ISSP had also been prepared.

## Appendix 4.5.20 PROVISION OF COUNSELLING FOR THE CHILD

Children who are admitted to care are entitled to counselling (CYFSA s. 66). Looking at the full sample of children, 20 of 36 (55.6%) children were receiving counselling. Counselling was not applicable for 5 of the child as a result of their age or developmental capacity. In a further 5 cases it could not be determined if counselling was being provided. The social worker was providing supportive counselling in 14 of the 20 cases.

## Appendix 4.5.21 ACCESS WITH PARENTS

The child was having access with parents in 25 of the 36 cases (69.4% of the sample). Access was ordered by the court in only 11% of the cases (4 cases). Access occurred with the following frequency:

### Table CIC 13: Access

| Frequency of visits | Number of Cases | Percentage |
|---|---|---|
| More than 1x per week | 8 | 32 |
| 2-4x per month | 4 | 16 |
| Monthly | 4 | 16 |
| Less than 1x per month | 5 | 20 |
| C/D /Missing | 4 | 16 |
| **Total** | **25** | **100** |

In 75% of the cases where access was taking place it appeared to be in the child's best interests. In only one case did the reviewer indicate that the access did not appear to be in the best interests of the child. In 22% of the sample it could not be determined if the access was in the child's best interests. In over 80% of the sample there was no indication that the child was being forced to have access. This information was either not applicable or could not be determined in the remainder of the sample.

Access was being supervised in almost 40% of the cases. Supervision was provided by the social worker (2 cases); family support workers (4 cases); a family member (1 case); care provider (1 case); others (6 cases).

## Appendix 4.5.22 PROVISION OF SERVICES TO THE CHILD

Other services such as regular medical and dental care, a life book and vision care are required to be provided to children in care annually. The following table describes the findings in these areas:

### Table CIC 14: Services to the Child

| Service | Number | Percentage |
|---|---|---|
| Life book | 6 | 37.5* |
| Annual medical examination | 16 | 44.4 |
| Annual dental examination | 12 | 60.0* |
| Annual vision care examination | 10 | 55.6* |

* Some cases not applicable due to age/development

Sixteen of the 36 children (44.4%) were in need of mental health or victim services. In 75% of those cases a referral for service had been made. In 13 of the 16 cases the children/youth were in receipt of mental health services.

## Appendix 4.5.23 SUMMARY

- The sample consisted of the files of fourteen girls (38.9%) and 22 boys (61.1%).
- The largest proportion of files in the sample was of adolescents (60%).
- The age and gender of the children in care has implications for the recruitment, support and retention of caregiver homes.
- About one-third of the children had been in care for one year or less; another third had been in care for one to two years; and the final third had been in care for more than two years.
- Almost 20% of the sample was children in care on a voluntary agreement; over 40% were in care on continuous custody orders.
- 22% of the children in the sample had been admitted to care previously.
- More than one in four children had a cultural affiliation, largely Innu.
- Most admissions to care had occurred due to physical harm, domestic violence and abandonment.
- Almost 45% of placements are in family based care.
- Over 16% of placements were in individual living or alternative living arrangements.
- The degree to which placement matching was occurring was difficult to determine as the broad range of information was not reflected on the files.
- In 36% of cases the children were seen by the social worker within seven days following a placement.
- In 22% of cases the required admission medical was obtained within three days of admission to care.
- A social/medical history was completed in about 14% of the sample.
- In almost 56% of the cases the child in care was seen by the social work once per month.
- Supervisory input was evidenced in two-thirds of the cases.
- Almost 60% of cases had one assigned worker during the past year.
- Two-thirds of the cases had plans of care in place as required.
- Of the cases with a plan of care, only 30% are receiving the required month review.
- ISSPs were in place in 15 of the 23 cases where a plan of care had been developed.
- In almost 70% of the cases the children were having access visits with members of their families. The access had been ordered by the court in only 11% of the cases. One third of the children were having access with the members of their family more than once per week.

- Life books had been developed for children in care as required in 37.5% of the sample.
- Annual medical exams had been obtained for the child in 44.4% of the sample.
- Annual dental exams had been obtained in 60% of cases.

# Appendix 4.6 CAREGIVERS

## Table of Contents



## List of Tables

## Appendix 4.6.1 PROGRAM DESCRIPTION

This program refers to the various placements that are provided by caregivers. Caregivers include relatives and significant others who are approved to provide substitute care for a child or youth in care and custody. It also includes non custodial parents who are approved as caregivers and non-relatives who are approved as caregivers. This section also includes the required process for approving, licensing and reviewing various types of caregivers.

## Appendix 4.6.2 STANDARDS, POLICIES AND PREFERRED PRACTICES

Standards have been interpreted based on the wording in the *Child, Youth and Family Services Policy and Standards Manual* and the *Risk Management System.* This includes any mandatory directions to staff which appear as part of the procedures narrative.

In addition, a small number of areas of preferred practice were included. These are identified as such where they occur.

## Appendix 4.6.3 DESCRIPTIVE INFORMATION

Twenty caregiver files were reviewed for the purposes of this project. Information regarding the approval date for the home was available in 17 of the 20 cases selected. The homes had been approved between 1985 and 2008 with 41% of the homes approved between 2000 and 2008. Of the files reviewed, 16 of the homes (80% of the sample) were open at the time of the review. Two homes had been closed. The status of the home could not be determined in the remaining two cases. Of the open homes, 13 (65%) were non-relative caregiver homes; three (15%) were relative/significant other homes.

## Appendix 4.6.4 INFORMATION REGARDING RELATIVE / SIGNIFICANT OTHER HOMES

The number of relative/significant other homes was very small, only three files (15%), in this sample. In two of the three files a preliminary assessment was completed before the placement of the child as required. This was described as not applicable in the third file. This preliminary assessment included a home visit and interview with all members of the household; a CYFS record check; verbal police checks on all persons 12 and over in the home; two verbal non-relative references; one verbal collateral reference; determination of the wishes of the child; preliminary verbal approval by a program supervisor. In addition, final approval was provided in the two applicable cases within 30 working days. While the sample size is very small, the compliance levels in two of the three cases are high. In the third case several factors were not applicable.

## Appendix 4.6.5 NON-CUSTODIAL PARENT APPROVAL PROCESS

This section was intended to evaluate compliance with standards in cases where children in need of protection were placed with non-custodial parents. No files selected for the review met the criteria for this section.

## Appendix 4.6.6 NON-RELATIVE CAREGIVER HOME APPROVAL PROCESS

A total of 16 files (65% of sample) were assessed according to the standards and procedures set out in this area. The standards are intended to make certain that applicants are thoroughly evaluated to ensure their capacity and suitability to care for foster children. This evaluation includes background checks, health and wellbeing assessments, references, home inspections, a social work assessment and financial assessments including all members of the household. This evaluation is to be completed in conjunction with the applicants' completion of the *PRIDE Pre-service Training Program* prior to the receipt of a placement.

### Appendix 4.6.6.1 Background Checks

In order to determine their suitability for the role of caregiver, applicants provide personal references and are screened for previous CYFS contact and criminal background. The file material was inconsistent in demonstrating the completion of these checks. Eighty-one percent of the caregiver homes in the sample had been screened for criminal records. Seventy-five percent had received medical assessments and forty-four percent had been assessed for financial status. Regarding references, almost seventy percent of files had the required references on the record and just over sixty-two percent of the homes had a completed safety inspection.

**Table CH 1: Background Checks for Caregivers**

| Type of Check | CYFS | Criminal Records | Medical | Financial | References | Home Safety |
|---|---|---|---|---|---|---|
| No | 5 | 1 | 4 | 7 | 5 | 5 |
| Yes | 7 | 13 | 12 | 7 | 11 | 10 |
| N/A: C/D | 4 | 2 | | 2 | | 1 |
| **Total Compliance** | **43.8%** | **81.3%** | **75%** | **43.8%** | **68.8%** | **62.5%** |

### Appendix 4.6.6.2 Application and PRIDE Training

Thirteen of the 16 cases (81%) had applications completed by the prospective caregivers. This information was missing in one case; in the remaining two cases the application had not been submitted. In eleven of the 16 cases in the sample (69%), the applicant caregivers had completed the required PRIDE *Pre-Service Training*. In three cases (19%) the training had not been completed. Information regarding completion of the training could not be located in two cases (12% of sample).

### Appendix 4.6.6.3 Documentation

As part of the assessment process, applicants are asked to provide and sign certain documents. Marriage certificates are required from the applicants, where applicable. In this sample 53% of cases had evidence that a marriage certificate had been requested. Birth certificates were required for all members of the household and these were evidenced in 53% of the sample.

The caregivers are requested to sign a confidentiality agreement and a caregiver agreement which outlines their duties and expectations. These were evident in 68% (confidentiality) and 50% (caregiver agreement) of the sample.

### Appendix 4.6.6.4 Approval Process

In 93.8% of the sample the caregiver home was approved. The approval or rejection of one home could not be determined. Thirteen of the 15 approved homes (81%) were informed in writing as required. None of the homes in the sample had been rejected although the status of one home could not be determined. In 56% of the sample a copy of the home assessment had been shared with the applicants. Twenty-five percent of the sample (four homes) had received temporary approval for a placement.

Where temporary approval was granted, certain requirements were not always met. For example, a CYFS record check was completed in only one of four cases; two interviews with the prospective caregiver were completed in only one of four cases; a home visit was conducted in only two of four cases. The subsequent full approval process was incomplete or information was missing in all four of these cases.

## Appendix 4.6.7 NUMBER OF PLACEMENTS

For this factor all caregiver homes were included (N=20). Provincial standards stipulate that approved homes have a maximum of two children at a time. Reviewers were asked to identify those situations where more than two placements had occurred over the past year and the reasons for the placements. Seven of the homes (35%) in the sample had had more than two placements during the year. Two homes had three children; two additional homes had four children; one home each had five and six children. Information was either unavailable, not applicable or could not be determined in five files. Reasons given for the additional placements were; keeping siblings together; the child had an existing relationship with the caregiver; an additional relative placement; and respite. There is also a provision to have more than two children under exceptional circumstances.

## Appendix 4.6.8 SOCIAL WORKER CONTACT

Following approval of a caregiver home, a social worker is required to maintain regular contact with the caregiver at a minimum of once monthly. Of the twenty files in the sample, the frequency of social worker contact could not be determined in eight cases (40% of the sample). Where the frequency of contact was documented, 25% of the homes had had contact with a social worker twice annually or less. Six homes (30% of the sample) had had contact with a social worker quarterly or more often. In 90% of the

sample contact with the caregivers was either undocumented or below the required standard.

**Table CH 2: Social Worker Contact**

| Frequency of Contact | Number of cases | Percentage |
|---|---|---|
| Twice monthly | 1 | 5 |
| monthly | 1 | 5 |
| Every two months | 1 | 5 |
| quarterly | 3 | 15 |
| Twice annually | 2 | 10 |
| Annually or less | 3 | 15 |
| C/D-Missing | 8 | 40 |
| N/A | 1 | 5 |
| **Total** | **20** | **100** |

## Appendix 4.6.9 SUPERVISORY / MANAGEMENT INPUT

Supervisory or management input is required at certain key points in the approval process and during the course of work with the caregiver home. Reviewers were asked to identify the evidence of supervisory input and to note how this had been documented. Overall, supervisory input was evident in 80% of the sample (16 cases). This information was absent or could not be determined in three files (15% of the sample) and was not applicable in one file. Supervisory input was noted in conference notes, supervision consultation, meetings with clients, signoff on records and approval letters. It was also evidenced in approvals for emergency placements and temporary approvals.

## Appendix 4.6.10 REVIEW OF CAREGIVER HOMES

As part of the monitoring process and a key safeguard for children in care, caregiver homes are required to receive an annual review. Annual reviews are *not* required on relative/significant other caregiver homes.
The summary that follows outlines the length of approval for each home and goes on to enumerate the frequency of reviews.
Sixteen files selected for the review represented caregiver homes where an annual review was mandatory. Ten of the 16 homes had been approved for more than five years. Four of the homes had been approved for two years or less. One home had never been approved and in another file information regarding approval was missing.

**Table CH 3: Review of Caregiver Home**

| Length of Approval | Number of Homes | Percentage |
|---|---|---|
| Less than one year | 2 | 12.5 |
| Between one and two years | 2 | 12.5 |
| More than five years | 10 | 62.5 |
| Never | 1 | 6.3 |
| Missing/N/A | 1 | 6.3 |
| **Total** | **16** | **100.0** |

## Appendix 4.6.11 FREQUENCY OF REVIEW

Twenty-five percent of the sample had never received an annual review. Two cases had been approved less than one year at the time of the review so would not have been due for an annual review to date. These homes are included in the missing/not applicable data. Three cases had received reviews at least annually as required by standards. Over sixty-two percent of the cases had not received the required annual review.

**Table CH 4: Frequency of Review**

| Frequency of Review | Number of Homes | Percentage |
|---|---|---|
| At least annually | 3 | 18.8 |
| Every two years | 6 | 37.5 |
| Never | 4 | 25.0 |
| Missing/N/A | 3 | 18.8 |
| **Total** | **16** | **100.0** |

## Appendix 4.6.12 DECISION TO CLOSE THE HOME

Information was considered for this variable from the full sample including relative/significant other homes and non-relative caregiver homes (N=20). In ten percent of the sample (2 files) a decision had been made to close the home. In both cases the reason given for the decision to close the home was "failure to adhere to Department policy regarding standards of care." One of the two cases also cited "changes in family composition which affects ability to care for children" as a reason for closing the home. In one of the two cases there was documentation that the social worker had met with the caregivers to explain the reasons for the decision to close the home. This was followed as required by written confirmation. This could not be determined from the records in the second case.

## Appendix 4.6.13 INVESTIGATION OF THE HOME FOR CHILD MALTREATMENT

Fifteen percent of the sample (3 homes) had been investigated regarding concerns of child maltreatment. In four cases information was missing or it could not be determined whether

the case had been investigated for reasons of child maltreatment. In all cases a social worker investigated the complaints. One of the cases was investigated jointly with the police as is required by protocol for incidents of physical and sexual abuse. This information could not be determined in one case and was not applicable in the third case. In two of the three cases the investigation was completed within 30 days. This information could not be determined in the third file. There was no indication on any of these files as to whether the outcome of the investigation had been reviewed as required by the director, program manager, investigating social worker and the social worker for the child and caregiver. In one of the three cases a copy of the investigation report was on the caregiver file.

## Appendix 4.6.14 SUMMARY

- 80% of the files in the sample were non-relative caregiver homes.
- 65% of that group of homes was assessed according to the prescribed standards.
- Background checks on caregiver applicants showed variable compliance. Of specific note was that less than half of the applicants had been checked for a history of involvement with CYFS.
- Over 80% of the applicants had completed the required PRIDE Pre-Service Training.
- Almost 94% of homes in the sample had been approved.
- Necessary requirements were not always met where temporary approval was required.
- 35% of the homes in the sample had had more than two placements at a time during the past year.
- There were significant deficiencies in determining the frequency of social worker contact with the caregivers. As a result, in 90% of the sample the contact with the caregiver was either undocumented or below the provincial standard of once per month.
- Supervisory input was evident in 80% of the cases reviewed.
- Annual reviews are required for all non-relative caregiver homes. Twenty-five percent of the sample had never been reviewed despite having been eligible for at least one review.
- Almost 19% of the sample had received annual reviews as required by standards.

# Appendix 4.7 YOUTH SERVICES: RESIDENTIAL AND NON-RESIDENTIAL

## Table of Contents



## List of Tables

## Appendix 4.7.1 PROGRAM DESCRIPTION

The goal of the Youth Services program, Child, Youth and Family Services Act (Section 11), is to assist youth to make the transition to adulthood. Services are provided to youth, up to the age of 21 who have been in care of the director prior to age 16. Also the program provides supports to vulnerable youth between 16 and 18 years of age and who enter into a voluntary agreement.

## Appendix 4.7.2 DATA RESULTS AND ANALYSIS

(Note: Due to issues with data collection and some regional differences at intake, both residential and non-residential youth services are reported together.)

### Appendix 4.7.2.1 Sample Size

In total 42 files were randomly selected for the review.

### Appendix 4.7.2.2 Age and Gender of Youth

The profile of the youth showed that almost 80% (37) were between 16 and 18 years of age. In terms of the file documentation in almost 10% the age of the youth was not noted.

**Table YS 1: Age of Youth**

| Age | Number | Percentage |
|---|---|---|
| 16 | 18 | 42.9 |
| 17 | 15 | 35.7 |
| 18 | 4 | 9.5 |
| 20 | 1 | 2.4 |
| Information Missing | 4 | 9.5 |
| **Total** | **42** | **100.0** |

#### *Gender*

There were 17 (40.5%) females and 23 (54.8%) males in the sample. In two of the files the gender was not noted. The profile is similar to the children in care population where there are more males than females prior to age 16.

### Appendix 4.7.2.3 Time in YS Program:

The following chart presents the time that youth have been in the program:

### Table YS 2: Length of Time in the Program

| Length of Time in YS | Number | Percentage |
|---|---|---|
| Less than 6 months | 14 | 33.3 |
| 6 to 12 months | 9 | 21.4 |
| 1-2 years | 12 | 28.6 |
| Over 2 years | 3 | 7.1 |
| No service provided | 4 | 9.5 |
| **Total** | **42** | **100.0** |

As this is a time limited program it can be expected that for the majority of youth, approximately 85%, the time in the program would be less than two years.

## Appendix 4.7.2.4 Case Status

At the time the file review was performed on the 42 files the case status was as follows:

### Table YS 3: Case Status at Time of Review

| Open/Closed | Number | Percentage |
|---|---|---|
| Receiving service | 23 | 54.8 |
| Closed | 18 | 42.9 |
| Cannot determine | 1 | 2.4 |
| **Total** | **42** | **100.0** |

All of the cases received some form of service within the time period of April1, 2007 to March 31, 2008.

## Appendix 4.7.2.5 Type of Service

Service provided to youth through the Youth Services Program is identified as residential or non residential according to need. During the period that was the focus of the review the type of service breakdown was:

### Table YS 4: Type of Services

| Type of Service | Number | Percentage |
|---|---|---|
| Residential | 27 | 64.3 |
| Non residential | 7 | 16.7 |
| Closed after assessment | 8 | 19.0 |
| **Total** | **42** | **100.0** |

A number of youth in the program had been in care previously. Also the program supports at risk youth who cannot live with their family. Therefore it is expected that there would be a higher proportion of residential supports provided (almost two thirds).

## Part A: ASSESSMENT

*Standards have been interpreted as they appear in the Child, Youth and Family Services Policy and Standards Manual and the Risk Management System. This includes any mandatory directions to staff which appear as part of the procedures manual.*

### *Youth Services Agreement*

The completion of a Youth Services Agreement (Form 14-627) is required for every case.

### Appendix 4.7.2.6 Reason for Eligibility for Service

**Table YS 5: Reason for Service**

| Reason | Number | Percentage |
|---|---|---|
| In care prior to age 16 | 9 | 21.4 |
| Family maltreatment | 11 | 26.2 |
| No parent or person to care | 3 | 7.1 |
| Single parent | 3 | 7.1 |
| Youth court ordered | 1 | 2.4 |
| Other * | 10 | 23.8 |
| Cannot determine reason | 3 | 7.1 |
| Missing information | 2 | 4.8 |
| **Total** | **42** | **100.0** |

* Other reasons included one youth who came to the program through a Child Welfare Allowance case; one who required respite support and one who was not living at home due to addiction issues. In 5 cases the reason for service could not be determined.

Almost one third of the youth are using the service due to family issues and maltreatment. Approximately 20% of the youth in the program were previously in care.

### Appendix 4.7.2.7 Youth Risk Screening

The standard states that within 7 days of the referral a Youth Risk Screening Tool may be completed in response to a referral.

Of the 42 cases the Youth Risk Screening Tool was completed and in the file for 29 (69%) of the cases and not completed in 6 (14.3%). For the remaining 7 cases, the youth were previously in care and did not require screening. However in two cases of youth in care the Youth Risk Screening was on the file and has been included in the data.

### Table YS 6: Youth Risk Screening Completion

| Service (YRS) | Number | Percentage |
|---|---|---|
| **Timeline for Completion:** | | |
| - Completed within 7 days | 24 | 82.8 |
| - 8 – 14 days | 3 | |
| - 15 days to one month | 1 | |
| - More than a month | 1 | |
| **Signed by the youth:** | | |
| - Yes | 24 | 82.8 |
| - No | 5 | 17.2 |
| **Manager's approval:** | | |
| - Yes | 10 | 34.5 |
| - No | 16 | 55.2 |
| - Cannot determine | 2 | 6.9 |
| - Missing | 1 | 3.4 |
| **Involvement of Others:** | | |
| **Parents** | | |
| - Yes | 18 | 62.1 |
| - No | 9 | 31.0 |
| - Not applicable | 2 | 6.9 |
| **Other Individuals:** | | |
| - Yes | 14 | 48.3 |
| - No | 13 | 44.8 |
| - Not applicable | 2 | 6.9 |

In one file there was an indication that as a result of the completion of the Youth Risk Screening a referral was made to the Protective Intervention Program in relation to risk for siblings under the age of 16.

In the 29 cases there was an over 80% rate of a timely response to the requirement for screening and involvement of the youth. Parents were involved in almost two thirds of the cases and others who know the youth in almost half. Managerial approval was noted in 10 files (34.6%).

## Appendix 4.7.2.8 Identification of Risk Factors

In completing the Youth Risk Screening the risk factors that were identified include physical abuse (7), sexual abuse (1), emotional abuse (16) and neglect (3).

Other reasons include: CWA placement, family violence, independent living, parent child conflict, parent abandonment, parent addiction and parent mental health. 1

For the 29 cases, the highest reported risk factors were physical 24% and emotional abuse 55.2%. 10 of the 12 other risks were related to family issues such as violence, parent child conflict and parents' issues. All of the risk factors can be connected to reasons for protective intervention and children in care

## Appendix 4.7.2.9 Residence Location

Of the 29 cases, 22 (75.9%) youth did not live with family and 5 (17.2%) lived with a parent or guardian. For the remaining 2 cases the information could not be determined or

was missing. Where the youth was living with parents, supports were provided to 2 families.

The number of youth not living with family is to be expected given the age and the risk factors identified.

# Part B: SERVICE PLANNING

## Appendix 4.7.2.10 Youth Services Agreement

Of the sample of 42 files an agreement with the youth was entered into in 28 of the cases. Not completed in 11 cases, was not applicable in 1 case and was missing from the file in 2 cases. The result is that the following data is based on 28 files, i.e. two thirds, of the sample.

In 25 files (89.3%) the agreement was in relation to residential services and in 3 cases it was for non-residential services. The agreement was in the file for 26 cases.

### Table YS 7: Youth Services Agreement

| Features of the Agreement | Number | Percentage |
|---|---|---|
| **Parent's financial contribution** assessed w/in 30 days | | |
| - Yes | 9 | 32.1 |
| - No | 5 | 17.9 |
| - Not applicable | 7 | 25.0 |
| - Cannot determine | 7 | 25.0 |
| **Voluntary nature of the agreement explained** to the youth | | |
| - Yes | 18 | 64.3 |
| - No | 1 | 3.6 |
| - Missing or can't determine | 9 | 32.1 |
| **Youth advised of legal nature** of the agreement | | |
| - Yes | 15 | 53.6 |
| - No | 1 | 3.6 |
| - Missing /can't determine | 12 | 42.6 |
| **Involvement of youth in setting goals** | | |
| - Yes | 22 | 78.6 |
| - No | 3 | 10.7 |
| - Can't determine / missing | 3 | 9.7 |

When a Youth Services Agreement was used it was most often for residential service and support. Youth are directly involved in the process of completing the agreement and a high number (22) work on setting goals (78.6%).

## Appendix 4.7.2.11 Planning / ISSP

It is expected that the services provided to youth focus on the development of goals for transition to independence and adulthood. Where the youth agrees, an Individual Support Services Plan (ISSP) is used.

### Table YS 8: Use of ISSP for Planning

| Completion of ISSP | Number | Percentage |
|---|---|---|
| **Youth agreed to plan:** | | |
| - Yes | 7 | 16.7 |
| - No | 21 | 50.0 |
| - Not applicable | 4 | 9.5 |
| - Can't determine | 10 | 10.0 |
| **Completion: (7 cases)** | | |
| - Within 30 to 60 days | 3 | |
| - Within 60 – 90 days | 1 | |
| - Over 90 days | 1 | |
| - Missing/can't determine | 2 | |
| **Type of Supports:** | | |
| - Education/training | 6 | |
| - Employment | 2 | |
| - Housing/IL | 6 | |
| - Career dev. | 2 | |
| - Counseling | 3 | |
| - Referrals | 1 | |
| - Transfer from YS | 2 | |

There was evidence of goals being set with the youth which support independence in all cases, including those with an ISSP.

### Table YS 9: Supports Provided to Youth

| | Number | Percentage |
|---|---|---|
| **Supports provided:** (28 service agreements) | | |
| - Basic living allowance* | 16 | 57.1 |
| - Financial support | 12 | 42.9 |
| - Referrals | 7 | 25.0 |
| - Health Care services | 7 | 25.0 |
| - Transition counseling | 4 | 14.3 |
| - Other | 1 | 3.6 |
| **Activities:** (42 cases) | | |
| - Attending school | 25 | 59.5 |
| - Support for transition | 21 | 50.0 |
| - Connecting youth to supports for after care | 18 | 42.9 |
| *** Receiving less than the basic foster care rate?** | | |
| - Yes | 8 | 19.0 |
| - No | 21 | 50.0 |
| - Not applicable | 5 | 11.9 |
| - Can't determine | 8 | 19.1 |

Almost 60% of youth in the sample of files reviewed are attending a school program and half of the files indicated that the youth is working toward independence.

## Appendix 4.7.2.12 Single Parent Youth

Of the 42 files, 5 were identified as single parent youth. The following information was gathered:

- Two were referred due to maltreatment at home and three were self referred.
- Three youth live independently, one with family and for the other the information was missing.
- A referral was made to protective intervention on behalf of the child in one case only.
- In none of the cases was an ISSP completed on behalf of the child of the parent.
- One of the 5 single parent youth was referred to Family Services for supports.

## Appendix 4.7.2.13 Exceptional Circumstances

No files were reviewed which involved youth receiving services based on exceptional circumstances.

## Appendix 4.7.2.14 Frequency of Face to Face Contact with the Youth

Of the 42 youth one third had direct contact with a worker monthly or more. Another third had quarterly contact.

**Table YS 10: Frequency of Worker Contact**

| Frequency (42 files) | Number | Percentage |
|---|---|---|
| More than once/month | 2 | 4.8 |
| Monthly | 12 | 28.6 |
| Quarterly | 14 | 33.3 |
| Less than quarterly | 5 | 11.9 |
| Not applicable | 5 | 11.9 |
| Can't determine | 3 | 7.1 |
| Missing | 1 | 2.4 |
| **Total** | **42** | **100.0** |

## Appendix 4.7.2.15 Renewal of the Youth Services Agreement

The standard is that the agreement is to be renewed with the youth every 6 months. Where there was a Youth Services Agreement on the file (28 cases); 11 were renewed, 5 were not and in 12 cases it wasn't applicable or was missing.

### *6 Month Review of Goals*

Of the 28 files with agreements, only 7 had documented review of the goals.
In 10 cases it was not on file, for another 10 it wasn't applicable and in one file it couldn't be determined.

### *Changes to Type of Service in Previous Year*

For the 28 youth with Youth Service Agreements, there were changes in residence noted in the file for 10. Eight youth reached either 18 or 21 years of age, the date at which they are no longer eligible to receive service. One youth moved from residential to non-residential service.

### *Number of Moves in the Previous Year*

Based on the total sample of 42 files the following indicates that the majority of youth were relatively stable in terms of living arrangements.

**Table YS 11: Number of Moves**

| Number of Moves | Number | Percentage |
|---|---|---|
| None | 18 | 42.9 |
| One-two | 14 | 33.3 |
| More than two | 1 | 3.0 |
| Not applicable | 7 | 16.7 |
| Can't determine | 2 | 4.8 |

## Appendix 4.7.2.16 Cancellation of the Agreement by the Youth

The standard states that when a Youth Services Agreement is cancelled by either the youth or the social worker, a Cancellation of Youth Services Agreement Form #14-827 must be completed and signed.

In the cases where there was a Youth Services Agreement on the file; 8 had been terminated by the youth and in five 5 the form was signed and completed by the youth.

## Appendix 4.7.2.17 Management Input during the Case

In reviewing the 42 files, the reviewers looked for evidence that supervisory approval and involvement occurred.
From the file documentation the most frequent managerial input was that of signing off records. It is a concern that there was no evidence of supervision in one quarter of the files.

### Table YS 12: Manager Input

| Manager Input | Number | Percentage |
|---|---|---|
| **Evidenced:** | | |
| - Yes | 31 | 73.8 |
| - No | 9 | 21.4 |
| - Missing | 1 | 2.4 |
| - Can't determine | 1 | 2.4 |
| **Form of input:** | | |
| - Conference notes | 1 | |
| - Supervision consultation | 10 | 32.3 |
| - Meeting with client(s) | 1 | |
| - Sign off on records | 20 | 64.5 |

## Appendix 4.7.2.18 SUMMARY

- The sample for the Youth Services program was 42 files.
- 80% of the youth were between 16 and 18 years of age; 40.5% were female and 54.8% males.
- 85% of the sample had been in the program for up to 2 years. Almost two thirds (64.3%) of the cases that stayed open for service after assessment were receiving residential supports.
- 9 youth (21.4%) had been in care of the director prior to age 16. One third was in the program due to family maltreatment and other issues.
- The Youth Risk Screening Tool was completed in 69% (29) cases. The timeline for completion (7 days) was met in 80% of the files. Managerial approval was noted in only one third of the files.
- Parents were involved (62.1%) as well as others who knew the youth (48.3%).
- Most frequent risk factors identified were: physical abuse (24%), sexual abuse, emotional abuse (55.2%) and neglect. These are similar to the risk factors identified in Risk Assessment and the Protective Intervention Program.
- Of the 29 cases, 75.9% of the youth were not living with their family.
- A Youth Services Agreement was entered into in 28 cases, was not completed in 11 cases and was not applicable or missing from the remaining 3 cases.
- Most often the Youth Services Agreement was for residential supports (89.3%).
- Youth were involved in setting goals and completing the agreement. However there is a low usage of the ISSP as the method of planning (16.7%).
- Of the original sample of 42 cases, 60% of the youth were attending school.
- Of the 5 single parent youth, in one case there was a referral to the Protective Intervention Program and in one a referral to Family Service.

- In terms of contact between the worker and the youth, one third had monthly or more contact and another third had quarterly contact.
- Documentation of activities such as renewal of the agreement and review of the goals was on the file in a quarter to a third of the cases.
- Youth were relatively stable in terms of the number of moves in the previous year with 18 (42.9%) not having any moves.
- The manger's input was evident on the file in 73.8% of the cases, mostly in the form of consultation (32.3%) and sign-off on records (64.5%).
- Overall there is evidence that the program is being used to support youth at risk. The level of service and documentation drops off to lower than the standard after the initial response to the referral.

## SUPPLEMENTARY APPENDICES OF FORMS

The data collection forms that were developed for each of the 7 programs are published separately.