

Ontario Association of Children's Aid Societies

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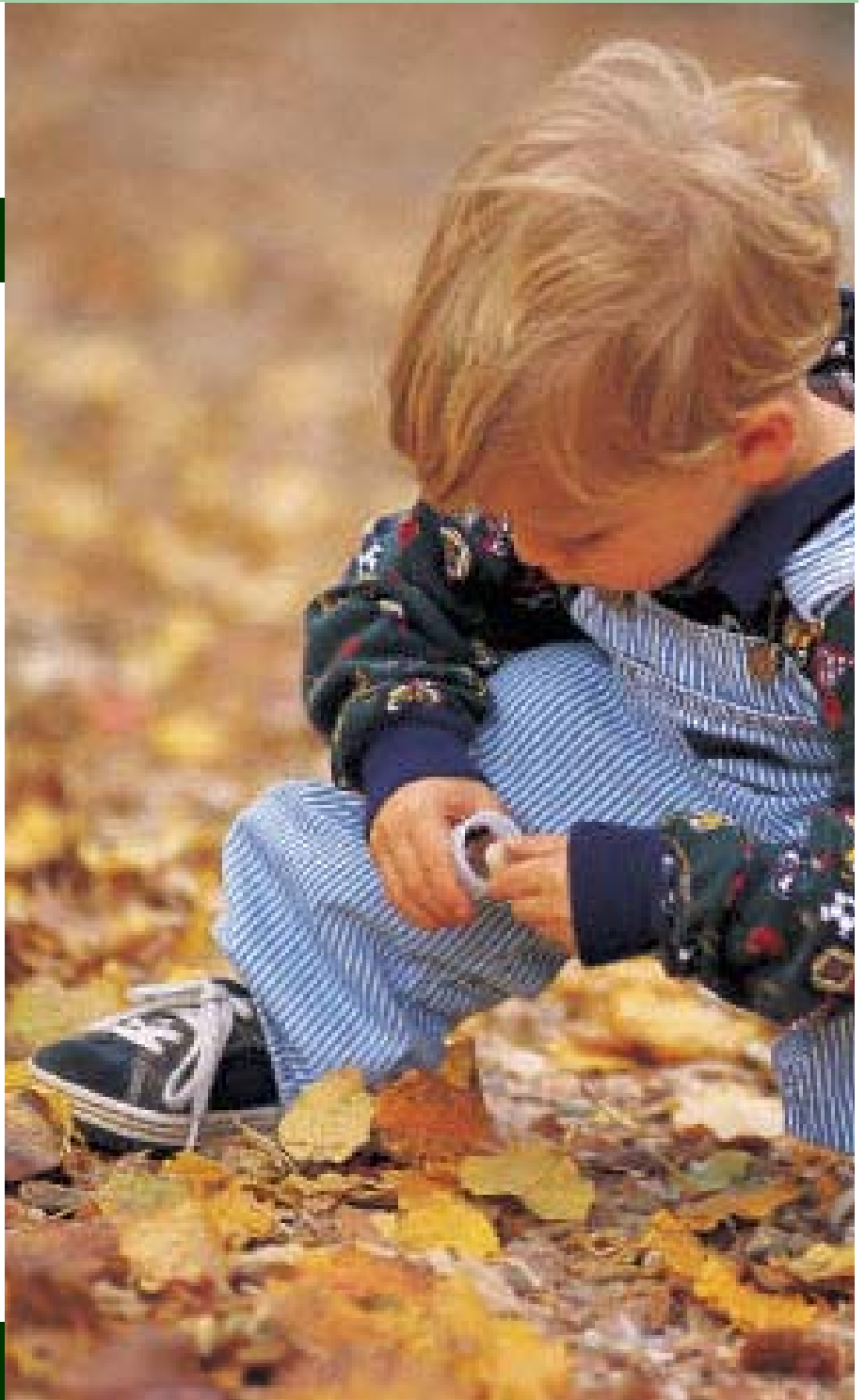
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*The voice of child welfare in Ontario*



*OACAS Website Communications Coordinator  
Kristine in her pre-computer days.*

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## Message from the Executive Director



*Jeanette Lewis*

The Child Welfare Secretariat's Transformation Agenda continues to move forward and OACAS continues to prepare for its implementation and keep members up to date on any developments.

The Request For Proposals (RFP) stage of the Single Information System project is completed, and the implementation of documentation standards, budget controls, status reporting and project planning is underway. A number of working groups are being established to correspond with the functionalities to be developed within the SIS. It is clear that a Single Information System for all CASs will significantly improve the consistency and quality of service, while reducing the effort and expense currently involved with maintaining numerous information systems. The Province has provided up to \$12 million to fund the development of the project to pilot test on two to four agencies.

The Secretariat will hold two-day Regional meetings to allow opportunities for CASs to provide input into the Accountability Framework and Differential Response. The meetings are scheduled to begin late October and conclude by mid-November. Meanwhile, as a basis for discussion at the regional meetings, the Secretariat

released a paper describing a proposed accountability/service system management framework. Also for discussion is a proposed process for consulting with communities about how to improve access to community services for CAS clients. On day two, the topic will be Differential Response. Proposals for changes to the risk assessment model, and proposals for strength-based family assessments will be on the agenda.

With the resumption of the work of the Legislative Assembly on October 11<sup>th</sup>, Bill 210: An *Act* to amend the *Child and Family Services Act* and make complimentary amendments to other *Acts*, is on the agenda. The second reading is being debated in November. The various amendments that have been introduced in this Bill include:

- Expanding the concept of foster care to include kinship care
- The introduction of custody orders, consistent with a continued emphasis on permanency planning
- Increased rights of foster parents and clarification of existing rights of foster parents
- Provision for openness orders or openness agreements in Adoption cases

In the midst of all the activity around the Transformation Agenda, OACAS is very busy laying the foundation needed to roll out a major Transformation training initiative that includes assisting agencies with project and change management, and understanding the Ministry policies and expectations. A number of preparations are being made for the fall and winter, and for what we think agencies may experience during the remainder of this year.

OACAS continues to work closely with the Secretariat throughout the Transformation Agenda, keeping sight of all our strategic goals and our primary purpose; meeting the needs of the children and youth served by our members.

# The Voices of Youth in Care: Learning from Focus Groups with Former and Current Crown Wards

By: Gail Aitken, Gitte Granofsky, Ryna Langer, Sally Palmer, Jacqueline Mankiewicz Smith

*The authors wish to acknowledge the invaluable help provided by the following agencies who facilitated the focus groups: PARC (Pape Adolescent Resource Centre), Toronto; Haldimand-Norfolk CAS; Halton CAS; London-Middlesex CAS; Nipissing & Parry Sound CAS, and; CAS of Owen Sound and the County of Grey.*

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## Background

In November 2002 the Children in Limbo Task Force of the Sparrow Lake Alliance met with five older youths who were or had been Crown wards to learn of their experiences with the Ontario family court system. The 14 seasoned professionals included psychiatrists, lawyers, social workers and psychologists. They found the youths' comments moving and disquieting. The discussion generated thinking about potential improvements in the system. The Task Force also realized the necessity of determining how representative these five were of Ontario's Crown wards, a population of over 9000 children and adolescents<sup>1</sup>. The Task Force agreed that assembling other focus groups from around the province would help

determine whether the initial group's experiences were typical. In February 2003 the authors made a submission through the Ontario Association of Children's Aid Societies to the CAS Directors of Service. Through OACAS leads and individual contacts with specific Children's Aid Societies, six more focus groups were conducted in various regions of Ontario. All groups were facilitated by social workers in the agencies involved with the young people. Groups ranged in size from four to nine participants, with five groups having both male and female members, one having female members only and one having nine male members. To ensure that various-sized communities were represented, the agencies ranged from very small rural agencies to medium and large urban centres, two being Toronto-based. All participants were or had been Crown wards.

Confidentiality was a major issue. Each young person signed a confidentiality agreement and no identifying information was included on the tapes. Also, in the transcriptions and analysis, coding was used to protect fully the identities of participants.

The methodology included the development of complete transcripts of each of the seven focus groups.

These were then analyzed by a researcher using the program "N-Vivo," useful in qualitative exploratory research of this nature to organize the material around recurrent themes. The themes are illustrated and emphasized throughout by selected comments of the participants in the focus groups, taken from the tapes of the discussions. This paper is based on the voices of these participants as they describe their experiences in becoming Crown wards. The authors have made minor edits to improve clarity.

## Experience of Coming into Care

Suddenness, confusion, uncertainty, and lack of explanation or information seemed to be associated with coming into care. Some youths pleaded to be told the truth:

When moving a child into a foster home, the worker should tell them straight up that they [the workers] have no idea how long they are going to be there.

Feelings of uncertainty and insecurity are compounded because these young people often do not understand who is making the decisions about their lives, and the social workers to whom they are assigned are frequently changed:

But what I feel is that I don't know who exactly is responsible

for me. Is it my foster parents? Is it my social worker? Is it my social worker's supervisor? Is it the police?

Multiple placements compound confusion. One young person, having had a succession of foster homes, recounted protesting to his worker:

Don't move me! I can't stand going to different placements. I have to get used to one place and stay there.

Vividly portrayed, especially by members of one group from a rural, northern agency, was the isolation felt by some youths who suddenly found themselves in placements quite distant from the schools and communities they knew. One told of being taken in the middle of the semester from his home to a group home in another northern city, and reflected dismay at facing strangers as foster parents, strangers as schoolmates and a strange community.

Frequently the young people described the stigma of being in care and the low status of foster children amongst schoolmates:

Once other kids find out that you're in foster care you get looked at in a different way; it's like you get judged. "Yes, you must have done something wrong" or "you're bad" or something." You get put away and, like, you're in your own section now; you're a loser.

Youths expressed anxiety, appreciation, and confusion regarding their placements after being taken into care. One was dismayed at finding she was placed in an open custody group home with youths who

were in and out of jail. "Cops were banging on our door constantly." A young Caribbean Canadian girl was concerned about being placed with a white foster mother whom she thought would know nothing about her cultural background or the special skin and hair products she needed. One young man, realizing that he could not stay with his mother, expressed gratitude for the foster care he was receiving:

Technically, they're opening their doors to you, putting a roof over your head, food in your stomach, clothes on your back — and you're giving them attitude?

Another expressed the confusion of having two families:

Living in this foster home for so long, I have actually grown to calling my foster mom "mom" and my foster dad "dad". When I start getting into a conversation with my foster parents they're, like, which mom?

In several groups participants portrayed concern about their birth families, especially their mothers, and, in some instances, guilt about the impact of their Crown wardship upon the family:

When they said it was final, there was a wall between my parents [and me]. And the bad thing is you can't fix it.

A recurrent theme was that despite knowing they needed to live away from their families, they felt guilty for the turmoil their Crown wardship had caused, a need to connect with their families, and in certain instances, a desire for parents to admit and accept their responsibility.

## Youths' Responses to the Legal Processes and the Court Experience

Many of the youths did not attend court, as children over 12 years old are entitled, but not required, to attend<sup>2</sup>, and children under 12 are presumed not entitled to be present at the hearing<sup>3</sup>. For a court hearing, there is no requirement that children have a lawyer, but the court may order legal representation<sup>4</sup>. In those cases, The Office of the Children's Lawyer in Ontario assigns lawyers to represent the legal interests of children. These lawyers are asked to meet personally with children or adolescents several times before the court hearing in order to determine the position to take on their behalf. In addition, a social worker assigned by the Children's Aid Society (CAS) to a child or youth is expected to ensure that the person understand the processes related to court.

Participants described having both good and inadequate preparation for court from lawyers and social workers. One girl was very satisfied with her lawyer, crediting her with instigating Crown wardship:

The process of me becoming a Crown ward started when I was speaking with [the lawyer] on the phone one night. I said, 'I know I don't want to go home'...so she said 'Do you want to become a Crown ward?'

Another was also pleased:

She [the lawyer] came to see me at my group home, and she talked through the papers with me.... She did tell me that my family would be there. I think she told

me that I wouldn't have to speak to them, and she prepared me for things like that. She told me what the judge would ask me, and what the process was.

On the other hand, many youths felt unprepared for hearings about their custody, because they were not notified until the day before the court hearing took place:

I just found out about being a Crown ward the day before the assigned court date and I was pretty upset about that.... The day I went to court was the first day that I met my lawyer. It wasn't even my lawyer — I had to borrow my parents' lawyer.... My Dad asked me if I wanted another lawyer, and I'm thinking to myself, "That's a little too late, isn't it?" I had no choice — it had to be right now.

Some youths could not recall any preparatory contact with their lawyers. One said he first met his lawyer only five minutes before he went into the courtroom, while another did not recall having a lawyer. Many youths said they did not expect to be represented by a lawyer:

I had no idea who he was — he just came into the hallway and said, "I'm the lawyer" [and I thought] "I have one of you guys? Where were you when I needed this? I could have used you before."

Several youths felt the court process had not been well explained to them. One said his social worker "explained what it was and told me to sign the papers." This was probably an "Agreed Statement of Facts" giving the reason why he was in CAS custody, and he said he was too

young to really understand what was happening. When asked what the term "Crown wardship" meant to him, he said, "taken away from my family." Later he added, "life sentence to CAS." One girl stated:

I met with my lawyer once...probably eight months before I became a Crown ward.... It was kind of a 'getting to know you' meeting." Closer to the court date, the lawyer phoned and she recalled: "We didn't really talk about the Crown ward process or anything.

Some participants felt unprepared for the questions in court, and pressure, not knowing the implications of their answers:

While the judge was talking, she [the lawyer] asked me, on the side, "Do you want a group home? Do you want to become a Crown ward?" I didn't know what Crown ward meant, but I thought it was going to get me out of my mother's house as fast as possible. So [I said] "Yes, I want to get out."

Give me some information...so I know ...what are the consequences of "yes" and what are the consequences of "no"...instead of [turning] to me in the middle of this environment that I'm not familiar with, and asking me questions.

It's not like I had time to think about it — there's people looking at me, and...the judge-judges are intimidating, and if they're looking down at you impatiently, waiting for an answer, you think, "Does yes sound good? Will you guys go away now?"

Some youths felt excluded from the court process: either they were not encouraged to attend, or they attended but believed they had little input into the decisions made at the hearing. This perceived exclusion often led to anger, frustration, and anti-social behaviour:

I didn't feel as though anyone thought about what I had to say, or considered me at any point there...not as much as I would have liked.... And then [at the conclusion of the hearing] it was just "Bang, bang — this is it!"

They did all the paper work they wanted to, and I never seen nothing, and all they say is, "Hey, now you're a Crown ward!" like it's some kind of joke....When I found out [about the Crown wardship]...I've been vengeful and on a rampage ever since.

Some older youths, when given notice of the proceedings, instead declined to attend court because they were nervous about the prospect of a court hearing that would determine their future lives. One youth said:

I don't even like hearing about it — it makes me think I don't want to go there.

Another said it made him think of a jail sentence.

Some youths who did attend court described feeling overwhelmed and powerless:

The room just felt huge...getting from the entrance to where I had to stand up beside the judge felt like three football fields.

Another recalled

[feeling] trapped in that room with my mom on my right and this big

man...with broad shoulders and this big black coat...I just felt really small and I didn't feel safe there...and I just wanted to do whatever it took to get me out of there as soon as possible.

Public exposure in the court setting was alarming:

I felt really uncomfortable because [there were] a lot of people walking around...[the lawyer] asked me if I wanted to remain in care or not...and I remember being really, really scared, because...everything stopped in the courtroom, and all eyes were on me...and I...kind of said "yes" because...I didn't want all that attention on me.

The language of the judicial process confused many youths. One recalled her worker talking with her at the courthouse, and "the wording she was using was really scaring me." Youths were sometimes reluctant to admit to their confusion:

Often things are said in ways that go way over your head, and then you're asked, "Do you understand?" and of course you say, "Yes — sure" but you don't.

Another stated:

They tried to explain the papers to me but I didn't understand so I just signed them.

After signing, he began to think he had not been told the truth:

They told me completely different answers than what they had just told me before I signed. I felt like I kind of got cheated.

The term Crown wardship was especially confusing. One youth said that different people gave him

different answers about the definition of Crown wardship:

Every time I hear Crown ward, I think of those crowns that you wear.

## Youth and Worker

The nature of the relationship between youth and worker is vitally important. The youths emphasized the need for trust, support, and continuity. They recounted a wide range of experiences from highly positive to negative. One youth, when asked if he met with his worker before attending court said, "I meet with her all the time," reflecting appreciation of the ongoing relationship. A young woman, recounting her experience before becoming a Crown ward, said:

My mother hated [the family worker], so basically she sort of stayed out of sight... I knew where [my worker] was though; she would check in once in a while to see where I was at.

By contrast, some participants indicated that they had little contact with their worker and did not receive the support and information they needed before the Crown wardship proceedings:

I think before the temporary wardship and stuff, it would have been a lot better for me if my worker had spent some time explaining [to me] — this is what's going to happen and this is what it means and these are the outcomes.

The facilitator asked, "Anyone else feel they wish they had more information at the time or were involved a little bit more in the

process?" to which the response was an enthusiastic "yes!"

## Youth and Family

Some youths expressed that their mother's attendance at court indicated that she cared about them. One girl said her mother lived four hours away from the court, and had been told by the CAS that she was sure to be made a Crown ward:

But my Mom said, "There is one chance that I'll be able to get my kids back...if I didn't show up that would show that I didn't care very much"...so I know she tried.

Others stated disappointment when parents did not come to court. One youth said her mother was not willing to attend court, so her social worker arranged a meeting prior to the court hearing: "[but] it took a lot of haggling on my social worker's part to get her to do that." Some youths were anxious about facing their families in court, possibly because of relationship problems related to their initial placement. Many youths had not had contact with their families while they were in agency care, so had no opportunity to discuss or begin to resolve these issues:

It was my first time seeing [my mother] after I left my house, so it was kind of awkward.

Sometimes conflict erupted at court:

There was almost going to be a shouting match or a fight breaking out between me and my mother in the courtroom...because she blamed everything that [had] happened in the house on me.

Some youths indicated that exposure of family issues in court had been

humiliating and demeaning for them:  
[giving evidence] I was facing the people sitting in the court, but trying not to look at my family...and that was kind of hard.

Another expressed how difficult it was to say publicly in court that she wanted to remain in care rather than return home:

My family was looking at me...it just was not a very good feeling... I love my Mom dearly, but she scares the crap out of me sometimes...and she was right there giving me this look of, "If you say no, you've abandoned us and you're out of the family".... Whatever was going to work in the past [in terms of reconciliation] was not going to work now.

She had also been unprepared to see her sisters in court, and recalled wanting to shrink away when her sisters gave testimony about the family's problems, especially when they pointed at her.

Under pressure, and feeling judged and exposed, parents might defend themselves by attacking a youth whom they view as having forced them into court. One participant had no contact with her mother before court, and was conflicted by having to tell the judge, in her mother's presence, that she wanted to become a Crown ward. She was afraid that her mother "would say something to make me feel smaller than I already felt." These fears were borne out after court, when her mother defended herself by saying, "Thank God I can celebrate now, I have one less headache on my hands."

When a youth becomes a Crown ward, his/her sense of identity may be threatened:

I was just going through a whole bunch of emotions of not knowing who I was, where I belonged and, now that I'm out of my mother's house, who cares.

Another linked the loss of his family with the loss of his identity over the time in the group home:

When I came out, there was almost nothing left...nothing left of myself.

One boy expressed feeling regret at not being able to live with his family or being a part of his family:

And my brothers and my sisters — I watch them grow real fast and yet I don't get to see every single day of their lives — I only get a glimpse. That hurts.... That's why I was so aggressive...because it hurts...there's a gap missing and I want it back!"

Court proceedings can cause a revival of painful memories. As part of the court process, some youths were asked to sign an "agreed statement of facts" about circumstances leading to the separation from their family. One youth was upset by having to review these written reports about himself and his family. He found some of the language difficult to understand, and was emotionally disturbed by the memories the reports brought back:

It was really personal, and it was hard to read...it was the past, and you are trying to get over it, and just reading it is bringing back a lot of memories...you are regretting nearly everything you have ever done.

Although youths generally remembered their court experiences, some acknowledged that their memories might not be complete. Time had passed, and often the hearings had taken place before the focus groups met. One girl, who described herself as traumatized by the conflict with her mother in court, said she had repressed some of her memories:

Unfortunately I kind of blank out when it comes to the court part.

## Recommendations of Youth Regarding the Court Experience

- Some youths thought a mediation process would have reduced the adversarial and alienating nature of the Crown wardship proceedings:

I think the entire event of sending a child to court, at any age, to pick a "yes" or a "no" answer that will inevitably determine the rest of their life in some way... It is not in the best interest of the child, I think, it is just for speed. It is just to get them in, get the answer, write it down and then go on and do what you have to do and then the kid goes home and hates his worker, hates his parents, hates the group home or hates wherever they are.

Someone to mediate "would have made a whole lot more sense... There should be more mediators available!"

- Many youths recommended more understandable information about the court process and



ensuing decisions, and suggested how the information could be delivered:

You need time to think through the options and...understand the court process, step by step...and the social worker who is preparing you for court needs to be able to say, "Ok, some of these things might be hurtful"... [It is better to know about potential stressful situations to be faced in court and still choose to attend as opposed to] the adult just saying, "Ok, you sign these papers. You don't have to come." So the kid has some "say" or some feeling that they understand why and they don't look back five years later and say, "It really sucked that I didn't go" [to court].

You know how, when you come into care and, they give you: "These Are Your Rights" or "You Are in Care"? I would just toss it in my room, in that drawer. So I think that it is good to have if you're going to read it, but most likely you're not... [Maybe if they changed it] and put it into sentence form, into words you would understand, and in 'our language'...and also expanded the whole thing so it's clearer!

[We should have] more pamphlets, stuff that you can take away...and bring back questions. Or videos, or puppets, [to help us understand what] Crown ward and the process means.

Appropriate sources of information for different age groups was suggested. Another

suggestion was contact with an older youth who had been through the wardship process, who could function as a "coach."

- Generally, the youths felt that decisions about Crown wardship should be done faster, preferably within a year:

It is really hard to get something resolved when you've been in care for a year and you're already starting to forget about it. At first, there are all these different kinds of emotions and feelings to other people and there's no resolving stuff and you have to put up with the stuff that's happening. And then...when you go to court in a year...everyone else is there and you're all emotional and you have to have all this counseling done because it's all messed up and you don't know what's going on.

When youths thought that information was being kept from them, they felt persecuted rather than protected.

The longer it takes before you get an answer [on how long you will be in care] the more I think there's something that has to be hidden that we can't see.

- The participants emphasized the importance of who accompanies them to court. It should not just be whoever is scheduled for work that day.

You may have better contact with someone else, and if you're scared or upset or vulnerable you might want to talk to them about it.

They suggested that they would like the opportunity to choose the person who would go to court with them, whether it was their social worker, foster parent or lawyer. This person would help to debrief after the hearing, to clarify the proceedings, and deal with the emotions and reactions.

## Conclusions and Recommendations

### Limitations and Usefulness of the Research

There are evident limitations to basing our findings and recommendations on analysis of only seven focus groups involving four to nine young people in each, who are or have been Crown wards of the Ontario child welfare system. In addition, and appropriately for this type of exploratory research, there was no attempt to ensure that groups were equivalent in size, gender composition, age, circumstances, or leadership. This would not have been feasible. Another limitation is the unreliability of recall; several youths acknowledged that their memories were "incomplete" or "inaccurate." This is understandable because the events remembered are part of a traumatic time leading up to placement in care. Thus, the information from these focus groups should be treated with some caution; however, the feelings expressed by the participants should be taken seriously by those around them who

could help prepare and support them through the court process.

Despite these limitations, we believe the findings highlight both the great inconsistencies in child welfare and legal processes around the province, and also issues of serious concern in these areas, which need improvement. What follows is a summary of some of those issues.

### **1. Continuity of Care and Contact**

Many participants indicated that they wanted, and did not have, continuity of contact with a social worker they knew prior to, during, and subsequent to coming into care, as well as support at times of status changes or court appearances. Nor did they have the consistent long-term placements they craved. In some instances they reflected confusion about who was in charge of decisions affecting their lives: the social worker, the CAS, the court, the foster parent(s), or birth parent(s).

### **2. Communication and Information Sharing**

These young people repeatedly emphasized that they felt poorly informed about court procedures involving their wardship, and spoke about bewilderment, confusion, and anxiety. Their comments highlighted the importance of assisting young people to obtain an age appropriate understanding of the court processes and outcomes, and of ensuring contact with their lawyer before and outside the court environment. Even those who do not make a court appearance require explanation and

support when they come into care or have status changes. These focus groups point up the need for greatly improved communication with the children and youth in our care, and for a child-centred focus.

### **3. Participation in Decision-Making**

A common perception of focus group participants is that their opinions were not adequately considered regarding decisions about whether or not they should become Crown wards, or choices regarding their care. They felt little appreciation of their feelings of guilt and responsibility for their families. Poignantly, they saw themselves as second-class citizens, stigmatized at school, labeled as inferior. Low self-esteem renders them exceptionally vulnerable to intimidation in the court, and makes them eager to comply in order to end stressful court procedures. If young people were better supported and informed, there could be substantial savings in terms of reduced court time, and substantial benefits in terms of improved outcomes.

### **4. Family Group Conferencing**

Because the young people in these groups expressed concern about their families, and supported the idea of mediation with their families, the authors strongly endorse "Family Group Conferencing" prior to the occurrence of Crown wardship processes. "Family Group Conferencing" is a means of actively involving the nuclear family, relatives and friends as well as both child and family workers in the long term planning process regarding a child's

safety and well-being. As stated by Schmid and Goranson<sup>5</sup>, such conferencing has several prospective benefits: families are more likely to respect plans they have participated in making, interpreters can be involved, suitable alternative placements with friends or relatives might be found to remove the necessity of Crown wardship, and fresh insights may be gained by the workers into the family dynamics and the young person's needs. Whenever feasible, "Family Group Conferencing" should be conducted prior to Crown wardship processes, to attempt to reduce the adversarial nature of the situation.

### **5. Limiting Limbo**

Comments support the importance of hastening court processes so that children and youth are not subjected to peremptory and startling occurrences without adequate preparation, or subjected to unnecessary delays. The voices heard in these groups portrayed the tension and stress of the uncertainty and insecurity of the "limbo status."

### **6. Long-Term Benefits**

Many of these recommendations are fully endorsed in theory by effective and conscientious social workers and lawyers. In practice, however, financial and workload pressures often prevent their implementation. Several of these recommendations could be instituted by improving training of social workers, legal and court staff, and by ensuring that all front-line workers have effective support and supervision. Despite administrative challenges to expediting court processes, some

measures could be taken without great expense, such as creating a more child-friendly, less threatening youth court environment. Our goal should be to provide a consistently high standard of social work and legal practice throughout Ontario. It is crucially important that we respect the dignity and human rights of young members of our society. We need to allocate the resources, human and monetary, to respond appropriately to the voices of children and youth for whom our society is responsible. Their wellbeing as adults and the health of our society depend on our doing so.

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<sup>1</sup> Child Welfare Review: Combined Summary Report 2000-2001, 2002: Crown Ward Review, Child in Care Review, Adoption Probation Review. Ontario Ministry of Children and Youth Services, Management Support Branch, April 2004.

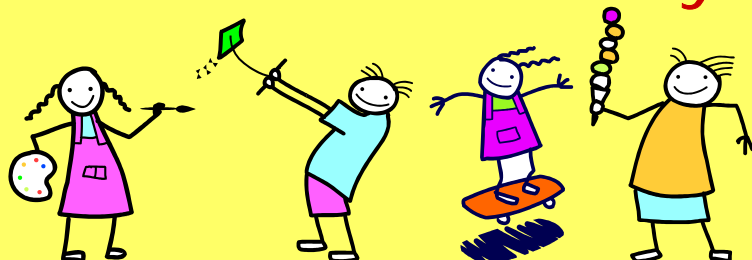
<sup>2</sup> Ontario. Child and Family Services Act, s. 39(4), Office Consolidation, March 14, 2003.

<sup>3</sup> Ibid, s. 39(5).

<sup>4</sup> Ibid, s. 38.

<sup>5</sup> Schmid, J., and Goranson, S. (2002). Family Group Conferencing: An Effective Tool in Planning for Children's Safety and Wellbeing. OACAS Journal, 46(4), 19-23.

## November 20 is National Child Day



Each year for **National Child Day** Ontario communities celebrate children and youth, and raise awareness about the need for our commitment to them. Voices for Children serves as the "hub" for Ontario activities and events: they gather ideas, promote activities, and connect people to what is happening in across Ontario. To help plan your own event, or to see what others are doing, visit

[www.voicesforchildren.ca](http://www.voicesforchildren.ca)

## Notable Quotes

***“The findings from this report give service providers, policy makers and other stakeholders a strong, comprehensive evidence base that can help them to help improve the lives of children in Canada and to protect children from harm...”***

**– Ujjal Dosanjh,  
Health Minister**

On the release of the report of the second cycle of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), a national child health surveillance activity that provides information in the area of child abuse and neglect.

A copy of the Canadian Incidence Study of Reported Child Abuse and Neglect - 2003 Major Findings is available at [www.phac-aspc.gc.ca](http://www.phac-aspc.gc.ca)

# Growing the Tri-CAS Treatment Foster Care Program<sup>1</sup>: A Fifteen Year Retrospective

By: Duane Durham, CCW; BA, Scott MacDonald, MSW; Sally Palmer, Ph.D; Kevin Sullivan, MSW

*Tom\* came to the Tri-CAS Treatment Foster Care Program (TFC) as a 4-year-old boy who had suffered multiple losses and separations, and had been exposed to undisclosed trauma. He was full of rage, fueled by his underlying sadness. Tom's mother, herself a former Crown ward who had been rejected by both her biological and adoptive families, could not meet Tom's needs as an infant and toddler; her own unresolved grief manifested in substance abuse and ongoing mental health issues. Tom came into Children's Aid Society (CAS) care, and was placed with an adoptive family. However, this placement failed and Tom was placed into another adoptive home. Again, Tom's very difficult behaviour led to the family's "failure to bond" with him, to the point of emotional rejection, and a second adoption breakdown. The CAS was determined to prevent a further placement breakdown, so Tom was moved into the home of parent therapists in our TFC. At this point, he had no selective attachment figure.*

*Throughout his first five years in care, Tom's behaviour was characterized by an insatiable neediness and intense negative interactions with his female parent therapist. His challenging behaviours included poor impulse control, rage, biting, kicking, name-calling, and property destruction. He feared being left alone and often fought off sleep. His parent therapists assessed Tom as being in a constant state of anxiety, with almost no capacity to regulate his emotions. In*

*conversation with his parent therapists, he would say that if he were a girl he would have been "picked" by a family. Tom's parent therapists, while up to the challenge, began to wonder about Tom's capacity to form a selective attachment and move beyond his intense rage. Due to Tom's extreme behaviours, the Society considered replacing him to a group home but because of his age, and the likelihood that another move would be permanently damaging, Tom remained in the parent therapists' home. He is still living there at age ten. While he is still impacted by past trauma and emerging mental health issues, he enjoys the security of long term placement, attends community school and is involved in community activities.*

## Overview of the Program

The Tri-CAS TFC Program has been operating out of Cobourg, Ontario since 1989. It provides residential treatment for 38 children in 24 foster treatment homes. The TFC serves three CASs: Durham, Kawartha-Haliburton, and Northumberland, with the latter handling administration. The three Societies have a combined budget of over \$80 million, and a combined staff of over 500. Most of the children in TFC are Crown wards; their average age is 9.6 years; and they have experienced an average of four placements prior to TFC.

TFC began to operate the Clinical

Service Support Program (CSSP) on April 1, 2004. This Program serves 64 foster families/children annually and aims to support permanency and prevent placement breakdown for children in all levels of the foster care system. Learning developed through the existing TFC Program is being applied with a great measure of success.

In general, treatment foster care is a growing response to the needs of children in residential care who have experienced trauma, neglect, abandonment, and whose consequent behaviour has led to multiple placements. The TFC program provides a safe and lasting placement in a family home, where the child's treatment needs can be met by well-trained and supported parent therapists. From the beginning, TFC was based on well established goals and methodologies and the Program Standards developed by the Foster Family-based Treatment Association (revised 2004). The essence of TFC is that the focus of treatment resides primarily within the daily life-space of the child. It consults with outside therapists, but the treatment is delivered within the child's home. As well as being less expensive than a group home, this allows children to live in a family environment, attend local schools, and participate in

<sup>1</sup> The Program is sponsored by the Children's Aid Societies (CASs) of Durham, Kawartha-Haliburton, and Northumberland  
\*Not his given name but he is a real person, which is the same for other children referred to in this paper.

community-based activities. Placements are usually long term and children have the benefit of establishing stable and enduring relationships.

Where possible, the children's biological families are included in the treatment process. In this paper, the terms "parent" and "family" will be used to refer to biological families, while "parent therapists" will be used for therapists providing family care. Our program gives special attention to children's families because we believe that children's loyalty binds and unresolved issues from their early experience often interfere with their progress in care. We have worked to improve relationships between children and their biological parents by the use of clinically managed access (Osmond, Durham, & Palmer, 2002), as described later in the paper. Family work is not a common theme in treatment foster care programs: in searching the literature, we found that most published articles on foster care and treatment foster care programs give little attention to the children's families.

### **Beginnings**

In the mid-1980s, the three Societies and the Ontario Ministry of Community and Social Services participated in the CAS Services Coordination Project. Among many other issues, this Project identified general concern about the escalating cost of residential care and the scarcity of quality local placements (Nutter & Sullivan, 1989). The study also found that children's needs were not being consistently met by their

existing programs: 68% of the children placed in group homes were identified as needing treatment, but placement decisions often seemed to be based on behaviour management issues rather than meeting children's treatment needs. Furthermore, 40% of group home placements were outside the area served by the child's own CAS. Coming out of this study was the resolve by the three Societies to develop a cost-effective, residential treatment foster care program which would allow children to stay in their own communities; the TFC Program began operation in October 1989.

### **Early Evaluation of the Program**

After 2½ years in operation, the TFC was evaluated in a Pilot Project Evaluation Study (Osmond, 1992). This study compared 32 children in TFC with 72 children who had been placed in group homes operated outside the CASs, in Outside Paid Institutions (OPIs). The children were compared on four variables: caregivers' ability to cope with children presenting problems; child outcomes; caregiver satisfaction, and; cost. In determining ability to cope with presenting problems, the children's behaviour was measured using a standardized behaviour checklist: the 72 children in OPIs were measured in 1989, while the 32 TFC children were measured as they entered the program. Program effectiveness was measured by a pre and post test of the children, using a questionnaire developed for the Ontario Child Health Study. This portion of research was conducted through a Ministry commissioned

study operated out of Queen's University. A softer measure of program effectiveness was obtained through a referring worker questionnaire, with a number of questions directed at service comparison. Often the workers had the same child in both an OPI and TFC setting. A similar questionnaire was developed for staff directly employed by the Program. Similarly, parent therapist satisfaction and functioning was also studied through a satisfaction questionnaire, and a pre- and post-test for family functioning.

Cost effectiveness was studied in two ways: (1) comparing the cost of TFC (including the treatment parent per diem) to the average costs of OPI care over a five year period, and (2) analyzing the costs of identified alternative care for the first thirteen children admitted to the program. The findings of this research were generally positive on all measures used: caregivers' ability to cope; service outcomes; caregiver satisfaction, and; cost.

### **Development Through the 1990's**

Through the 1990's, TFC did not increase in size, but it continued to develop and refine its treatment approach and day-to-day practices, as will be described later.

Clinical input was sought from a number of external consultants including: Psychiatrists, Dr. Paul Steinhauer and Dr. Jim Wilkes; Psychologist Dr. Nitzza Perlman and Behaviourist Jim Reaume; our staff Psychologist Dr. Anita Halpern, and;

Art Therapist, Ed Hagedorn. TFC began to integrate and apply trauma and attachment theory in developing child-specific milieu-based treatment plans. Over its 15 years, TFC has enjoyed stability with staff and parent therapists. Two of the present staff and five parent therapists have been with the program since it began.

In 2002, the TFC conducted a detailed review. It sought the views of all stakeholders, including CAS staff, parent therapists, outside consultants, and children in the program. The purpose of the review was to set future direction. The main strengths of the program were identified as:

- team work and inter-professional collaboration
- timely, quality support to parent therapists
- high quality, long tenure professionalism and personal suitability of TFC staff
- quality assessments and treatment plans
- advocacy and good relations with schools
- relevant and high quality training
- persistence with children resulting in longevity of placement
- quality of care provided to children
- work with children's families.

The main problems facing TFC were identified as:

- the instability of funding
- competition for parent therapists from the private sector
- the need to firm up the overall clinical direction of the program.

The review confirmed the important role of treatment foster care in our spectrum of services. We established a comprehensive work plan, setting out future directions in the areas of:

- program philosophy and direction
- work priorities of staff
- funding stability
- recruitment, and development and retention of parent therapists and consultants
- development of mobile "wraparound" responses to all levels of foster care
- clinically-managed access
- development of mixed-modality beds for children in limbo
- incorporating more family work into the child's treatment.

The results of the review reinforced our belief that TFC had a unique position in the heart of child welfare, and confirmed the usefulness and advantages of the three CASs pooling their time and resources in this way. At TFC's request, the Centre of Excellence for Research in Child Welfare, based in the faculty of Social Work, University of Toronto, is currently evaluating the Program.

Presently the average age of children in the Program is 9.6 years with a fairly equal distribution of boys and girls. Early on in the life of TFC the average age of children was around 12 years of age with boys outnumbering girls three to one. Prior to coming to TFC, children have experienced an average of four placement breakdowns. Each of the previous placements have been an average of

10 months in duration. Now, over 80% of the children grow up in the home where they were first placed after coming to TFC with no subsequent moves.

## Team Approach

Parent therapists have continual access to support in providing treatment for the children in their homes from other TFC staff members: a Clinical Case Consultant (CCC), an Art Therapist, and a Psychologist. As well, parent therapists are also part of the core TFC Team. The core team consists of parent therapists, CCC's and CAS workers. Many team members contribute to formulating the assessment and treatment plan for each child and to supporting parent therapists in developing a therapeutic milieu. We have worked to make the team a respectful, safe, and supportive structure to help parent therapists meet the challenges of placement.

## Role of Clinical Case Consultant

Following the Foster Family Treatment Association (FFTA) Standards and Practices, Clinical Case Consultants (CCCs) provide intensive weekly support to our parent therapists. The CCCs have a Child and Youth Worker diploma or a Social Work degree, plus residential experience caring for emotionally disturbed children in a treatment center or group home. Their role is to provide the clinical leadership to the child's individual treatment team by developing the assessment and treatment plan and implementing the

treatment plan, in collaboration with the parent therapists.

The CCCs have assigned caseloads, with each supervising four to five homes involving a total of 9-10 children. This allows for close collaboration, with the CCCs and parent therapists learning together to understand a particular child and how best to respond to their internalizing and externalizing problems. Over time, our CCCs have gained an in-depth understanding of child welfare, especially fostering.

### **Role of Parent Therapists**

During the early stages, TFC attempted to identify some of the differences between parent therapists and regular foster parents. At that time we defined the word foster as “to love and cherish as is.” As a system, we were asking foster parents to incorporate children into their family, with the expectation that a healthy family environment would meet most of the child’s needs; yet many of our children have had their development seriously compromised and required professional treatment. In establishing the role of parent therapist, we wanted to take the best of fostering and add a more in-depth treatment component that would be part of the child’s daily life, i.e. the therapeutic milieu would be the parent therapists’ home. While this is the case for most foster homes, treatment is often not developed to the child’s maximum advantage. Some children would receive additional treatment from psychologists or psychiatrists, but the parent therapist would be the “central

agent of change.” We also trained the parent therapists to expect and understand the spillover effects when children had individual therapy with a consultant; we wanted to ensure that the placement could withstand the behavioural manifestations of the “stirring up” caused by therapy.

Moving a child’s therapy into the home requires a good deal of communication and teamwork. As the program has matured, and the parent therapists have participated in training, they have moved into the role of the child’s primary therapists. They have become more independent in knowing how to seize “the therapeutic moment” and use it as a learning opportunity for the child. Moreover, they have become effective advocates for the children in their homes.

The health of the parent therapists’ family is an important core value in TFC; thus the CCCs also monitor the pressures on a parent therapist family, and help parent therapists to recognize their own familial stress. Parent therapists accrue the right to two days respite per month for each placed child, a benefit provided by the sponsoring Societies. We encourage parent therapists to take this time off to rejuvenate their families. We also hold groups, as needed, for the parent therapists’ own children, recognizing that their acceptance of a child in their home is crucial to the success of the placement.

### **Role of Art Therapist**

A key person in the TFC from the beginning is Art Therapist, Ed

Hagedorn, who provided art therapy assessments for all children in the program. The main purpose was to provide the parent therapists with an assessment of the children’s adaptation to the therapeutic milieu in the new home, as well as the children’s view of their own family relationships. Thus, the art therapy modality has acted as a “barometer” for the work being done in the therapeutic milieu. Now, art therapy assessments are conducted annually for all children in the program.

### **The Placement Process: Selection of home and initial assessment**

From the beginning, we have involved parent therapists in the selection of children for their homes. After a CCC completes an initial intake and determines the child’s appropriateness for TFC, the CCC reviews the file with a potential parent therapist. If the parent therapist accepts the idea of placement, an initial child and family screening is arranged at the TFC office in the presence of the parent therapists, CAS workers, and TFC staff. The CCC interviews the child and family in an attempt to understand their “story” better for the purpose of making a placement decision. Parent therapists also ask questions and participate fully in the decision-making process. After the placement decision is made, a pre-placement process is initiated, and children usually move into their new placement within a couple of weeks.

With the support of the CCCs, the

parent therapists are expected to record the child's baseline behaviour, generate daily logs, institute routines and structure to support behavioural change, and contribute to the assessment of the child. The CCC undertakes a comprehensive milieu-based assessment, in conjunction with the parent therapist, and including the findings from an art therapy assessment. Often the child's treatment team recommends a psychological assessment, which may be conducted by the staff psychologist or a community-based psychologist. A comprehensive assessment may also be done of the child's family by the CCC or CAS worker, who reviews the file and sets up meetings with family members. The results of these assessments are discussed at a special conference to which all members of the TFC clinical team are invited. The findings of the initial assessment are then used to formulate a plan for the child's treatment.

### **Inter-Agency Relations**

An important part of our teamwork has been strengthening relations between the Program and the sponsoring Societies. We have spent time defining our roles and responsibilities in order to function as an effective team. Child protection and the treatment of children are highly integrated processes that can and do reinforce each other. The TFC Program shows that good clinical work can be done within CASs. This point is reflected in the fact that Society staff and parent therapists participate in joint training sessions with our external consultants.

### **Training for Team Members**

Ongoing training has been an important part of our team building. The CCCs work individually with parent therapists to help them develop their own professional goals and fill the gaps in their learning. Along with other team members, parent therapists have developed their clinical knowledge base through training programs in which we have made liberal use of external consultants. Gradually, our own staff have taken leadership in our training and in recent years we have been able to provide training opportunities to staff and foster parents in all three Societies.

### **External Consultants**

Early in TFC development, Dr. Marshall Dorosh, a psychologist with experience as supervisor of a TFC program at Thistleton Regional Centre, was brought in for weekly clinical consultations with staff. This helped TFC to develop clinical thinking, as well as the structure of the program. Gradually, TFC began to bring in other clinical consultants in the areas of trauma, attachment, developmental delays, family work, and mental health. Depending on their primary presenting problem, each of the children in TFC is discussed in a "Grand Rounds" format, i.e. the child's history and progress is reviewed in sessions that are open to all parent therapists, CAS workers and our own staff, with external consultants being brought in depending on the child's needs. The parent therapists reported that they all benefited from the experience and

were able to put the new learning into practice with the children in their homes.

### **Staff-led Training**

**Monthly group sessions – "Parent Therapist Training Groups."** A regular training program for parent therapists has been critical to the development of the program, in helping team members to develop a common knowledge base of clinical understanding and expertise. TFC provides this through a monthly training and support group that brings together the parent therapists from all three Societies, as well as all TFC staff. While some external trainers are used, TFC staff develops and delivers most of the training, which maximizes the integration of learning across the team.

### **Shared background**

**experiences.** The effectiveness of the training led by staff is partly attributable to the backgrounds of our TFC team staff members, in residential treatment programs and other relevant settings, such as children's mental health centres and schools. These earlier experiences allow them to make the training 'come alive,' to identify with the parent therapists, and contribute to a climate of mutual respect. Parent therapists have now developed to the point where they are delivering their own training directly or in concert with TFC staff.

Compared with their earlier work in group care, staff has found the family



milieu a new and exciting way to work with emotionally-disturbed children. They experience parent therapists as eager to learn, and having a mature sense of normal family development beyond what most workers have attained through their education and work experience. The staff also values the advantages of family-based care in terms of more caregivers per child, more individual attention, and less contagion from other disturbed children.

**Layers of training.** Staff-led training is delivered as a “layering in” process—laying a foundation of basic skills and understanding, and then adding more complex subjects to this foundation. The consecutive layers are: milieu therapy, behaviour modification, mentoring the child’s family, and clinically-managed access.

**Milieu therapy.** This form of treatment uses ordinary life events as corrective teaching opportunities. Included in this training is a primer that includes ego psychology, a systems approach to treatment, nature and purpose of milieu therapy, components of a milieu, assessment in the milieu, and opportunities for growth in the milieu. This training has been well received by the parent therapists, as they have easily grasped the theory and practical suggestions, from their previous fostering experiences. As a staff member noted, “We were just helping them look at what they did in a more planned and meaningful way.”

**Behaviour modification.** The next cornerstone of training focuses

on behaviour. Initially, we adhered strictly to behaviour modification principles, aimed at changing a child’s external behaviour. After a few years, we began to move beyond this approach to think about what ‘the child’s message behind the behaviour’ was and how we could respond in a manner that felt safe and supportive of the child. Our training is now focused on behaviour formation, assessment, normal vs. abnormal behaviour, and options for changing behaviours. Other aspects of training have expanded over time to become part of our basic approach to helping children, thus they will be discussed in more detail.

### Key Components of the TFC Model of Treatment:

#### Mentoring the Child’s Family

Historically, relationships between a child’s parents and foster parents have been difficult and often fraught with tension. We needed to develop our parent therapists’ willingness and ability to work with the children’s parents. Our work with children is based on the assumption that parents are usually victims of adverse experiences and unmet needs in their own developmental history, which limits their ability to function as parents to their own children. We have taken an inclusive approach to foster care, encouraging parent therapists to become mentors to the child’s family. Parent mentoring can be defined as a form of direct service to client families, in which the foster parent approaches the biological parents of a child in care with guidance, teaching, and coaching in

the techniques and tasks required to care for their children. The relationship is informal and requires the treatment foster parent to develop a positive relationship with the child’s parents over time.

Parent therapists were enthusiastic about the mentoring approach. Once they accepted the view of children’s parents as victims, they slowly but surely developed a passion for working with them. Now, often the strongest bond in the system is the bond between the parent therapist and the child’s parents. As one parent said about her parent therapist, “No one else shares in the daily living with our child.” Even in some of our most contentious cases, where a child’s parents are very angry at the CAS, they may remain allied with, and supported by, the parent therapist. Our training has focused on the importance of children’s relationships with their families, the debunking of myths and attitudes about parents, and the introduction of family reconnections within foster care.

#### Clinically Managed Access

Concern about managing child-parent access has developed over the years, as experience in Ontario’s child protective services has shown that Court orders for child-parent access can be difficult to implement, and may create difficulties for caregivers. In the process of reaching an agreement during a Court proceeding, the CAS may agree to conditions that are not compatible with the child’s treatment needs. This sets the stage for problematic child-parent contact over the long term, which may be

further aggravated by a lack of agency resources to manage access. Thus the children's actual experience of visiting may diverge significantly from the treatment plans. (Osmond et al., 2002).

Managing ongoing family connections for children in out-of-home care can be a challenging task. Often a child's important early relationships have been troubled and disrupted, damaging their capacity for attachment. If they then experience a period when parental responsibility is not clear, while decisions are being made, their development may be seriously compromised. Under these conditions managing access effectively becomes increasingly important. The case of Tyler and Lorraine illustrates how clinically managed access can contribute to treatment.

Tyler, four, was placed in foster care following a police investigation of physical abuse by his mother, Lorraine. His behaviour was intensely and continuously anti-social. He bit, spat, ran, urinated, and defecated in all the wrong places, refused to eat, and damaged property. He was hurtful to animals, people, and himself. He was quickly rejected by his first two foster placements and referred to TFC.

Lorraine had experiences early in life that made her distrustful, especially toward people in authority. The person Lorraine chose to trust first was Pam, the parent therapist. Rather than instructing Lorraine about parenting Tyler, Pam modeled for her, using a variety of innovative parenting methods. Pam taught

Lorraine a simple technique for managing non-compliance and reinforcing compliance. Lorraine began to share with Pam her own childhood experiences that led to her difficulties in putting limits on Tyler. By sharing these feelings with Pam, Lorraine entered into a therapeutic relationship. For the next year Pam mothered Lorraine while Lorraine learned to meet Tyler's need for structure.

Well-managed access can be an important clinical vehicle for ensuring that family relationships contribute as much as possible to a child's well being. Well-managed access does not always lead to a reunion; sometimes it contributes to permanency by assisting children to come to terms with the past, so they can move on with their lives in out-of-home placement. In foster care, there are often too few resources for managing access in a way that improves the parent-child relationships. Staff training in this area can influence workers to undertake clinically managed access, using family visits as an opportunity for teaching parents how to interact constructively with their children.

### **Trauma from Abuse**

Another cornerstone of our training has been learning to work with traumatized children, particularly children who are dealing with the aftermath of sexual abuse. Our training and support to parent therapists focused on helping children to tell their 'story'. When children come into TFC, they may be unable to talk about their abusive experiences, but may cue us with behaviours that hint at what has

happened. The caregivers become careful, thoughtful listeners and interpreters, so that children may come to know their own stories and find a path to healing. This treatment is carried out in the child's day-to-day living environment by sensitive and well-trained parent therapists who offer comfort and guidance to the child. Other forms of treatment may be used as well, but these are viewed as supplemental, not central, to the child's progress. Our experience in using this model in the TFC environment suggests that parent therapists can reliably assist severely traumatized children, sometimes with remarkable results. The following is an example of a real life conversation between a foster child and a parent therapist helping her to heal from the aftermath of sexual abuse.

At six years of age, Angie had a question she could not answer: "Why did my mommy marry Ivan when she knew Ivan was hurting me? Why did she pick him instead of me?" Joan, her parent therapist, waited for the right moment: "Boy, Angie, you just think and think about that question. It is very important for you to have an answer." Angie: "I want to know. Why did my mommy do that?" Joan: "Yes, you want to know. Have you thought of any answers?" Angie: "Me?" Joan: "Yes. Why do you think mommy did that?" Angie: "Maybe she didn't know Ivan was hurting me?" Joan: "Oh, I'm confused, I thought she did know?" Angie: "Yeah. I told her. I'm mad, mad, mad! Mom should have picked me". Joan: "You sure are mad. If I were a little girl in care whose Mom had married the man who hurt me, I think I would feel mad

too." Angie: "She cried you know." Joan: "She cried?" Angie: "When I told her. She called the Children's Aid, and then she cried." Joan: "Why was she crying, do you think?" Angie: "I don't know. I can't get inside my mother's head! Can I go now?" Joan let her go. For today, Angie had taken a big step. There were many steps to go, but the first one had been taken.

Joan did not answer Angie's questions directly, but encouraged Angie to express her own feelings. Joan did point out reality, by reminding Angie of what she had told Joan earlier—that her mother knew about the abuse. Joan could have used Angie's statement about her mother crying to reassure Angie that her mother did feel pain about the abuse, although she apparently was not strong enough to leave Ivan. Joan might also try to find out more about the mother's own possible victimization, to help Angie understand why her mother was limited in her capacity to protect her.

### **Attachment-Related Difficulties**

Another important part of training was the development, management, and treatment of children and families with attachment-related difficulties. Children in foster care may be expected to struggle with feelings of separation and disrupted attachments. Some have limited ability to form attachments, because of insecurity experienced in their formative years. Moving into an unknown home tends to exacerbate difficulties related to attachment: children may withdraw, or act out their frustration, leaving

caregivers feeling rejected, exhausted, and impotent. In under-supported placements, there is a high risk of placement breakdown. Through training and support, our parent therapists become attuned to the needs of the child, learn to identify their attachment styles, predict their behavioural and emotional responses, and develop appropriate strategies for handling these. The approach taken with the child should be realistic, but should also provide hope to both the child and the parent therapist family. Melanie is an example:

Melanie appears to be guarded and wary of her caregivers. She often seems aloof, resistant to their direction, and inner directed. She seems somewhat emotionally detached in general from human relationships. She appears mainly interested in what she can get from people or what they give her, rather than engaging in a mutually satisfying relationship. The parent therapists feel that she treats them exactly as she does people who are peripheral in her life (e.g. volunteer driver, crossing guard, or swimming instructor). The parent therapists have become quite adept in avoiding power struggles, and they give Melanie the time, space, and support in managing her episodes of upset and anger. The parent therapists work hard to recognize that Melanie's lack of emotional response to them is part of her inability to attach, and not to interpret this as a sign of their failure as parents. With this attitude, they are able to give her messages of safety, acceptance, and support, and to experience a minimum of frustration.

In addition to teaching parent therapists about attachment, TFC has developed a "Remembering Book," a workbook similar to the life story books often used with children in foster care. The Remembering Book is designed to help children with the impact of poor initial attachments followed by multiple separations, by providing information about their personal histories. Reviewing the past, and filling in gaps in the child's information can help them to accept living apart from their families. Parent therapists can learn about, and interpret to children, the role of events and conditions over which neither the child or their parents had much control, such as family poverty, and the parents' limitations arising from their own childhood experiences. Without this understanding, children tend to blame themselves for being rejected, and to build defenses against forming attachments with new caregivers. An example is Sheila, age ten, who felt compelled to write, after working on her Remembering Book, to her mother who had died of a drug overdose.

Dear Mom,  
I want to know why you did drugs. It was a bad thing to do. I loved you so much, and you died, because you took drugs. I really loved you but you did the wrong thing. You probably know it was the wrong thing but you couldn't stop. I am so sad that you died because I loved you and I will always love you. You were so pretty like I am. Remember, that was wrong, but I will forgive you because you were my Mom.  
Love, Sheila

The TFC program has been able to successfully provide long term care for many children with severe attachment issues through the informed and sensitive work of our parent therapists.

### Future Directions

The Tri-CAS TFC Program remains strong and vital 15 years after its tentative beginning. We have managed to grow and develop as we have learned from our experience, and from the work of others, as documented in the treatment foster care literature. We are able to provide for high needs children and help them through their treatment journeys, through our trained and dedicated parent therapists, who continue to be supported by all team members, including external consultants as needed.

TFC is now receiving referrals for younger children, some as young as three. This means that adoption may be the preferred option for permanency as opposed to long-term foster care. Thus, we are beginning to train prospective adoptive parents in the same way as parent therapists. Bringing on foster and adoptive parents as full members of the TFC team is seen as the single most important ingredient to the success of our Program.

Areas of clinically managed access, mixed modality staffing response for children in limbo, and increased family work with families of origin remain exciting objectives for the future.

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### Further information about the Program can be obtained by writing:

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## November is Adoption Awareness Month

To experience healthy development, and create a sense of their own self-worth, children need to have roots and feel they belong to a family that cares for them.

In Ontario, adoption can be arranged through **Children's Aid Societies** (CASs), private adoption agencies, or directly through the courts if you are a relative or stepparent.

Each CAS is responsible for adoption in the area it serves, and the children waiting for adoptions are in that agency's care.

If you decide you'd like to adopt, the CAS will conduct a home study that involves several visits to your home. By working together through this process, a decision can be made about whether adoption is right for you, and what kind of child or children you could parent.

**For more information on  
Adoption in Ontario, contact  
your local Children's Aid  
Society.**

## Child Neglect: A Community-wide Problem

*Peel Children's Aid develops position paper to begin addressing this growing problem.*

An exploration of the research into child neglect can be a frustrating, if not discouraging, undertaking. Twenty years ago, there was such a paucity of studies into the topic that Worlock and Horowitz (1984) declared a "neglect of neglect" by their colleagues in the research community. Neglect, unlike other forms of maltreatment, was ambiguous and did not provide observable evidence, except in cases of extreme physical neglect. Neglect was also thought to be a set of circumstances present in many child abuse cases, rather than a specific form of child maltreatment in its own right. Today we acknowledge neglect as a stand-alone concept in child protection work; we have accumulated a great deal of information that helps us to identify its symptoms and record its very serious consequences for children.

It is now widely recognized that neglect is a pernicious form of child maltreatment, and although its ramifications are indisputable, the prevention of neglect is still very much an evolving science. In the Region of Peel, with its great ethnic, linguistic, and cultural diversity, neglect prevention is one of the most significant challenges facing the Peel Children's Aid. Chronic neglectful situations persist. The complex nature of child neglect does not allow for easy solutions. Peel Children's Aid is dedicated to the coordination of a strategy that will bring together our professional and lay partners to

address this important risk to the Region's vulnerable children.

Neglect of children can take a variety of forms, including but not limited to, physical, medical and emotional neglect of a child's needs and a lack of care and supervision that can lead to sexual abuse and exploitation or a child's involvement in criminal activity. Peel Children's Aid has prepared a position paper on neglect which summarizes not only the various ways in which children are neglected, but also looks at the signs and symptoms of this type of child maltreatment. The paper, which has been set out with the professional in mind, explores the circumstances that are often associated with neglectful situations and examines possible strategies to address their impact. It begins to tackle the tough questions of how communities can reduce the incidence of child neglect and provide comprehensive, effective interventions for families.

Like all jurisdictions, Peel Children's Aid receives hundreds of calls each month from professionals and from lay community members reporting concerns for the care of children. These calls are screened by social workers who gather the information and review the agency's records before presenting the case to the team. Though the risk factors in one call may be minimal, a series of such calls may be indicative of more complicated problems. A pattern of concern for less than adequate care,

hygiene and supervision, for instance, may signal a potentially neglectful family situation. The screeners track the frequency of calls to the agency and their subject, rating and severity. The case may be opened for investigation if the child's care appears to be substandard over a period of time, and especially if there is a history of failed attempts to ameliorate these same types of concerns in the past.

Almost half the calls received do not meet the test for eligibility as set out in the Ontario Risk Assessment Model. Many of these situations are deemed to involve caretaking that is *less than adequate*, perhaps, but not *less than marginal*. Concerns may include those for a child's supervision, physical care or hygiene. Taken in isolation, these concerns may not put the child at immediate risk or compromise his or her long-term health and safety. For these situations, there will likely be no face-to-face contact between a child protection worker and the family.

This leaves a decided gap in services to families. Our referrals suggest that there are many family problems and stressors which, while they may be in their early stages, confound families' abilities to provide adequate care to their children. These problems and stressors can be the precursors to child neglect and can impact family functioning and the long-term well-being of children, particularly over time. A bold new initiative is needed

to help these families before their problems become more entrenched and complex.

Peel Children's Aid is determined to take the lead in a comprehensive response to the needs of families struggling to provide care to their children. If the Region is to address the issue of child neglect, it must first be acknowledged that this is a problem for which there is a collective responsibility and the need for collective redress. Many of our partners have identified stressors for families and are mandated to provide support in these areas. Other partners work specifically with particular groups of at-risk children and their parents, including young, isolated parents, those with a

childhood history of abuse and neglect, and those who struggle with substance abuse or domestic violence issues.

For the Region of Peel, the prevention of neglect, like the efforts to address its impact, are tasks made more complex by the diversity of language, culture and ethnicity that makes Peel unique. Peel Children's Aid has established a commitment to work alongside its partners to develop an outreach and intervention track to meet the needs of the diverse community that it serves. We will continue to seek the guidance of colleagues who work with new Canadians so that the early signs of child neglect within a family's cultural traditions can be identified. With the

support and participation of the all sectors of our Region, the agency is committed to a neglect prevention program which features a coordinated and differential response to the needs of families and children.

Copies of Peel Children's Aid's position paper on neglect may be obtained from the website [www.peelcas.org](http://www.peelcas.org).

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**In the next edition of the *Journal*, Peel CAS position paper "Emotional Matreatment of Children and Child Welfare Intervention" by Bryon Shone, MSW, and Henry Parada, PhD.**

## Dysfunction and Opportunity within the Residential Group Care Sector in Child Welfare

### The Development of Treatment Homes at FACS Waterloo<sup>1</sup>

By: *Kiaras Gharabaghi, Ph.D, Manager of Residential Resources* © August 2005

In 2004, Family and Children's Services of Waterloo Region re-designed two of its residential group programs and opened Society-operated Treatment Homes. The idea of the Treatment Home was developed as a way of responding to several issue areas within the group homes, including poor outcomes for children and youth, alienation of families, increasing levels of violence and dysfunction within the group homes, and very poor staff morale.

The term 'treatment' was chosen to reflect a relatively broad set of interventions that may be relevant in different client situations. Early in the development process, we decided that a number of core principles would form the foundation of the Treatment Homes:

- Any and all decision-making and case planning pertaining to the client must be collaborative and include, in a non-hierarchical

manner, the client him/herself, the client's parents and siblings, any extended family involved, as well as any professionals that are involved.

- Wherever possible, children should be admitted in a planned way, with a pre-admission process that would include at a minimum, a pre-admission meeting in which the goals and purpose of the admission would be

<sup>1</sup> For a full evaluation report of these programs, please contact the author.

determined with the client and his/her family as well as any relevant professionals, and a tour of the physical site prior to the actual admission.

- Clients cannot be admitted without a concrete discharge plan in place. This plan must include a date and a place and the maximum length of stay cannot exceed four months.
- The goal of the program is not to resolve the issues for the client or the family, but instead, it is to provide the family with the tools to resolve issues and concerns themselves in reasonably functional ways.

Based on these core principles, the Treatment Homes were established in May 2004; we were able to limit occupancy to a maximum of five children, ages 6 to 18. We decided to operate identical programs at two sites; one in a suburban location, and the other in a rural location at the edge of town. The staffing model is pre-dominantly a single staff model for most of the day and on overnights. In the evening hours there two staff members present in the program. Based on our group home experience, we knew that the most important factor impacting on especially adolescent clients in a residential program is peer relationships; therefore, we decided that we would not only be prepared to serve children and youth of all ages, but that we would in fact seek out clients from each of the major age groups in order to mitigate the impact

of peer relationships taking over as the dominant concern of the children and youth while living with us.

We also decided early in the development of the program that we would not structure the program in a pre-determined manner by, for example, developing an extensive and detailed program schedule. The reason for this was simply that we were determined to mitigate the feeling of separation families experience when their children are placed in residential care. Therefore, an expectation of families, parents as well as siblings, was that they be physically present in the program as often as possible. Suggestions for participation for parents included coming for dinner, participating in any program outings, coming over to assist their children with school work, or simply just hanging out with the kids at the program.

Another important concept incorporated into the design of the program pertained to the manner in which rules are established. Unlike in the group homes, where rules are determined by the staff and are generally implemented with a view of maintaining consistent expectations and consequences for all residents, in the Treatment Homes the rules for each client are determined by the parents prior to admission. In the pre-admission meeting, parents are asked about their expectations with respect to the major routines and activities of their children, including wake up times, bedtimes, contact with friends, TV watching, playing of video games, and even allowances,

etc. The purpose of this is to ensure that children do not assimilate to one set of rules and expectations within the Treatment Home, and then have to re-assimilate to a different set of rules and expectations upon discharge home. In addition, having parents set out their rules and expectations provides the staff with an opportunity to understand where some of the conflict within the family might be originating – excessively rigid rules can thus be questioned, as can the absence of sufficient rules.

As we were developing the Treatment Homes, substantial evaluation mechanisms were built in right from the start. These included:

- Client satisfaction
- Parental and Worker expectations and feedback
- Family reunifications
- Dispositions versus Plan
- Client accomplishments – education
- Client harms – police involvement and criminal charges
- Client experiences – violence, running, other serious occurrences
- Job satisfaction for staff
- Human Resource Processes
- Financial efficiency

The results of the first evaluation period (the first 10 months of operation) are quite impressive. In virtually every one of the key evaluation areas, the Treatment Homes have outperformed other types of group homes operated by

FACS Waterloo. In some important respects, the differences are startling:

- Disposition versus plan analysis shows 85% correspondence
- Criminal charges within the Treatment Home are 90% lower than in other group homes
- Education accomplishments are three times higher than in other group homes
- In 10 out of 13 cases where children/youth came into care directly from their family home, they were discharged back to the family home
- Staff morale is extraordinarily high in the Treatment Homes
- Parents report considerable satisfaction with the program, noting in particular their level of involvement and access to all facets of case planning
- The number of Serious Occurrences in the Treatment Homes barely reaches 25% of the same number in other group homes

One of the unintended consequences of developing the Treatment Homes has been the increasing use of the staff from the program to assist other agency departments in the assessment and early intervention stages of family situations. As it turns out, the child and youth work approach to engaging with families is frequently greeted with much less apprehension on the part of families; child and youth workers are able to engage with parents and children/youth in the living environment of the family, which empowers the family and

mitigates the often criticized formalities of the child welfare intervention. In this way, a number of family situations were managed for short periods of time in such a way that the family was able to function reasonably well without requiring the child/youth to be admitted into care. Moreover, given that the residential program is staffed 24/7, providing families access to phone support has helped to maintain stability in the home.

The outreach component of the program has enabled us to provide families with other types of valuable resources. In some cases, a worker from the program may provide respite to the family by taking one or more children out of the house for some activities. In other cases, we have included children/youth in program activities without those children actually being clients in the program.

As it turns out, having a residential program available 24/7 provides opportunity for all kinds of resources to be activated, including access to program activities, phone support from staff, peer engagement and mentorship, participation in therapeutic groups for children, youth, or parents, etc. In this way, the outreach component is not only capable of replicating the work of other outreach programs in the community, but this work is enhanced and enriched through its connection to the residential program.

## Conclusion

It is becoming increasingly clear that the Child Welfare sector is about to experience a major paradigm shift. A new Ministry just in time to review the major legislation driving the child welfare process (*CFSA*), clearly concerned about the swelling numbers of children in care, the often poor outcomes for these children, and the enormous costs associated with the child welfare system, should be sufficient evidence of the coming change. There is little question that reducing the reliance on residential care, cost intensive and seemingly ineffective as it is, will be a major part in any deliberations and formulations of new directions. The residential review currently underway is not likely to overturn this prediction.

FACS Waterloo has stood out amongst most CASs given its focus on developing its own group care. While the reasons for doing so were valid and well thought out at the time, the agency is once again considering its options. The development of the Treatment Homes certainly has pointed the way to an altogether different conceptualization of residential care within the child welfare sector. Rather than seeing group homes as a placement of last resort for the “unfosterable” ones, residential service is seen as one of many resources available to a team of stakeholders that includes first and foremost the family and the child/youth him/herself.

One of the great benefits of this model is that it maximizes the resources already engaged; family



work is not the exclusive domain of Family Service Workers; the discipline of child and youth workers is quite capable of contributing to this work, and in many cases, of leading the way in a manner that is seen as more responsive by families than the social work/court-based approaches practiced by Intake and Family Service departments.

Perhaps what stands out as the most significant lesson learned so far through the operation of the Treatment Homes is that a residential “hub” for the provision of all kinds of residential and *non-residential services* can contribute substantially to a community-building, asset-based approach to service provision. Other forms of residential care have failed to do this and have, in many cases,

contributed instead to the isolation and alienation experienced by so many families, children, and youth who have come into contact with our sector.

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## Youth Thanks Uncle for Saving her from Abuse

“I didn’t know that what was happening to me wasn’t normal,” says Deborah Rochon, now 20 years old. “I thought all kids were going through what I was because when I told people what was happening, nobody did anything, so I thought it must be okay.”

But what was happening to little Debbie was not okay.

From the time her parents brought Debbie home from the hospital, she suffered severe neglect as a result of her parents’ alcoholism. Although she wasn’t even old enough to attend school, Debbie’s parents left her alone overnight. There was never enough food at home so when Debbie started to attend functions at other peoples’ homes, and later at school, she began stealing food. As she got older, her parents’ drinking binges manifested into violent rages. Debbie shamefully wore the bruises, telltale signs of the physical violence she endured.

Debbie’s uncle suspected something wasn’t right when her mother would show up at family functions with dirty, ill-fitting clothing, and sometimes spoke about excessive physical punishments. Afraid of getting his brother in trouble, he, like the rest of the family, remained silent. It wasn’t until a neighbor called to say Debbie’s parents were fighting again and that they feared for six-year-old Debbie’s safety that he decided to take action.

That evening, Debbie was brought to her uncle’s home. When Debbie’s aunt saw the bruising on her niece’s frail body, she insisted Debbie stay with them. This time when Debbie spoke, they listened — closely.

After Debbie spent a week living in the safety of her aunt and uncle’s home, her father was scheduled to be released from jail and insisted Debbie come home. Without any other way to protect the little girl, her guardians knew they would have to contact the local Children’s Aid Society. Debbie’s uncle struggled with the knowledge

that the family would not support his decision, but his wife was firm— Debbie needed help. She needed someone to care enough to *be her voice*.

The decision to contact the Children’s Aid Society in situations where abuse or neglect is suspected is one many residents of Ontario struggle with. A recent survey commissioned by the Ontario Association of Children’s Aid Societies (OACAS) found that 85% of Ontarians would report child abuse if they were certain it had occurred. Alarmingly, only 46% of Ontario respondents indicated they would report suspected signs of child abuse. These disappointing results indicate that there is still much to be done to raise the public’s consciousness of the seriousness of child abuse.

Starting this October, Children’s Aid Societies across Ontario will launch a new public awareness campaign aptly named “Use Your Voice.” The goal of the campaign is to inform citizens of their responsibility to report both known and suspected signs of child abuse, including neglect. The

campaign will mark the start of October's Child Abuse Prevention Month.

"Each of us has a responsibility to ensure that our children and youth are safe and secure," said Joe Aitchison, Board President, Ontario Association of Children's Aid Societies. "Abused children are often silent, powerless victims. We hope that by providing information we can help break down the barriers that are preventing people from coming forward while children needlessly suffer."

The "Use Your Voice" campaign has special significance for survivors of child abuse like Debbie. "If I could say one thing to a person who thinks a kid is being abused," advises Debbie, "I would say: report it. No

matter if you are sure, or not. Better to report it and nothing happen, than not report it and risk what *could* happen."

Today Debbie is married, attends post secondary education classes and works part-time. She is optimistic about her future and credits this to the involvement of the Children's Aid Society and her uncle's bravery.

"When my uncle reported the abuse, I really felt like I meant something. It meant a lot that someone stuck out their neck for me ... that someone cared about me ... that someone wanted me to be safe. I know it was hard for him but I am so grateful to him for giving me my life back."

"Ultimately, children will have more self-respect when they know that the people around them – their family, friends, and community – are willing to defend and protect them," adds Mr. Aitchison.

We can all help by being a voice for children who need us; children like Debbie.

*For more information on the signs and indicators of physical, sexual, and emotional abuse including neglect, or how to contact your local Children's Aid Society, visit [www.useyourvoice.ca](http://www.useyourvoice.ca).*

## The launch of the *Use Your Voice* Campaign



*OACAS President, Joe Aitchison*



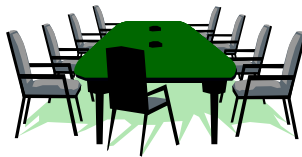
*The Campaign posters*



*OACAS Executive Director, Jeanette Lewis*



*Three of the children who volunteered to be the faces of the Campaign attended the launch*



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**OACAS, in support of its members, is the voice of child welfare in Ontario, dedicated to providing leadership for the achievement of excellence in the protection of children and in the promotion of their well-being within their families and communities.**