3 Community Services: Child Welfare – Investigations, Monitoring, and Foster Care

Summary

The Department of Community Services responds to allegations of child abuse or neglect, assesses the level of risk to the child and determines how quickly the allegations should be investigated based on the risk assessment. While this aspect of the child welfare program is working well, investigations are not always started on time or completed in a timely manner. Further, deficiencies in the program, particularly in ongoing monitoring of foster children, families under court supervision and foster families, significantly impair the Department's ability to protect children's interests or support foster families on an ongoing basis.

We found many lapses in policy-mandated contacts to monitor children and foster families. We identified 13 situations in which the required three-month contact with the foster family did not happen for more than a year and 18 situations in which the required 30-day contact with children in care was more than 60 days late. When monitoring did occur, we found issues were appropriately addressed by the Department. One quarter of the children in care files we tested had no care plans; most plans we found were completed late and regular plan reviews were late in more than 70% of the files tested. These plans are significant because they document the services the child or family needs.

We tested 140 investigations. In each case, the Department determined how quickly an investigation was required based on its assessment of risk to the child. However, following this assessment, we found investigations were not always started or completed in a timely manner. Investigations began late for 12% of the files we tested and one quarter of investigations had gaps of more than three weeks with no investigative activity. Once allegations were examined, we found the Department's processes were adequate to ensure reports of abuse and neglect are appropriately investigated.

Screening and approval of regular foster families was generally adequate. However, little guidance exists for screening and approval of kinship foster homes. We identified many inconsistencies in approving these homes and recommended new policies be implemented to address this area.

The Department does not know how long it takes to approve foster families. Having an adequate number of foster families to care for children in need is a major challenge in the foster care system and this information would assist management in evaluating the effectiveness of its current process.

We found the Children and Family Services Act has gaps related to age limits for foster care and an outdated definition of neglect. We recommended those areas of the Act be updated.

3 Community Services: Child Welfare – Investigations, Monitoring, and Foster Care

Background

3.1 Child Welfare Services includes child protection and children in care. It covers investigations into allegations of abuse or neglect, monitoring children and families, and foster care. The Department of Community Services administers child welfare programs in Nova Scotia. The Department's Program Division is located in Halifax, and is responsible for the policies, procedures and oversight for 19 district offices throughout the Province.

3.2 All child welfare services fall under the Children and Family Services Act. The purpose of this Act is *"to protect children from harm, promote the integrity of the family, and assure the best interests of the child."*

3.3 From April 1, 2010 to September 30, 2012, there were 25,833 reports of possible abuse or neglect, of which 14,919 were investigated. Many complaints do not warrant an investigation due to the nature of the complaint. 1,883 cases were opened for ongoing services and 519 of those resulted in 819 children being brought into care.

3.4 When complaints are investigated, Community Services may find nothing further is required, may monitor the family, or may remove the child from his or her home and bring the child into care. Once a child is removed from the home, that child becomes the responsibility of the Minister of Community Services and may be placed with a foster family or in a residential child care facility (for those requiring greater supervision than that provided by foster families). The Department can also offer services to the child's family if staff feel this would be helpful in situations in which ongoing monitoring or removal from the home are not warranted.

3.5 As required by the Act, child welfare services becomes involved with children and families when reports of child abuse or neglect are investigated. If an investigation determines allegations are substantiated, a risk assessment is completed and Department staff decide whether ongoing services are required.

3.6 A child protection team is responsible for ongoing services. Staff may determine it is appropriate to leave the child in the home and develop a case plan for the parents and child. The case plan outlines the goals, objectives and tasks to mitigate the risk to the child. If the child protection team determines this voluntary approach will not work, the team may pursue a supervision order in court which provides the child protection team with the power to enforce the case plan. Alternatively, if the team believes the risk cannot be mitigated with a supervision order, it may petition the court to remove the child from the home and place the child in care.

3.7 If child welfare services determine there is imminent risk of harm to the child, they can remove the child from the home immediately. In these situations, Department staff must justify these actions to a judge within five days.

3.8 When a child is taken into care, the children in care team develops a care plan which includes details on the child's placement, physical and emotional needs, family and social relationships, and educational or developmental progress. This plan is a key monitoring tool for ongoing review of children in foster family homes.

3.9 In addition to monitoring children in care, child welfare services also recruits, assesses, approves, trains and monitors foster families. Each foster family has its own social worker to monitor and support the family; families would also have contact with the child's social worker.

3.10 As of March 2013, there were 1,365 children in care, with 935 residing in foster homes. There were approximately 725 foster homes across the province. One-third (around 238) of these were kinship homes, situations in which family friends or relatives become the child's foster family.

Audit Objectives and Scope

3.11 In winter 2013, we completed a performance audit of certain child welfare services at the Department of Community Services. Our audit covered investigations; monitoring of children in their family homes or in foster homes; and approval and monitoring of foster families. This involved a number of program areas at the Department including foster care, children in care and child protection.

3.12 We wanted to determine whether the Department of Community Services:

- has processes to ensure allegations of child abuse or neglect are adequately investigated;
- has processes to ensure foster families are adequately screened prior to approval and appropriately monitored thereafter; and
- performs appropriate monitoring to protect the best interests of children placed in foster care.

3.13 The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

3.14 The objectives of the audit were to assess whether:

- the Department of Community Services' processes to investigate reports of alleged child abuse or neglect are adequate;

- the process to screen and approve foster families is adequate;
- the Department's monitoring of children in foster care; families with voluntary care arrangements; or supervision orders is adequate;
- the Department's monitoring of foster families is adequate;
- timely and appropriate action is taken to address issues identified; and
- the Department is fulfilling its requirements under the tri-partite agreement between the governments of Nova Scotia and Canada, and Mi'kmaw Family and Children Services.

3.15 We excluded matters relating to adoption and monitoring of children living in residential child caring facilities from our audit. We did not review financial remuneration or the provision of services, such as counselling, to children in care or foster families. Our work on Mi'kmaw Family and Children Services was limited to assessing whether the Department of Community Services met its requirements under the tri-partite agreement.

3.16 Criteria were developed specifically for this engagement. The objectives and criteria were discussed with, and accepted as appropriate by, senior management of the Department.

3.17 Our audit approach included interviews with management and staff at the Department; review of documentation; and testing of investigation, children in care, child protection, and foster family files for compliance with Department policies. We selected the policies that we determined were the most relevant and important to assessing our audit objectives. We conducted our audit in the fall of 2012 and winter 2013 using data for the period from April 1, 2010 to the start of field work on September 27, 2012. We visited seven district offices across the four Provincial regions.

Significant Audit Observations

Department-wide Issues

Conclusions and summary of observations

Policy manuals for child protection, foster care and children in care lack clarity in certain areas and need updating. The Children and Family Services Act should be amended to address gaps related to age limits when children can be protected and the definition of harm; the existing Act does not reflect modern views regarding risks to children. The Department has a central file audit process for child protection investigations and children in care case files. We recommended this process be extended to include foster family

approval and screening. Although the Department has a public complaint process, some complaints through regional offices are not tracked.

Policy and Procedure Manuals

3.18 During the audit, we reviewed the Department's three child welfare policy manuals. Our testing was based on selected standards and recommended practices from these manuals.

- Child Protection Services Policy Manual
- Foster Care Manual
- Children in Care and Custody Manual

3.19 *Child protection manual* – The child protection manual is over fifteen years old and has not undergone any substantial review or revision. Regular reviews are needed to ensure content remains relevant. Additionally, the manual is not available electronically, only as a binder of many hundreds of pages which is very difficult to navigate. Without a common electronic version, staff must insert updates when the manual changes.

3.20 While the investigative framework outlined in the manual is reasonable, we found the manual lacked clarity in some areas. For example, the maximum time period to initiate an investigation into lower risk allegations is not clear. Different sections refer to 21 days versus 21 working days. During our testing, it was clear that some staff interpreted this as 21 calendar days while others interpreted working days as Monday to Friday, which would allow 29 calendar days to start an investigation. We also found staff had different interpretations regarding which elements of an investigation would always be required versus those which would be optional depending on the circumstances. These differences may lead to inconsistent approaches in investigations.

Recommendation 3.1
The Department of Community Services should update the Child Protection Services Policy Manual to ensure it clearly describes current processes and required documentation. The manual should also be provided in a user-friendly, electronic format.

Department of Community Services Response:
The Department agrees with the recommendation, and will make the manual available in an electronic format. The Department has recently initiated a standards renewal project to review and update child protection standards.

3.21 *Foster care manual* – The foster care manual is also outdated and not reflective of current processes for foster family screening and approval. The manual is available only in paper format and there is a reliance on individual workers to update manuals

as changes are communicated. This could result in different manuals across the province.

3.22 The manual includes references to forms which are no longer in use, and the version we were provided had several sections noted as either under revision or targeted for revision. Most notably the section dealing with kinship homes is outdated, includes no specific standards, lacks appropriate process descriptions, and does not reflect current practice. Kinship homes are discussed in greater detail later in this chapter.

Recommendation 3.2
The Department of Community Services should update the Foster Care Manual to ensure it clearly describes current processes and required documentation. The manual should also be provided in a user-friendly electronic format.

Department of Community Services Response:
The Department agrees with the recommendation, and will make the manual available in an electronic format. As noted in the audit, the Foster Care Manual is revised, on a section by section basis. A new chapter on kinship care is at the drafting stage, and will be submitted for approval shortly.

3.23 *Children in care and custody manual* – Although the children in care and custody manual is available in a searchable electronic format, it is nearly ten years old and has not had a complete review.

3.24 *Regular review* – Community Services does not have a process to regularly review and update its child protection, children in care, and foster care manuals. Although management told us they review and update manuals on a section by section basis, there is no schedule to ensure all sections are reviewed regularly and no required timeframe for reviews. Regularly scheduled reviews would help ensure manuals are appropriate and reflect current practices. Up-to-date manuals are important to promote consistency and are also useful in training new employees.

Recommendation 3.3
The Department of Community Services should establish a regular review schedule for its child protection, children in care and foster care manuals. As sections are reviewed, any changes identified should be implemented promptly.

Department of Community Services Response:
The Department agrees with the recommendation and will immediately develop a roster which sets out a formal review schedule.

Legislation

3.25 *Legislative gaps* – The Children and Family Services Act came into effect in 1990; it is more than 20 years old. Department management identified two areas of concern with the Act which could expose some children to unnecessary risks.

3.26 *Age limits* – Under the current legislation, Community Services has no authority to investigate complaints of possible abuse or neglect if a child is between the ages of 16 and 18, unless the child is already in care. Allegations regarding a child already in care can be investigated. This provision means the Department has to treat children who are the same age differently depending on individual circumstances. In some provinces, children in need of protection are covered up to age 18.

3.27 *Definition of neglect* – The Children and Family Services Act deems a child to be in need of protective services due to neglect when there is physical harm, or risk of physical harm. This conflicts with modern views of neglect. Limiting the definition of neglect to only physical harm ignores the emotional and developmental impact that neglect can have on a child. The Act's wording limits the Department's authority to investigate complaints related to emotional and developmental neglect. Harm is defined more broadly in other jurisdictions.

Recommendation 3.4
The Department of Community Services, in partnership with Executive Council, should update the Children and Family Services Act to ensure it adequately addresses modern practices related to age groups covered by child welfare and includes a modern definition of harm due to neglect.

Department of Community Services Response:
The Department agrees to submit these recommendations for consideration by the Government, when the Children and Family Services Act is next amended.

OAG Comment: *This response describes a process which does not exist. It does not address our recommendation. It is clear that the Department does not intend to initiate a revision to the legislation.*

Other Matters

3.28 *Complaints process* – The Department has a documented complaints policy called *"When You Disagree."* It provides for escalation of complaints through Department hierarchy until resolution. It does not apply to cases before the courts. Some complaints are initially addressed at regional offices and may not proceed to the formal *"When You Disagree"* process. The Department only tracks complaints which are received by head office. There is no complete record of all complaints received and addressed within the province.

3.29 A system to record complaints and the work completed to resolve these would provide valuable information to staff and management. For example, complaints may highlight particular areas in which the Department needs to make improvements, or in which further public education is required. Furthermore, it would provide a means of ensuring each complaint is responded to appropriately.

Recommendation 3.5
The Department of Community Services should record and track all complaints, including any investigation carried out and the resolution.

Department of Community Services Response:
The Department agrees with the recommendation. It tracks provincial data from case reviews under the "When You Disagree" policy, including investigations and outcomes. It will work with the regional and district offices to establish a data collection process at those levels, by August 1, 2013.

3.30 *File audits* – Throughout its work on investigations, monitoring and foster care, the Department requires regular supervisory reviews to help ensure appropriate decisions are made. In addition, one staff member at the Department's program office is responsible to complete file audits and assess compliance with child protection standards.

3.31 Since 2008, 15 of the 19 district offices have been reviewed. Two reviews have also been completed of Mi'kmaw Children and Family Services (see discussion of the tri-partite agreement later in this chapter). The file audits do not cover foster family screening and approval. Foster families are key to a well-functioning child welfare system; the approval process could benefit from regular file audits.

Recommendation 3.6
The Department of Community Services should extend its file audits to cover all aspects of foster care, including screening and approval of foster families.

Department of Community Services Response:
The Department agrees with this recommendation. The Department will develop a work plan to review foster process, to begin September 1, 2013.

Child Protection Investigations

Conclusions and summary of observations

In all 140 investigations we tested, Community Services reviewed allegations of abuse or neglect and determined the timeframe in which the investigation should start based on the Department's assessed risk to the child. Once this initial examination occurred, we identified significant concerns with the timeliness of investigations. 12% of the investigations we examined were not started within the required time frame based on the assessed risk; in one instance, a response required the same day took three days. During investigations, 27% of the files we tested had gaps of more than three weeks with no investigative activity. Seven investigations took more than six months to complete and one of these was still ongoing when we completed our audit. Once investigations were completed, we generally found the

Department's framework for investigation and supervision was followed. However, we found two instances in which allegations were not investigated but should have been based on the case information. In both cases, the individuals involved were investigated later based on subsequent complaints. Our audit did not comment on whether investigation conclusions were reasonable; we assessed whether the Department's policies were followed.

3.32 *Investigated allegations* – We reviewed 140 child abuse or neglect case files in which the Department conducted investigations. We assessed the initial response to the allegation and compliance with the investigation process detailed in the child protection policy manual. We did not attempt to determine whether the conclusions reached in the investigations were correct, but instead tested to determine whether the Department's policies were followed.

3.33 The initial decision to investigate an allegation includes determining how quickly the investigation must be started based on an assessment of the risk to the child. There are four risk categories, with the highest priority allegations requiring a response within one hour. For the 140 allegations we tested, we found the Department responded to the allegation by assessing risk and determining how quickly an investigation should begin. There was appropriate evidence of supervisory involvement in this decision in 139 of the 140 files.

3.34 The child protection policy manual is not clear regarding the maximum time to begin an investigation for the lowest risk category. The manual states the investigative response should be *"beyond two working days and within 21 days."* Another section of the manual as well as the referral intake form both refer to this standard as 21 working days. In practice, we found regional staff used 21 working days based on a Monday to Friday work week which results in 29 calendar days. This is a significant difference in measurement, and it is unclear what the original intent was. For testing purposes, we accepted the Department's practice of 21 working days and assessed each sample accordingly.

3.35 Following the initial assessment of risk, investigations were not always started in a timely manner. For 17 (12%) of the 140 cases we tested, responses were not initiated within the required time. In one higher risk case, requiring same-day response, three days elapsed before the investigation was started.

3.36 15 (88%) of the 17 late responses were in the lowest risk category; this means a response should begin within 21 working days. However, in three of those instances, the responses were significantly delayed, taking 57, 58 and 130 days. Although these cases were assessed as lower risk, an investigation is still required and until it has been carried out, the Department cannot be certain the child is safe.

3.37 Investigations into allegations of abuse or neglect should always be started within the required response time based on the assessed level of risk; this ensures the risk to the child or children is the primary consideration.

Recommendation 3.7
The Department of Community Services should clarify the priority response times for commencing child abuse or neglect investigations.

Department of Community Services Response:
The Department agrees with the recommendation, and will immediately amend the Intake Form to ensure the response time for low risk category, 21 days, is defined consistently with Standard 3.15 in the Standards Manual.

Recommendation 3.8
The Department of Community Services should commence all investigations within the assigned priority response times.

Department of Community Services Response:
The Department agrees with this recommendation. The report indicates that of the 140 investigations sampled, there were 2 moderate to high risk situations, 1.4% of the sample, where the mandatory response time was not met. [OAG note: Sentence deleted – misinterpretation of audit conclusion.] The Department will work with staff to ensure that all investigations are begun within the assigned response time. The Department will follow up on the two high to moderate risk cases, to determine what transpired in those situations, and what, if any changes are necessary to prevent a reoccurrence.

3.38 134 of the 140 investigations we tested were complete at the time of our audit. We found applicable policies were followed for all 134 completed investigations. The remaining investigation were not complete at the end of our audit period.

3.39 In 73 (55%) of 134 files with completed investigations, as well as for five of the six ongoing investigations, we found the length of investigation exceeded the Department's six-week guideline. Management told us this guideline is a recommended practice and staff are not required to complete investigations within six weeks. However, we found extending an investigation beyond six weeks requires supervisory approval; this implies an expectation that the timeframe be met. Following an investigation, the child protection manual requires supervisors to verify *"the maximum six week time-limit has been met for completing an investigation, unless supervisory approval given for extension."* Staff in two of the regions we visited also expressed concerns with difficulties completing investigations within six weeks.

3.40 Six of the investigations we tested were not completed at the end of our audit period. One investigation had been ongoing for 47 weeks as of September 2012, due in large part to numerous periods with no investigation activity.

3.41 The following table provides more detail on the number and length of investigations, and measures the time spent to the end of our audit period on the incomplete investigations.

Duration of Investigations		
Length of Investigation	**Number of Sample Items**	**Percentage of Sample**
0 – 6 weeks	62	44%
Over 6 – 7 weeks	18	13%
Over 7 – 12 weeks	36	26%
Over 12 – 18 weeks	10	7%
Over 18 – 24 weeks	7	5%
Over 24 – 30 weeks	4	3%
Over 30 – 36 weeks	1	1%
Greater than 36 weeks	2	1%
Total	**140**	**100%**

3.42 There are many reasons why investigations may take longer than six weeks, including some valid challenges such as difficulty contacting people or the need to interview a large number of people. We excluded these instances from our reporting of investigation gaps. We found general inactivity was often a significant factor in extended investigations. Of the 78 investigations we tested which took longer than six weeks, 38 (49%) had gaps of more than three weeks without any activity. Within those 38 cases, we found a total of 52 gaps, with the longest extending 24 weeks. The tables below provide more details on these gaps, and show the extent to which many of these cases had no investigative activity for extended periods of time.

Gaps in Extended Investigations		
Number of Gaps per Case	**Number of Sample Cases**	**Percent**
1 gap of three weeks or longer	27	71%
2 gaps of three weeks or longer	9	24%
3 gaps of three weeks or longer	1	2.5%
4 gaps of three weeks or longer	1	2.5%
Total Cases	**38**	**100%**

Duration of Investigation Gaps		
Length of Gap	**Number of Gaps**	**Percent**
3 – 4 weeks	13	25%
Over 4 – 6 weeks	19	37%
Over 6 – 8 weeks	8	15%
Greater than 8 weeks	12	23%
Total Gaps	**52**	**100%**

3.43 The manual does allow investigations to extend beyond six weeks. We found 44 (56%) of the 78 extended investigations had no evidence the supervisor approved the extension; a further 10 cases (13%) had supervisory approval but no rationale for the extension.

Recommendation 3.9
The Department of Community Services should document supervisor approval and rationale for all investigations exceeding six weeks.

Department of Community Services Response:
The Department agrees with this recommendation. The Department's intention is to immediately review the requirement, and may modify it. However, if it is retained, it will require supervisory approval.

3.44 *Completing the investigation* – The child protection policy manual outlines the approach to reach and document the decision whether an allegation is substantiated and to determine what action is required going forward. Supervisory consultation is required throughout. These processes provide a framework to help ensure appropriate decisions are made based on the facts of the case.

3.45 We tested 140 investigation files and found the decision whether an allegation was substantiated was appropriately documented in 134 files. There was evidence of appropriate supervisory involvement in 133 of the 134 cases for which a decision had been made and was adequately documented. The remaining six investigations were not complete at the time of our audit.

3.46 In our sample of 134 completed investigations, 50 cases were substantiated. This means the allegation was founded; the Department then has to decide whether to open a file and provide services to the family. Alternatively, the investigation may show that although the allegation was substantiated, there is no ongoing risk to the child and thus no need for further action. This could occur if the allegation dealt with someone who is no longer associated with the child, or it was determined this was a one-time incident which the investigator does not anticipate reoccurring.

3.47 We found the decision whether to open a file was properly documented and had appropriate supervisory consultation for all 50 substantiated allegations.

3.48 *Risk assessments* – When allegations are substantiated following investigation by the Department, a risk assessment is conducted in consultation with the supervisor to help determine whether ongoing child protection services are needed. These assessments were completed in 44 (92%) of 48 files for which an assessment was required. Risk assessments were not completed in the remaining four instances.

3.49 *Case audits* – When an investigation is completed, supervisors are to complete a case audit to verify that key steps have been met and supporting documentation is included in the file. Case checklists, although not mandatory, are often used by supervisors to demonstrate they have completed the required case audit. We found the checklist was not completed for 36 (27%) of 133 files we tested. Without a checklist, there is no way to verify that the supervisor completed the required case audit. It is an important quality assurance tool to help demonstrate the completeness of the investigation.

Recommendation 3.10
The Department of Community Services should require case checklists be completed on every file closed at intake or opened for ongoing child protection services as evidence the supervisor completed the required case audit.

Department of Community Services Response:
The Department agrees with this recommendation. Standard 7.6, case audits, is comprehensive, and sets out twelve areas for supervisors to review, when auditing files. An audit checklist is already provided in the manual, under Guideline 7.7, as an aid to assist supervisors when completing file audits. The Department make the optional checklist mandatory.

3.50 *Allegations not investigated* – When the Department receives an allegation, an initial assessment is completed to determine whether an investigation is required. We tested 60 files in which the Department determined child protection investigations were not warranted; we found that decision reasonable in 58 (97%) of the 60 files. For the two remaining files, we determined an investigation should have been conducted based on the reported information. Department management agreed these situations should have been investigated. Subsequent to the allegations we reviewed, the individuals involved in both cases were investigated following new complaints. In all 60 files tested, we found that the decision not to investigate was documented with evidence of supervisory involvement.

Screening and Approval of Foster Families

Conclusions and summary of observations

Overall screening and approval of regular foster families was generally adequate, although we found minor issues in many files. We found significant inconsistencies in kinship foster family screening. The foster care manual has limited policy direction for kinship homes; policies for regular foster families are applied inconsistently to kinship homes. Staff noted confusion regarding which policies applied and many files we tested were missing required information. One-fifth of the kinship home files we tested were missing detailed assessments which are required within six months of a child being placed. We also found regular foster families are not always screened and approved in a timely manner; one approval we tested took two years to complete. The Department told us more foster families are needed in Nova Scotia; this emphasizes the need for a timely screening process.

3.51 *Screening and approval of foster families* – We tested 60 foster family files for compliance with the screening and approval processes defined in the foster care manual.

- 17 files met all the requirements (eight kinship, nine regular).
- Seven files had a single minor deficiency (seven kinship).
- 25 files had minor deficiencies (12 kinship, 13 regular).
- 11 files had significant deficiencies (11 kinship).

3.52 We defined significance based primarily on the volume of issues noted in each file; specific concerns included missing or late application documents. Minor deficiencies covered areas such as medicals, proof of insurance, general concerns with timeliness of the various steps in the process, or the failure to sign all documents.

3.53 *Lack of information on approval times* – Department management and regional staff told us the number of foster families is declining and cited this as a significant challenge. Given this situation, every effort should be made to approve new foster families as quickly as is reasonable while following related policies.

3.54 The Department does not know the average time to approve a new foster family. Management told us the only way to determine this would be to review each individual file.

3.55 For the 60 files we tested, we reviewed detailed case notes to determine the time to approve the foster family. Ten percent (6 of 60) took more than one year to complete the foster family screening and approval process. In one instance, this process took two years. These delays are not reasonable for potential foster families waiting to help care for and protect at risk children at a time when the Department is concerned it does not have enough foster families.

3.56 The availability of management information is key in making program decisions. This data is important to assess whether the current system is limiting the number of available foster families with unnecessary delays in approval. Department management should take the steps necessary to collect this information and use the information to take corrective action as needed. Given the small number of foster family applications the Department receives annually, this information could be tracked using a simple spreedsheet.

Recommendation 3.11
The Department of Community Services should track and monitor the length of time it takes to approve all foster families.

Department of Community Services Response:
The Department agrees with the recommendation, and if feasible from a cost perspective, will implement the proposed tracking and monitoring system into the Computerized Case Management System.

3.57 The foster care manual identifies specific screening requirements for foster families; the initial home consultation and home safety review are key steps in screening. We found the home safety review took place for all 60 files we tested. There was one instance in which the home consultation was not included in the file, but there were case notes indicating it had occurred. We identified concerns with the timeliness of both the home consultation and home safety review. These issues may contribute to the overall slowness in approving foster families.

3.58 *Kinship homes* – Kinship homes are foster homes in which the children already have a relationship with the foster family. The foster parents may be members of the child's extended family, neighbours, or close family friends. Kinship foster families are approved and children placed in the home much faster than for regular foster homes. Some of the required documentation is obtained after the child moves into the kinship home. For example, a detailed assessment is supposed to be completed within six months of approval of the kinship family arrangement; this includes greater details of the kinship parents' family history and environment.

3.59 Guidance for screening and approval of kinship homes is minimal. Management told us that, in practice, most foster family screening requirements apply to kinship files. However, we noted confusion among management and staff concerning screening requirements for kinship homes. There were a number of instances in which required information had not been collected for the kinship files we tested. Compliance with file documentation was generally better for regular foster family files than for kinship.

- 27 (71%) of 38 kinship files did not have required medical records. Only one (5%) of 22 regular foster family files was missing this information.
- Nine (24%) of 38 kinship files were missing required references. Only one (5%) of 22 regular foster family files did not have this information.
- Six (22%) of 27 kinship applications were missing long-form assessments. These must be completed within six months of a child being placed in a kinship home. For an additional seven files, the assessments were completed more than six months after placement. There is no comparative for regular foster care homes since the entire application process must be completed before children are placed in the home.

3.60 Management has draft policies and procedures for kinship arrangements and told us they hope to approve these soon.

Recommendation 3.12
The Department of Community Services should update the foster care manual to include clear, well-defined kinship foster family policies and procedures.

Department of Community Services Response:
The Department agrees with this recommendation. A new section on kinship care has been drafted and is currently being reviewed for approval, which has well defined

standards, policies and procedures for kinship foster care. Unless stated otherwise in the standards, policies and procedures that apply to general foster care, will also apply to kinship foster families.

Monitoring of Children in Care and Parents

Conclusions and summary of observations

Monitoring of children and foster families is inadequate to ensure the interests of the child are protected. We found significant concerns related to monitoring of children in 43% of the files we tested. A common problem was failure to meet social worker-child contact standards. In addition, 24% of the files we tested did not have care plans. Of the files we tested with care plans, the majority of plans were completed late and 74% of periodic plan reviews were not completed on time. One third of child protection files we tested did not have case plans. Monitoring of foster families was also inadequate to protect the interests of the child or to support the foster family. We found significant problems in 53% of these files; again, social worker-family contacts were a common issue. We found issues identified by social workers during monitoring were appropriately addressed.

3.61 *Monitoring children* – We tested a sample of 130 case files in which children were required to be monitored by the Department. They included the following:

- 68 children in care files;
- 32 court-ordered supervision files; and
- 30 child protection files (supervision in the home, not court-ordered).

Children in Care

3.62 We tested the 68 children in care files for compliance with Department policies and concluded:

- two files (3%) met all requirements;
- 33 files (48.5%) had minor deficiencies; and
- 33 files (48.5%) had significant deficiencies.

3.63 We defined significant deficiencies in children in care files as lacking a care plan, failing to meet with the child as required, or failure to follow up as required by standards. We also included files with many minor issues such as lack of required medical checks, supervisory reviews, or short delays in required contacts.

3.64 *Care plans* – We found care plans were missing in 15 (24%) of the 62 children in care files for which a plan was required. Care plans document the child's status (for example, physical and emotional state, relationships, developmental progress) upon

entering care and the interventions or services required to meet the child's needs. Without care plans, there is a risk the child does not receive the necessary structure and support.

3.65 In most instances, care plans were not completed in a timely manner. 37 (79%) of the 47 care plans we examined were not completed within 99 days of the child entering care. The Department's standards require plan completion within 90 days; we allowed for a reasonable overage of 10% in evaluating the results.

3.66 We also found significant lapses in the ongoing review of care plans. Department standards require plans be reviewed every 90 days. We allowed for 10% overage. 31 (74%) of 42 files were missing regular care plan reviews during our testing period.

- Five files had no reviews completed.
- 18 files had one lapse ranging from 100 days to 240 days.
- Seven files had two lapses ranging from 111 days to 469 days.
- One file had three lapses ranging from 106 days to 172 days.

3.67 Failure to monitor care plan implementation may result in the child not receiving the necessary services.

Recommendation 3.13
The Department of Community Services should prepare, and monitor compliance with, Comprehensive Plans of Care for all children in care according to policy requirements.

Department of Community Services Response:
The Department agrees with this recommendation. A new Case Planning Tool has been submitted for approval, which will streamline and simplify the planning process, and thereby enable the Department to implement the recommendation. The Department's goal is to provide training on the new planning tool beginning in September 2013.

3.68 *Initial contact* – Initial contact with the child (and parent) is required within seven days of placement. We found this standard was not met in 26 (38%) of the 68 files we tested. In two cases, the initial meeting did not take place for approximately three months following placement. In four cases, the initial meeting did not occur. This meeting is important to ensure the child is properly settling in, the foster family is comfortable with the child's needs, and appropriate services are in place.

Recommendation 3.14
The Department of Community Services should conduct all initial contact meetings within seven days following a child's placement in care as required by policy. Meetings should be documented in case files.

Department of Community Services Response:
The Department agrees with this recommendation, and is already following up on this issue. It has been working jointly with the Federation of Foster Families on the "Dialogue with Foster Parents" project. The committee is developing a number of new planning aids, to improve social work/foster parent contact, including a new scheduling tool, which will support the implementation of the recommendation.

3.69 *30-day contacts* – Social workers are required to make contact with a child at least every 30 days. We found this did not occur consistently in 50 (74%) of 68 files tested. 25 files had three or more lapses of the 30-day contact standard. The table below provides additional details on the instances of 30-day contact lapses we found during our testing.

Frequency of 30-day* contact lapses – Children in Care		
Number of Files	**Number of Lapses per File**	**Percent**
13	1	26%
12	2	24%
8	3	16%
7	4	14%
3	5	6%
2	6	4%
1	8	2%
1	9	2%
1	13	2%
2	No contacts	4%
50		**100%**

** We used 33 days to allow a reasonable overage of 10% in evaluating the results.*

3.70 During our testing, we identified 146 lapses in the 30-day contact standard. In those situations, the average contact period was 60 days which is double the timeframe required by policy. 88% of missed contacts were made within 90 days. The table below provides a breakdown of the duration of lapsed 30-day contacts.

Duration of 30-day* contact lapses – Children in Care		
Duration of Lapses	**Number of Lapses**	**Percent**
34 – 59 days	90	62%
60 – 89 days	38	26%
90 – 179 days	16	11%
180 – 270 days	2	1%
Total	**146**	**100%**

** We used 33 days to allow a reasonable overage of 10% in evaluating the results.*

Recommendation 3.15
The Department of Community Services should comply with the 30-day contact requirement for all children in care.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, it is developing a new Core Training Program for children-in-care workers, to begin in September 2013.

3.71 *Medical and dental requirements* – Medical standards for children in care were not consistently followed and dental standards do not specify the age at which a child should begin regular dental visits.

3.72 A medical is required within the first 30 days of placement and annually thereafter. Medicals were not completed in 21 (31%) of 67 files.

3.73 The Department's policy is not clear regarding the age at which children should start regular dental visits. A child is to visit a dentist within 90 days of placement and annually thereafter. Regional offices generally used between two years of age and four years of age which results in inconsistent application of the policy across the province.

Recommendation 3.16
The Department of Community Services should clarify dental standards for children to address the age at which visits are first required.

Department of Community Services Response:
The Department agrees with this recommendation, and will seek expert advice upon which to develop the standard.

Recommendation 3.17
The Department of Community Services should comply with health and dental standards for all children in care.

Department of Community Services Response:
The Department agrees with this recommendation and will follow up with the concern noted in the audit.

Court-ordered Supervision

3.74 *Supervision orders* – We tested 32 case files with court-ordered supervision.

- 22 (69%) files met all requirements.
- Seven (22%) files had minor deficiencies.
- Three (9%) files had significant deficiencies.

3.75 When monitoring did not occur within reasonable timeframes, we considered this a significant deficiency. We classified short lapses in meeting required timeframes as minor deficiencies.

3.76 The Department does not have monitoring standards for supervision orders and management told us that the court rarely establishes ongoing monitoring requirements. None of the 32 supervision orders we tested had court-ordered contact requirements. We discussed this issue with Department management around the province; they told us that monthly contact was considered the minimum acceptable practice. Accordingly, we evaluated the Department's monitoring of supervision orders against a 30-day standard.

3.77 We found monitoring occurred within 30 days in 20 (65%) of 31 applicable cases. In the remaining 11 files, the 30-day timeframe was exceeded a total of 22 times, with three of these lapses greater than 100 days.

Recommendation 3.18
The Department of Community Services should establish monitoring standards for families under court-ordered supervision.

Department of Community Services Response:
The Department agrees with this recommendation. It will develop a standard following consultation with key stakeholders.

Child Protection

3.78 *Child protection* – In certain situations, Community Services may determine it is appropriate for the child to remain in his or her home with ongoing Department involvement. Department staff are required to have a risk management conference in which staff document risks and prepare a case plan outlining the steps to address these risks. The case plan assists the social worker by providing a framework for goal setting and healthy development for the family; it forms the basis of monitoring by the Department.

3.79 We tested compliance with policies when the child remained in the home with ongoing Department involvement. We defined significant deficiencies in child protection monitoring as the absence of a case plan, a case plan missing more than two components, or failing to conduct a risk management conference. Minor deficiencies typically included preparing the case plan slightly later than required, not defining the objectives in measurable terms, or parents not signing the plan. We considered situations with multiple minor issues to be an overall significant deficiency.

3.80 We tested 30 child protection files and found:

- two (7%) files met all requirements;

- eight (26%) files had minor deficiencies; and
- 20 (67%) files had significant deficiencies, including one file for which a risk management conference was not conducted.

3.81 We found 20 (67%) of 30 files tested had case plans. However, nine case plans were not completed within the 30 days required by policy; four plans took more than 100 days to complete, including two which took more than 200 days.

3.82 We also noted deficiencies in the case plans, including nine (45%) of 20 files in which case plans did not include objectives. This reduces the plan's usefulness in guiding monitoring. Without timely and complete case plans, there may be risks to the child which are not properly addressed.

Recommendation 3.19
The Department of Community Services should prepare complete case plans within 30 days as prescribed by standards.

Department of Community Services Response:
The Department agrees with this recommendation. It will implement the recommendation by introducing a new planning tool, which has already been developed and submitted for approval. It will streamline and simplify the planning process, to reduce delays. The Department will begin training on the new tool, in September 2013, as part of the new Core Training Program for child-in-care social workers and casework supervisors.

3.83 We found evidence of supervisory file review every 90 days as required by standards for 23 (77%) of 30 files tested. However, only six (30%) of the 20 files with case plans evaluated the plan for achievement of objectives. Families with ongoing monitoring by the Department should be accountable for achieving objectives and reviews by supervisory staff would help provide assurance of this.

Recommendation 3.20
The Department of Community Services should conduct supervisory reviews to assess progress implementing case plans every 90 days, or sooner if defined in the plan. These reviews should be documented in the case file.

Department of Community Services Response:
The Department agrees with this recommendation. The Department will work with staff to ensure the case plans are reviewed, and the review is documented in the case file.

Foster Family Monitoring

3.84 *Testing* – We examined a sample of 100 foster family files for compliance with the Department's monitoring standards.

- 10 (10%) files met all requirements.

- 37 (37%) files had minor deficiencies.
- 53 (53%) files had significant deficiencies.

3.85 Minor deficiencies involved shorter lapses in required contacts or failure to properly update the safeguarding plan. Significant deficiencies included situations in which required contacts or reviews were either not completed or there were longer lapses between contacts.

3.86 Monitoring requirements are the same for regular and kinship foster homes. We did not identify significant differences in the monitoring results between regular versus kinship homes; accordingly, they are reported together for this section.

3.87 *Contacts* – Policy requires the social worker make contact with foster families in the home at least once every three months. This contact is to *"ensure that the foster family is able to maintain the expected standard of care and to meet the terms of the Foster Home Agreement."*

3.88 75 (78%) of 96 files were missing at least one three-month contact. We found numerous instances in which there were significant lapses in foster family contacts. 60% of the files we tested had three or more contact lapses and 33% of all lapses exceeded six months. The tables below summarize the frequency and duration of the contact lapses.

Frequency of Lapses of Three Month* Foster Family Contacts		
Number of Lapses per File	**Number of Files**	**Percent**
1	12	16%
2	18	24%
3	22	29%
4	20	27%
5	3	4%
Total	**75**	**100%**

** We used 99 days to allow a reasonable overage of 10% in evaluating the results.*

Duration of Lapses in Three-Month* Foster Family In-Home Contacts		
Duration of Lapses	**Number of Lapses**	**Percent**
100 – 120 days	64	31%
121 – 180 days	75	36%
181 – 270 days	36	17%
271 – 360 days	21	10%
Over 360 days	13	6%
Total	**209**	**100%**

** We used 99 days to allow a reasonable overage of 10% in evaluating the results.*

Recommendation 3.21
The Department of Community Services should meet with all foster families every three months in the foster home as required by standards.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, a new five-day training program has been developed for the foster care program. Delivery to foster care social workers and their supervisors will begin in June 2013.

3.89 *New placements* – Foster care standards also require the social worker make contact with foster families within five working days of a child's placement. Our sample included 63 new placements during our audit period. 28 (44%) of those placements, had no contact with the foster family within five working days. This initial contact ensures the foster family understands the Department's involvement and helps identify any concerns of either party early in the placement.

Recommendation 3.22
The Department of Community Services should have initial contact with all foster families within five working days of each child's placement as required by standards.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, a new five-day training program has been developed for the foster care program. Delivery to foster care social workers and their supervisors will begin in June 2013.

3.90 *Annual reviews* – An annual review of each foster family is required. 49 (63%) of 78 files had at least one review which was not completed within a reasonable timeframe. This includes ten files for which 18 to 24 months elapsed prior to an annual review, and eight files with the time between reviews exceeding two years. The annual review is important to assist foster families in developing the competencies required for effective foster parenting and to identify any issues related to the family's ability to address the needs of children in care.

Recommendation 3.23
The Department of Community Services should conduct annual reviews of each foster family as required by standards.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, a new five-day training program has been developed for the foster care program. Delivery to foster care social workers and their supervisors will begin in June 2013.

3.91 *Issues identified during monitoring activities* – For all files we tested, any issues identified as a result of monitoring were appropriately addressed by the department.

Mi'kmaw Family and Children Services

Conclusions and summary of observations

We determined the Department is fulfilling its obligations under the tri-partite agreement with the Federal government to monitor the operations of Mi'kmaw Family and Children Services. The Department of Community Services has conducted two detailed reviews of Mi'kmaw Family and Children Services and reported the results both to the agency and to the Federal government.

3.92 *Mi'kmaw Family and Children Services* – The Federal government has jurisdiction over the provision of foster care related services to native Canadians living on reserve in Nova Scotia. Under a 2009 agreement among Mi'kmaw Family and Children Services and the Governments of Canada and Nova Scotia, Mi'kmaw Family and Children Services is responsible to provide services consistent with the Children and Family Services Act of Nova Scotia, and related standards. The Province has a limited role; it is only responsible to monitor the agency's activities and report results to the agency and the Government of Canada. Management indicated they have a strong relationship with the agency and are working with them to provide additional support, such as training, where possible.

3.93 The Department of Community Services completed two reviews of Mi'kmaw Family and Children Services in 2010. These reviews covered intake, child protection and children in temporary care. The results were communicated to Mi'kmaw Family and Children Services and the Government of Canada. Based on the results, the Department provided additional training and follow-up file testing was conducted.

Department of Community Services Additional Comments

The Department of Community Services welcomes the Auditor General's report, as an opportunity to make improvements to service delivery.

There is no greater responsibility than to protect vulnerable children who may be at risk of child abuse or neglect. Accordingly, the first responsibility of a child protection worker is to respond to reports of child abuse and neglect. The Department has implemented a Risk Management System, with 9 key decision points, to ensure social workers act quickly and decisively to assure the safety of children.

[OAG note: Paragraph deleted as it misinterpreted our audit conclusions.]

The Department believes [OAG note: wording change to prevent misunderstanding relating to audit conclusions] that social workers understand the formal risk management system, and take the necessary steps to prioritize their work, in order to achieve these critical benchmarks. There is always room for improvement, and the Auditor General's Report sets out important areas where adjustments and changes are needed. Indeed, many of these areas are under way, as noted, in the Department's response to individual recommendations.