

Preventing Child and Parent Homicides: A Road Map to Implement Recommendations from the Ontario Domestic Violence Death Review Committee

Report Date: November 30, 2022

Funder: Ministry of Children, Community and Social Services - Child Welfare and Protection Division

Partners: The Centre for Research and Education on Violence Against Women and Children (CREVAWC)

London Family Court Clinic (LFCC)



DEDICATION

This report is dedicated to the children who lost their lives to domestic homicide and those who survived but had their lives forever changed when they lost a parent to domestic homicide. These children's stories are the foundation of our research. The multiple warning signs that were overlooked and many missed opportunities to intervene must become common knowledge. Public awareness and professional education are repeatedly highlighted as essential steps to change. Although this report focused mainly on one system - the essential role of child welfare - the whole community needs to work together to end these homicides. We must learn from these deaths and honour the victims as well as surviving family members and communities that have been forever impacted. One child homicide is one too many.

ACKNOWLEDGEMENT OF PROVINCIAL STEERING COMMITTEE

We would like to acknowledge the contributions of our steering committee, who provided us with valuable feedback and guidance throughout the implementation of this project.

Tope Adefarakan, PhD

Director, Black Women, Girls and Gender
Diverse Peoples (B-WGGD) Initiative

Marisa Cicero, MSW, RSW

Interim Director, Shared Services + Strategic
Operations
Ontario Association of Children's Aid Societies

Ruth Cohen

Social Worker & Survivor

Farishta Dinshaw, MA.

Lecturer & Field Placement Co-ordinator
Immigration and Settlement Studies, and
Criminology and Social Justice Graduate
Programs Toronto Metropolitan University

Crystal L. Doolittle, MSW, RSW

Director, Family Well-Being
Association of Native Child and Family Services
Agencies of Ontario (ANCFSAO)

Julie Erbland, MSW, PhD

Executive Lead – Child Welfare
Child and Youth Death Review and Analysis
(CYDRA) Office of the Chief Coroner,
Ministry of the Solicitor General

Kim Evans

Manager of Central Intake & Investigation
Dufferin Child & Family Services

Jon Farmer

Program Supervisor, Men's Program
CMHA Grey Bruce Mental Health and Addictions
Services

Elaina Groves

Director, Children's Aid Society for the Districts
of Sudbury and Manitoulin

Marlene Ham

Executive Director
Ontario Association of Interval & Transition Houses

Asifa Malik

Youth Mentor Youth Works Program
Toronto Children's Aid Society

Archana Medhekar, Barrister and Solicitor, B. Sc., LL.B. LL.M.

Archana Medhekar Professional Corporation
Certified Family Law Specialist

Rylee Melchiorre, MAPS, MSW

Manager of Quality Assurance
Children's Aid Society of the District of
Thunder Bay

Jennifer Moore

Manager, Human Resources and
Organizational Development
Dufferin Child and Family Services

David Paquin B.A., C.Y.W.

Coordinator, Supervised Access Program
Algoma Family Services

Kristine Pearce

Social Worker, VAW Team
Ottawa Children's Aid Society

Maureen Reid, MSW

Child Welfare, Consultant

Sarah Robertson

Director of Service
Child and Family Services of Grand Erie

MINISTRY LIAISON

Mark Horrocks

Program Supervisor, West Region,
Community and Social Services

ACKNOWLEDGEMENT OF FUNDING

This research was made possible thanks to the funding provided by the Ministry of Children, Community and Social Services (MCCSS).

The opinions expressed and the recommendations provided in this report reflect the opinion of the authors and not necessarily our expert provincial steering committee. In our work, we attempted to find consensus on our findings and recommendations for future policy and practices with our expert provincial steering committee, but many members were not authorized to do so in their role as provincial civil servants or representatives of organizations and agencies that may be in a conflict of interest in supporting certain actions. Some members could speak only as individual committee members but could not speak for their organizations.

Suggested Citation:

Scott, Katreena; Saxton, Michael; Reif, Katherine; Bukhari, Shaz; Ashbourne, Dan; Jaffe, Peter. (2022). Preventing Child and Parent Homicides: A Road Map to Implement Recommendations from the Ontario Domestic Violence Death Review Committee. London, Ontario: Centre for Research & Education on Violence Against Women & Children.

EXECUTIVE SUMMARY

This research focused on a review of recommendations made by Ontario Chief Coroner's Domestic Violence Death Review Committee (DVDRC) over the past decade (2010 – 2020) and the challenges in implementing changes required to prevent the deaths of children and/or their parents. It was initiated in support of child welfare redesign. The aim was to provide evidence-based direction on how to enhance child, youth, and family safety and well-being across sectors by improving accountability and sustainability through development of a roadmap to implement necessary changes in the child welfare sector.

This project was co-led by the London Family Court Clinic (LFCC) with the Centre for Research and Education on Violence Against Women and Children (CREVAWC) with strong support from the Ontario Association of Children's Aid Societies (OACAS), and the Ontario Association of Interval and Transition Houses (OAITH) and a steering committee of more than 20 members including representatives from a number of Children's Aid Societies and Child and Family Service agencies, the Association of Native Child and Family Services Agencies of Ontario (ANCFSAO), the Ontario Association of Children's Aid Societies (OACAS), Child and Youth Death Review and Analysis Committee, survivor services, men's service providers, and expert consultants in diversity and family law. This Committee considered DVDRC recommendations and responses against the reality of practice and, from this, outlined a potential road map for implementation of change. The unique issues for Indigenous families are recognized in this report in the context of existing government commitments which recognize problems in child welfare response created through colonization and oppression together with the fundamental reforms that are needed to support self-determination.

Findings of this research are divided into two major parts. **Part 1** summarizes the overall recommendations of the DVDRC in cases involving dependent children across all sectors. **Part 2** focuses on the child welfare system and needed changes in that sector to address past, repeated DVDRC recommendations.

PART 1: RECOMMENDATIONS FROM THE ONTARIO DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE IN CASES INVOLVING DEPENDENT CHILDREN

Between 2010 and 2020, the DVDRC reviewed 219 cases of domestic homicide. Over half 55% (121 of 219) of cases reviewed involved dependent children. These 121 cases involved 24 children who were killed and a total of 250 dependent children who were impacted. Thematic analysis of the 239 DVDRC recommendations made in these 121 cases identify the following major areas of recommendation:

Area 1: Recommendations for education and training on domestic violence (DV)

- DVDRC reviews have frequently identified education and training on DV as key to preventing future deaths. Since 2010, 66 recommendations have been made for professional training and education in DV across a range of service sectors (e.g., nursing, social work, policing, law). Thirty-eight recommendations have called for broad public education and awareness. Many of these recommendations directly mentioned the need for consideration of intersectional realities as part of training.

Area 2: Recommendations for conducting, sharing and learning from review of DV-related deaths

- Since 2010, the DVDRC has made twenty-six separate recommendations for conducting, sharing and learning from reviews of DV-related deaths; nineteen calling for reviews internally by agencies serving families and 7 for multi-agency, community-based reviews to learn from DV-related deaths.

Area 3: Recommendations for Coordination and Collaboration

- A key contributor to DV-related deaths is the failure of agencies working with family members to share critical information about escalation of risk and to collaborate to manage risk and promote safety. The DVDRC has made 19 recommendations in this area; 13 for better referral to and utilization of DV services and 6 for better multi-agency collaboration/case management. Many recommendations also include a call for consideration of intersectional factors in collaboration.

Area 4: Recommendations for risk assessment, risk management, and safety planning

- To prevent DV-related deaths, service providers must be able to engage in effective risk assessment, risk management, and safety planning. Since 2010, the DVDRC has made 26 recommendations for better risk assessment, risk management and/or safety planning to a range of professionals including probation/parole officers, police, family courts, lawyers, PAR agencies, school professionals, social workers and child welfare workers.

Area 5: Recommendations specific to policy, programs, and guidelines

- A final area of recommendation is policy change – with 23 recommendations focused on changes in policies, programs, guidelines and legislation relevant to DV and eight recommendations for improved funding and program development in the DV service sector.

Part 1 concludes with the reflection that determining the extent to which recommendations have, and have not, been implemented requires multiple voices to understand the realities in practice and map out a process for change implementation. We must learn from these deaths and honour the victims as well as surviving family members and communities that have been forever impacted.

PART 2: ROAD MAP TO IMPLEMENT RECOMMENDATIONS FROM THE ONTARIO DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE IN THE CHILD WELFARE SECTOR

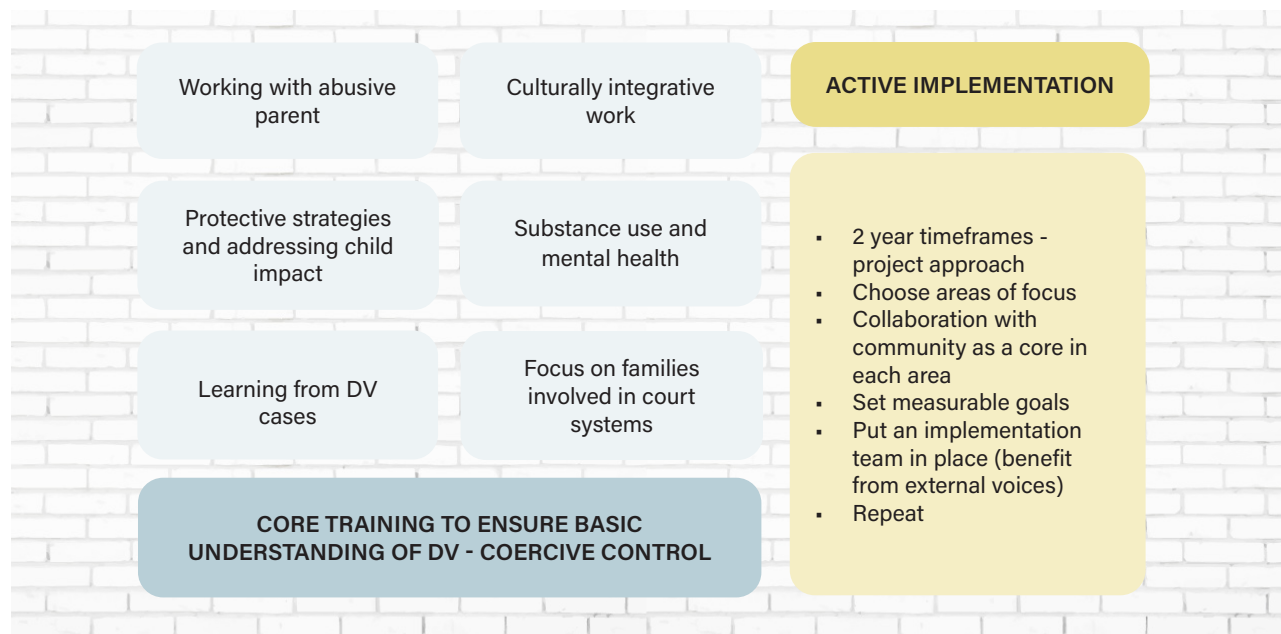
Part 2 of this report focuses specifically on recommendations made by the DVDRC that are directly relevant to the child welfare system. There was widespread agreement that change is needed in how the child welfare system recognizes and responds to DV. Concerns were expressed that ongoing and potentially escalating DV risk is not consistently and reliably recognized and responded to by child welfare services across the province. The child welfare system often responds in ways that conflate DV with bidirectional couple conflict, equates separation with safety and focuses on the protective capacity of the primary caregiving parent (most often mothers) as opposed to changes required in the perpetrating parent. Failures to recognize, articulate, and respond to children's safety needs relevant to exposure to DV are intensified when families are involved in multiple court systems (particularly post- separation, family court), when caregivers present with co-occurring challenges with mental health and substance use, and when families are coming from diverse backgrounds and cultures. Despite strong practice standards in this area, the reality "on the ground" is that leadership and support is needed to create change.

Discussions of recommendation from the DVDRC and their implementation identified a number of concrete steps for change in the areas of professional education and training, case review, coordination and collaboration and risk assessment/management and safety planning. Four major themes of these recommendations are as follows.

Roadmap for change within child welfare agencies

Change within child welfare will not happen with training, policy change or case review alone. It must be led, driven and monitored as part of plan to implement change. Figure 1 summarizes the areas of development and change needed within child welfare service agencies. A necessary foundation is mandatory core training for all child welfare workers to ensure basic understanding of DV. Building upon this foundation, six main areas of work should be the focus of change. Each area involves advanced training, development of relationships across child welfare and community-based services and practice opportunities – directed at specific, monitored outcome goals. Not all communities have the same needs and within each community, the child welfare agency can identify the most important initial area or areas of change, identify whether training will be offered to all child welfare workers or to specialized teams, gradually working to build on each "block" of change. MCCSS can take a leadership role by requiring the child welfare agencies outline and report on change.

Figure 1



Creating guides for assessing, and responding to, DV related risks

To fundamentally change the way in which the child welfare system responds to child exposure to DV, leadership by MCCSS will be needed. The province can lead by mandating DV training for all CAS workers and supervisors and by supporting the development and dissemination of a child welfare guide to comprehensive assessment and management of cases involving child exposure to DV. This assessment should identify and specify actions necessary to address: a) patterns of abuse and coercive control used by the perpetrating parent to harm the non-offending parent and children, including risk for lethality, with associated goals for intervening early to prevent and manage ongoing perpetration and escalation; b) The safety needs of the non-offending parent with associated goals for reducing vulnerability and increasing the safety of the non-offending parent; c) The impact of DV exposure and the associated needs of the child exposed. It should also outline ways that, with child welfare redesign, child welfare can work more collaboratively with community-based agencies as an essential partner in monitoring change.

Ensure that lessons learned from DV and child homicides are more readily available and are used to continuously improve response

MCCSS and the Ministry of the Solicitor General need to ensure that the lessons learned from DV and child homicides are readily available to CASs, other agencies, and the public through their website in a de-identified form and on a timely basis to communicate widely on how to prevent future deaths in similar circumstances. Communicating the findings of the DVDR and the Child and Youth Death Review and Analysis Team (CYDRA)/ formerly the Pediatric Death Review Committee -Children Welfare (PDRC-C) is essential. CASs also need to share their internal reviews with each other and include cases in which parents were killed but children survived and had their lives forever changed.

Provincial leadership to strengthen collaboration and coordination

A final priority and theme in the recommendations is broad collaboration and coordination, with child welfare agencies as one key partner. Following from the Renfrew recommendations, this report calls on the Ontario government to clarify and enhance the use of high-risk committees for DV situations to support enhanced coordination and collaboration and prevent systems working in silos. It also calls for provincially led work to develop policies and practice regarding coordination of family and criminal court proceedings and child welfare services for children exposed to DV.

SUMMARY OF ALL RECOMMENDATIONS

In addition to these highlighted areas for change, specific actions in each area of review are summarized as follows:

Area 1: Recommendations for education and training on DV

Specific Action 1.1: MCCSS to mandate 20 hrs. of initial training and 6 hrs. of ongoing professional education (on a three-year cycle), for all child welfare workers

Specific Action 1.2: Review and update online components of OACAS's 2018 Collaborating to Address the Intersection of Intimate Partner Violence (IPV)/ Violence Against Women (VAW) & Child Safety training. Consider providing flexible options for training with/by community-based agencies.

Specific Action 1.3: Mandate 6 hrs. of DV specific training for new supervisors/managers. This training could be part of OACAS's supervisor/manager advanced training offerings.

Specific Action 1.4: MCCSS to mandate 20 hrs. of initial training and 6 hrs. of ongoing training (on a three-year cycle), for all child welfare legal counsel

Specific Action 1.5: Provide direction and support OACAS (and potentially other organizations) to develop advanced training offerings (recommended 6 hrs. per module including a minimum of 2 hrs. practical "hands-on" learning) on the following specific topics: a) Engaging fathers who perpetrate DV to manage risk, promote accountability and prompt change; b) Expanding recognition of survivor strategies, including survivor strategies used by children and their impact; c) Collaboration in complex cases with co-occurring DV and serious mental illness, including substance use; d) Culturally integrated models of practice, including newcomer, Black and Indigenous families and e) Working with families involved in multiple family and criminal court proceedings. These advanced modules could be used to meet 3-year training review requirements.

Area 2: Recommendations for conducting, sharing and learning from review of DV-related deaths

Specific Action 2.1: Extension of the mandate of the PDRC/CYDRA and for internal CAS reviews to include cases where a parent has been killed in a domestic homicide

Specific Action 2.2: Enhance coordination between the DVDRC and the PDRC/CYDRA for homicide reviews in the context of DV and CAS involvement

Specific Action 2.3: Increase information sharing of PDRC/CYDRA Reviews

Specific Action 2.4: MCCSS and the OCC develop and share a set of best practices for internal review within child welfare agencies

Specific Action 2.5: Increase information sharing of internal reviews by child welfare agencies

Specific Action 2.6: Consider funding a scenario-based “lessons-learned workshop” in communities across Ontario to contribute to ongoing learning and enhance collaboration

Area 3: Recommendations for Coordination/Collaboration included the following:

Specific Action 3.1: Spread information about information sharing guidelines and protocols.

Specific Action 3.2: Provincial leadership to clarify and enhance the use of high-risk committees for DV situations

Specific Action 3.3: Provincial leadership to develop policies and practices regarding coordination of legal proceedings and services for children exposed to DV in multiple court actions

Area 4: Recommendations for risk assessment, risk management, and safety planning included the following:

Specific Action 4.1: MCCSS should support the development and dissemination of a child welfare guide to comprehensive risk assessment in cases involving child exposure to DV. This assessment should identify: a) patterns of abuse and coercive control used by the perpetrating parent to harm the non-offending parent and children, including risk for lethality b) The safety needs and safety strategies being used by the non-offending parent; and c) The impact of DV exposure and the associated needs of the child exposed

Specific Action 4.2: MCCSS should support the development and dissemination of guidelines for managing risk and promoting safety in cases where DV has been identified or suspected. Such guidance should include strategies to prevent and address ongoing perpetration and escalation of abuse with the offending parenting, support safety needs of the non-offending parent and children, and advocate for children’s access to services and resources that can help address the impacts of DV exposure

Specific Action 4.3: Consider alternate models of collaboration between child welfare and community-based DV services as part of child welfare redesign

PART 1: RECOMMENDATIONS FROM THE ONTARIO DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE (DVDRC) IN CASES INVOLVING DEPENDENT CHILDREN

Domestic violence (DV) continues to be a significant public health concern and social issue across the world. In extreme cases, DV results in the deliberate killing of an intimate partner and/or child(ren). In Ontario, domestic homicide is defined as “all homicides that involve the death of a person, and/or his or her child(ren) committed by the person’s partner or ex-partner from an intimate relationship” (Office of the Chief Coroner for Ontario, 2015, p. 2). Domestic homicide is a gender-based crime. Specifically, in 2017, the rate of domestic homicide was 5 times higher for female victims than for male victims in Canada; 79% of Canadian domestic homicide victims between 2007 and 2017 were women (Statistics Canada, 2017). While occurrences of domestic homicides are rare, these tragic deaths continue to reinforce the danger DV can pose for families.

Increased recognition of the need to understand and proactively prevent domestic homicides has led national, state, or provincial governments to create DV death review committees (DVDRCs) across the globe. Committees exist in the United States, Australia, New Zealand, United Kingdom as well as seven Canadian provinces (Ontario, New Brunswick, Alberta, Manitoba, Saskatchewan, British Columbia, and Quebec; Jaffe et al., 2013; The Canadian Press, 2017). These multidisciplinary committees gather data on domestic homicide deaths, identify risk factors, potential interventions, and provide recommendations with the ultimate goal of preventing future domestic homicides.

Canada’s oldest DVDRC is in Ontario. Since 2003, Ontario’s Office of the Chief Coroner has completed reviews of all DV-related deaths through its DVDRC. Between 2003 and 2020, the Ontario DVDRC has reviewed 386 domestic homicide cases (541 deaths) and have provided recommendations within their published case reviews. Reviews of DV deaths show that this type of violence rarely occurs in isolation. Rather, there is often a history of recurrent patterns of abuse within the home, with children both directly and indirectly involved in this violence (Kuijpers, Van der Knaap & Winkel, 2012; Hester, 2007) and multiple risk factors that can be identified in retrospect through DVDRC reports. Such findings have led researchers to conclude that domestic homicides are among the most predictable and preventable forms of homicide (Jaffe, Scott & Straatman, 2021).

Recommendations of DVDRCs may be considered alongside those of inquests and commissions into DV related deaths. A 150 + page summary of recommendations from inquests and inquiries was recently produced as part of the Nova Scotia Mass Casualty Commission (<https://masscasualtycommission.ca/files/documents/COMM0063226.pdf>). Major Ontario inquests include:

- Inquest into the Death of Margret Kasonde and Wilson Kasonde (Ontario, 1997)
- Inquest into the Deaths of Arlene May and Randy Iles (Ontario, 1999)
- Inquest into the Deaths of Gillian Hadley and Ralph Hadley (Ontario, 2002)
- Inquest into the Deaths of Lori Dupont and Marc Daniel (Ontario, 2007)
- Inquest into the Deaths of Vu Duy Pham and Frederick Preston (Ontario, 2012)
- Inquest into the Deaths of Carol Culleton, Anastasia Kuzyk, and Natalie Warmerdam (Ontario, 2022)

These can be added to recommendations from major federal reports such as the Promising Practices to Prevent Violence Against Women and Girls: Standing Committee on the Status of Women (House of Commons, 2015), the Reclaiming Power and Place: National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) and The Shadow Pandemic: Stopping Coercive and Controlling Behaviour in Intimate Relationships (Standing Committee on Justice and Human Rights, House of Commons, 2021) processes and reports.

Although the current work focuses on recommendations from Ontario's DVDRC, many of these recommendations are consistent with those from inquests and other review processes.

RECOMMENDATIONS FOR PREVENTION

The first task of DVDRCs needed to be to understand patterns of risks for domestic homicide and to make recommendations for change. With a body of 386 reviews in Ontario, the next task is to focus on recommendations and their implementation. A recent study by Jones and colleagues (2022) examined the types of recommendations made by death review committees across various jurisdictions. The overarching themes of recommendations were increased training and awareness about dynamics of DV and domestic homicides (including community involvement), provision and coordination of services, recommendations specific to children impacted by this violence, increased resources and service provision for victims, as well as enhancing processes specific to these committees. An earlier review of recommendations in Ontario finds similar themes, with most recommendations focused on increased awareness and education, assessment, and intervention, and identified areas of necessary service provision support (Jaffe et al., 2013).

A next step to reviewing the impact of DVDRCs is to consider whether committee recommendations have been implemented and whether, following implementation, they are effective at reducing incidents of serious, potentially lethal and lethal DV (Reif, 2019). As the recommendations are not legally binding and there is no mandate for agencies to respond to them, their implementation is often not effectively tracked (Bugeja et al., 2015). Storer, Lindhorst, & Starr, 2013 found that these recommendations are both underutilized and under-evaluated. A lack of funding and ineffective utilization of resources can affect the implementation of recommendations (Jones et al., 2022). One study (Storer et al., 2013), found that although recommendations were felt to be in accordance with agencies' priorities, these agencies were less likely to identify their implementation as a priority. These findings identified the need for organizations to provide incentives to implement recommendations (e.g., positive media coverage of good practice, innovation grants). Further, training and support were also deemed necessary to help make the shift towards implementation (Storer et al., 2013).

CONSIDERING CHILDREN

Children have seldom been the focus of research on DV homicide (Jaffe, Campbell, Reif, Fairbairn, & David, 2017). The limited focus on children is especially surprising and concerning given the serious impact that these deaths have on children's lives. Reviewing results from DVDRC's across Canada, Jaffe et al. (2012) estimate that approximately 7% of DV homicide victims are children, in an additional 22% of cases they are direct witnesses and in a further 30% of cases, children are present at the scene. Moreover, even if they are not present, children are heavily impacted (Alisic, Krishna, Groot, & Frederick, 2015; Jaffe, Campbell, Hamilton, & Juodis, 2012; Lewandowski, McFarlane, Campbell, Gary, & Barenski, 2004). When children lose parents, they are vulnerable to a cascade of impacts and adversities associated with that loss. Too often, children carry crushing guilt associated with a misperception that, if they had only done something differently, then they could have prevented the homicide from occurring. Research suggests that there are no differences in major risk factors between DV risk factors for DV homicides that do, and do not, involve the death of children (Hamilton, Jaffe & Campbell, 2013). However, differences are noted in the number of agencies involved, and hence, in the opportunities for prevention. In their comparison of DV homicide without child victims and with child victims Hamilton et al. (2013) found that there was an average of 9.3 agencies involved with the family in cases with children as compared to 6.3 agencies in DV homicides that did not involve children. Clearly, there is considerable potential for prevention of DV homicide in cases involving many professionals.

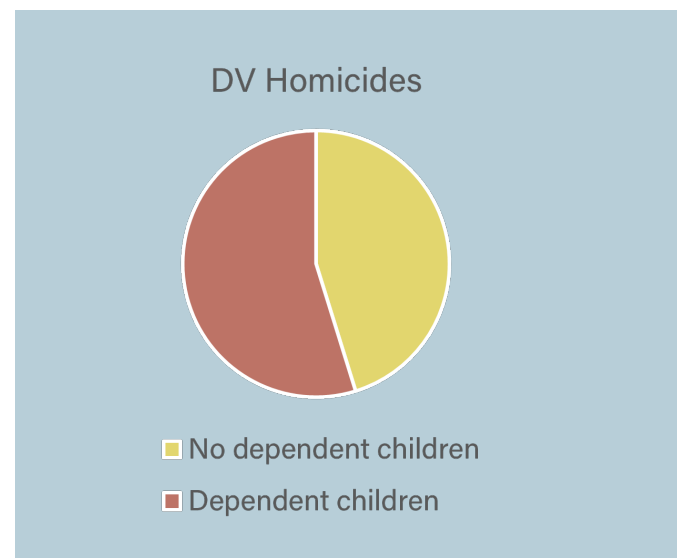
PURPOSE

The purpose of Part 1 of this project was to review all the Ontario DVDRC recommendations over the past decade (2010 to 2020) in cases of DV homicides that occurred in families with dependent children. The project was undertaken by the Centre for Research and Education on Violence Against Women and Children (CREVAWC) and the London Family Court Clinic (LFCC).

METHODS

Identifying cases

Between 2010 and 2020, the Ontario DVDRC completed **219** case reviews. Initial analysis determined whether the DV homicide victims had dependent children. Determination was based on the summary of case information. Dependent children were defined as children under the age of 18 who were the biological, step, or adopted children of the DV homicide victim or perpetrator. Several cases were also included due to their unique circumstances¹. **In total, 121 of the initial 219 cases, or 55% of cases, involved dependent children.** These 121 cases were then used in all subsequent analyses.



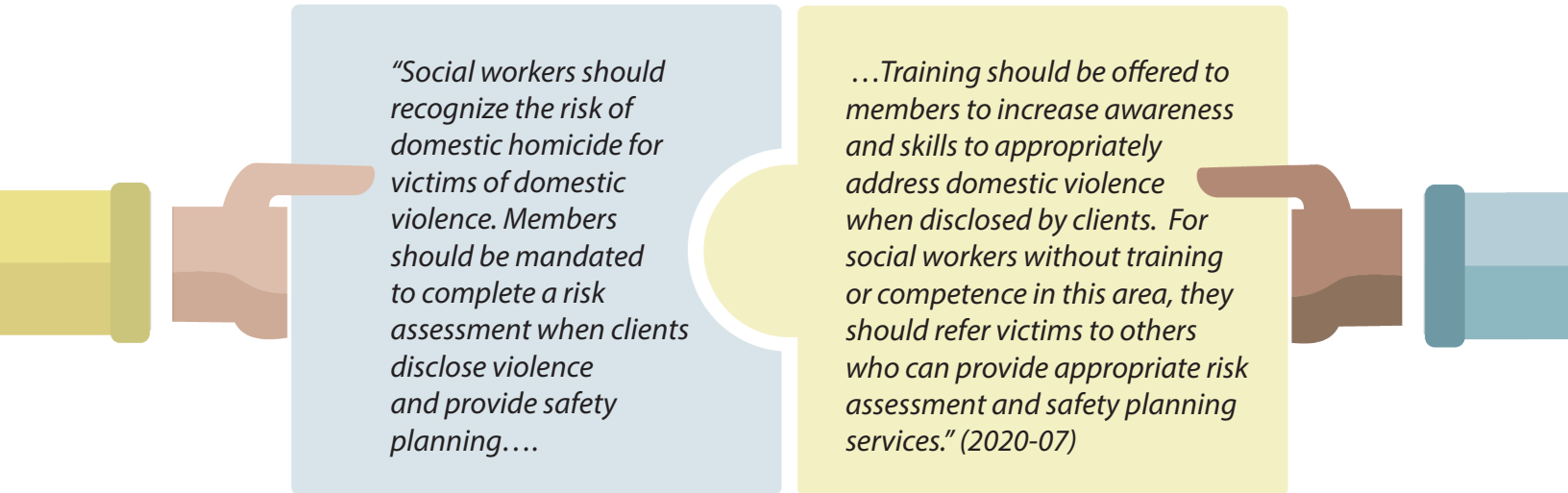
¹ Three unique cases were also included in the current project. The first involved the family of a 21-year-old daughter with significant physical and cognitive disabilities. The second case involved the domestic homicide between dating partners who were both under the age of 18. The third case involved the grandparents who were primary caregivers of their daughter's children.

It is important to note that this summary of 121 underestimates the impact of DV homicide on children. The data does not fully capture the loss of significant caregivers to children. Grandparents, in particular, are worth noting. There were at least six cases of DV homicide involving grandparents who played substantial and significant roles in their grandchildren's lives, for example as regular after school caregivers. While these cases were not included in analysis, it is significant to acknowledge the far-reaching impact of homicides of extended family members (i.e., grandparents, aunts, uncles, etc.) on children within a family. It is also important to note that our count of children impacted is likely an underestimate. In particular, non-biological children may have been omitted (e.g., children cared for by the perpetrator in a former relationship) because they were not listed in the DVDRC data.

Coding recommendations

A total of 210 individual recommendations were provided in the DVDRC case reviews that were included in the current project. Of the 210 recommendations, there are two distinct categories. The first is made of 140 newly created recommendations that were provided between 2010-2020. The second category is 70 restated recommendations that were created for cases in previous years. These recommendations are repeated as they remain relevant to issues identified in newer cases and determined to not be fully addressed at the time of review.

There were several occurrences where multiple distinct components of a single recommendation. These distinct components were coded to recognize each distinct component separately. A good example of an individual recommendation with multiple components is below. Here, the first half discusses the need for risk assessment and safety planning; the second half discusses the need for specific training. Distinct components of recommendations were coded independently. Consequently, there were a total of 239 distinct recommendations captured across cases reviewed between 2010-2020.



“Social workers should recognize the risk of domestic homicide for victims of domestic violence. Members should be mandated to complete a risk assessment when clients disclose violence and provide safety planning....”

...Training should be offered to members to increase awareness and skills to appropriately address domestic violence when disclosed by clients. For social workers without training or competence in this area, they should refer victims to others who can provide appropriate risk assessment and safety planning services.” (2020-07)

Coding Process

A multistep coding process was undertaken using a research team consisting of members with diverse backgrounds and experiences. The initial steps of this process involved compiling, organizing, and uploading all the redacted Ontario DVDRC case reports into a central repository (i.e., Dedoose software). Next, cases were examined to identify any demographic information based on the case overviews. Focus was placed on identifying intersectional aspects within cases including identifying vulnerable populations (i.e., differently abled, Indigenous, LCBTQ2+, racialized populations). Cases were also classified based on if children were present and/or killed in the context of DV.

Next the research team worked together to develop coding guidelines to be used for all the DVDRC recommendations. The coding guidelines were developed through a three-stage process. The first involved several members of the research team independently reading a subsample of case recommendations to evaluate recurring themes. The second was discussing these themes with the larger research team and develop codes and definitions. These code definitions then formed the code book which was tested on several cases to ensure suitability and completeness. Once consensus was achieved by the team, the resulting codebook was used in the third stage to code all case recommendations. The qualitative software Dedoose was utilized during the coding process. Consultations and deliberations continued throughout the coding process with the research team to ensure that the procedures and interpretation of the recommendation codes were appropriate.

RESULTS: CHILDREN IMPACTED BY DOMESTIC HOMICIDE

As mentioned earlier, 55% (121 of 219) domestic homicides reviewed by the DVDRC between 2010 and 2020 involved dependent children. Like all years prior to 2010, women are most frequently victims of domestic homicide (see Figure 2) and men the perpetrators (approximately 87% of perpetrators). Also consistent with past DVDRC reports, 75% of cases included 7 or more risk factors (see Figure 3).

Figure 2: Individuals Killed

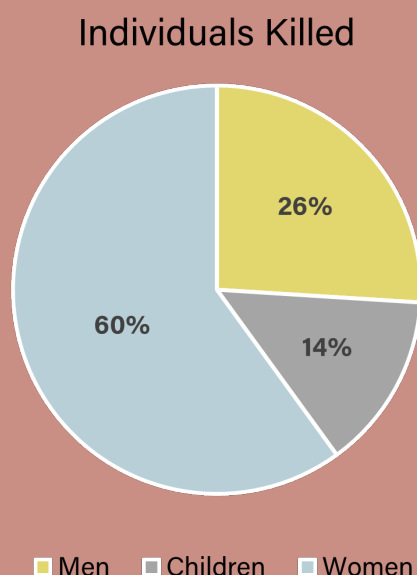
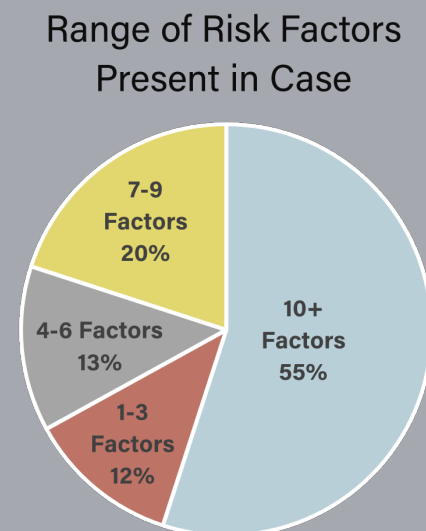


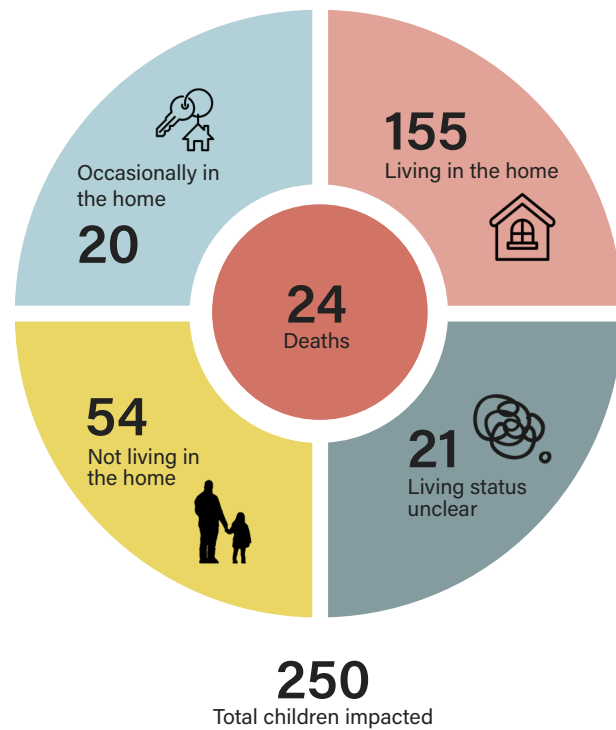
Figure 3: Range of Risk Factors Present in Case



Examples of risk factors that were present in some of these cases included actual/pending separation between the parents, sexual jealousy, perpetrator’s prior threats to harm children, perpetrator’s depression, and the victim having a new partner.

In the 121 DVDRC cases with dependent children, a total of 250 children were found to be within the family constellation. Twenty-four of these 250 children were killed. Figure 4 provides a visual representation of the nature of children’s relationship in the family constellation. As shown, **155** dependent children were living in the home of victim of the DV homicide. These children will therefore have lost their parent and their home. An additional 20 children lived in the home of the victim occasionally. This category of children included those with shared access arrangements. 54 children were not living in the home, due to custody issues, immigration, etc. Finally, there were 21 children for whom unclear information was provided about living status.

Figure 4



AREA 1: EDUCATION AND TRAINING

The first major area of recommendations made in review of the 121 cases involving dependent children was Education and Training. There were 131 recommendations made for increased Education and Training. Codes within this category included broad education/public awareness, intersectional considerations of education/training provisions, and specific training/education.

Recommendations specific to education and training included the following:

- 27 recommendations specific to intersectional considerations
- 66 recommendations for training and education to specific professional groups
- 38 recommendations for broad education and public awareness

Considerations of Intersectionality in Education and Training

Twenty-seven recommendations within the education and training recommendations highlighted the need for intersectional considerations as part of education and training. These are highlighted first, as they are relevant to all subsequent recommendations.

Cultural competence in training

Many of these recommendations discussed aspects of cultural competencies and components that should be addressed in training. For instance, several recommendations discussed how service providers should further develop awareness and ability to address the needs of victims and perpetrators through incorporating cultural frameworks of understanding:

“It is recommended that the Ontario Association of Children’s Aid Societies (OACAS) work with the Association of Native Child and Family Service Agencies of Ontario to ensure that all child welfare workers that may work with Indigenous families receive training on how to effectively respond to Indigenous families that have experienced and/or are experiencing domestic violence. The training should be offered on a regular basis to ensure that all relevant staff can receive it.” (2016-09)

“Health professionals (including addiction counsellors and nurses) who are involved with Indigenous communities should receive additional training and education on the issue of domestic violence and how it may be impacted by substance abuse, mental health and other factors within the community.” (2018-15)

Broad education for diverse communities

Recommendations toward broad education that is culturally relevant for diverse communities were also identified. The Kanwayhitowin Campaign and Anawayhitowin were identified as two examples of a public awareness campaign in First Nations communities. One example of this was including public awareness campaigns that are specifically designed by, and for, Indigenous populations:

“Individuals and organizations providing services and support to Indigenous communities are reminded that the Kanawayhitowin Campaign (based on the Neighbours, Friends, and Family program) is a valuable resource to provide information and education on addressing the issue of domestic violence involving Indigenous people in Ontario.” (2017-18)

Similar types of recommendations were also found in relation to new immigrants, for instance:

“New immigrants and their homeland families should be provided with resources (including contacts, shelters, resource centres, etc.) that can assist them with understanding Canadian law (e.g., immigration, domestic violence), equality, women’s rights, employment, and education. New immigrants should also be made aware of and encouraged to initiate contact with police and/or other resources.” (2018-02)

Overall, the intersectional consideration subtheme within training and education focused on developing an understanding of DV and related factors that are uniquely related to cultures and diverse experiences.

Training and Education for Specific Professional Groups

Recommendations made for training and education directed at specific professional groups were characterized and coded under “Specific Training and Education”. This category included 66 recommendations, with the largest sub-category highlighting areas of education and training for medical and healthcare professionals.

Training for Medical Professionals and Faculties of Medicine

There were 14 recommendations provided by the DVDRC, specifically directed to medical professionals and faculties of medicine, including doctors specializing in Naturopathic Medicine, highlighting the importance of educating doctors surrounding the warning signs of DV, as well as the advantages of early identification and intervention. The DVDRC directed recommendations to the following professionals and associations: Family Physicians, Psychiatrists, Deans or Chairs of Departments of Medicine, Medical schools, departments of Psychiatry within medical schools, Ontario Psychiatric Association, Canadian Psychiatric Association, College of Family Physicians of Canada, College of Physicians and Surgeons of Ontario, Society of Obstetricians and Gynecologists of Canada, Canadian Pediatric Society, College of Midwifery of Ontario, Ontario Association of Naturopathic Doctors, the Canadian Association of Naturopathic Doctors, the Canadian College of Naturopathic Medicine, and the College of Naturopaths of Ontario.

The recommendations directed to the professionals and associations noted above were similar in their suggestions. Many of the recommendations advised these parties to highlight the issue of DV, as well as corresponding risk assessment, risk management and safety planning training provided to professionals, including mandating this training as part of the certification processes. Some of these recommendations further highlighted the significance of ongoing training to professionals who most probably have significant interactions with potential victims of DV.

For example:

“It is recommended that the College of Family Physicians of Canada, the Ontario Psychiatric Association, in conjunction with the Canadian Psychiatric Association, and the Society of Obstetricians and Gynecologists of Canada develop and/or promote educational interventions that highlight the role of physicians in identifying a history of abuse in assessing patient’s health concerns. Studies indicate that minimal intervention can lead to disclosures of intimate partner violence, with resulting positive outcomes (e.g., increased use of victim services; more safety behaviours; less physical abuse).” (2015-01)

Recommendations for training emphasized the importance of recognizing specific aspects of risk that are likely to be known to health practitioners, such as assessing individuals with a history of mental illnesses (e.g., depression and anxiety), as well as heightened likelihood of abuse during vulnerable periods of time, such as pregnancy.

Some of these recommendations focused on the unique risks associated with firearms possession among patients with mental health difficulties²:

“It is recommended that the College of Physicians and Surgeons of Ontario provide information on how physicians’ can begin the process of encouraging patients to relinquish firearms or collaborating with police to remove firearms from a patient’s home when they are experiencing depression and/or suicidal/homicidal ideation and/or if they are experiencing conflict within their intimate relationship (e.g., pending, or actual separation). The information should include assessing risk, how to talk with patients about the risk of firearms in the home, and protocols for how to work with police to remove firearms when risk is assessed.” (2018-10)

Recommendations were provided on methods and aspects of understanding types and signs of DV and risks of lethality. For example, one of the recommendations assessed involved suggestions to psychiatric departments within medical schools to mandate degree content pertaining to DV:

“It is recommended that the Ontario Psychiatric Association, in conjunction with the Canadian Psychiatric Association, develop and/or promote educational materials that highlight the correlation between depression and the risks associated with intimate partner violence (IPV).” (2015-03)

Training for Child and Family Services/Child Protection

Approximately 10 recommendations were coded under “Specific Training and Education” involved improvements to the training provided to professionals within the child welfare sector. Agencies, associations, and ministries identified included: OACAS, Ministry of Children and Youth Services, and the Ministry of Children, Community, and Social Services. Recommendations highlighted areas requiring enhanced training for service providers and frontline workers, particularly with respect to risk assessment, dynamics of DV, and effective intervention. For instance:

² Youngson, N., Saxton, M., Jaffe, P. G., Chiodo, D., Dawson, M., & Straatman, A.-L. (2021). Challenges in Risk Assessment with Rural Domestic Violence Victims: I Implications for Practice. *Journal of Family Violence*. <https://doi.org/10.1007/s10896-021-00248-7>
Straatman, A. L., Doherty, D., & Banman, V. (2020). Domestic homicides in rural communities: Challenges in accessing resources. In *Preventing Domestic Homicides* (pp. 39-61). Academic Press.
DeKeseredy, W. S. (2020). *Woman abuse in rural places*. Routledge.

“It is recommended that the Ministry of Children and Youth Services [now called Ministry of Children, Community and Social Services] update and enhance the training available to all CASs regarding assessing potential for domestic and intimate partner violence and ensure that it reflects the most recent literature and best practices. It is recommended that the training of front-line CAS workers and supervisors include training on issues related to intimate partner violence.” (2015-03)

Training for Counsellors, Therapists, and Social Workers

Non-medical professionals, including counsellors, therapists, and social workers, were involved in specific education and training recommendations made to improve current practices surrounding DV. Sixteen recommendations were directed to individuals working within social services, mental health, and fields relating to victim, child, and family counselling. Certain recommendations made to governing boards of non-medical professionals followed an emphasis on case review to thoroughly analyze aspects of certain incidents, to better equip specialists for potentially similar cases in the future:

“It is recommended that the facts and circumstances of the case be used to assist in the education of members of the Canadian Professional Counsellors Association (CPCA) about the dynamics of domestic violence and the risk factors of lethality so that they can adequately assess and counsel clients with relationship problems.” (2015-03)

Two recommendations were made specifically to the Ontario Association of Marriage and Family Therapy for increased professional development in domestic homicide:

“The Ontario Association of Marriage and Family Therapy and the Ontario Association of Social Workers should be encouraged to promote professional development related to preventing domestic homicide including a review of DVDRC annual reports and the links between domestic violence and domestic homicide.” (2015-09)

Training for Legal Professionals

An additional sub-category involved the education and training of legal professionals. Seventeen recommendations coded under “Specific Training and Education” highlighted the importance of educating legal professionals, specifically law students and practicing family lawyers, on the intricacies and various forms of DV, as well as risk assessment, risk management, and safety planning, including mandating training as part of the curricula for law school programs. For instance:

“Domestic violence and risk assessment should be part of the mandatory Ethics & Professional Responsibility course to be required by law schools for all students starting with the class of 2015.” (2011-02)

Some of the recommendations for continuing education were specific to judges and justices of peace:

“It is recommended that there be a province-wide review of the treatment at bail hearings of cases deemed to be at high-risk for further domestic violence. In particular, Justices of the Peace should receive enhanced training around risk assessment and risk management as they relate to

domestic violence, especially when these cases involve accused persons who have demonstrated mental instability, suicidal ideation, and a history of family violence, including threats to kill.” (2012-19)

Training for Police and Probation

Ten recommendations coded under “Specific Training and Education” focused on police. These recommendations were specifically directed to regional police, Ontario Provincial Police (OPP), as well as the Working Group, co-chaired by the Ministry of Community Safety and Correctional Services and the OPP. Recommendations focused on increased training to police on the dynamics of DV in general and improved responses to circumstances of DV specifically involving children. Those recommendations emphasized training on appropriate measures and protocols in high-risk cases, especially those involving child custody and access or parenting plan evaluation situations. Others highlighted the need for training surrounding interactions with victims of DV and intimate partner violence exhibiting reluctance of interacting with police officials. For example:

“It is recommended that there be ongoing training for police on the appropriate response to domestic violence cases that involve child custody and access, which may be at high risk requiring special vigilance. Even when there is no reported history of violence between the couple, these cases require a protocol that includes appropriate risk assessment and subsequent attention to safety planning when there was alleged prior abuse against any children in the relationship. Such a protocol needs to be accompanied by appropriate training focused on addressing the potential danger for the victim and/or the child if either has been subject to previous abuse by the perpetrator during separation.” (2013-14)

“Policy, procedures and training for Ontario police services should continue to outline strategies to deal with reluctant victims of domestic violence who may recant statements or refuse to support charges, especially in circumstances that reflect an ongoing pattern of abuse and high risk, based on a mandatory risk assessment required for all domestic violence occurrences.” (2020-07)

Broad Education and Public Awareness

Broad education and public awareness were major themes of recommendations on education and training, with 38 recommendations relating to this theme. An overwhelming majority of recommendations were for public service announcements, guidelines, and educational programs specifically targeting individuals who may be experiencing forms of domestic abuse and violence, alongside neighbours, friends, family, and work colleagues of individuals experiencing DV. Across recommendations, instructions for forms of education were discussed, with the overarching goal being to highlight warning signs and potential dangers and lethality of individuals experiencing and living with DV. Methods of public education differed, depending on the individuals being addressed within each recommendation. Sub-categories of recommendations include those focused on workplaces, neighbours, friends, and families, separating couples and within educational institutions.

Educate workplaces on recognizing and responding DV

Four recommendations focused on specifically educating employers and/or colleagues of individuals who may be experiencing DV were addressed using suggestions for guidelines and public education programs administered within the workplace:

“The Ministry of Labour should work collaboratively with the Ontario Women’s Directorate in workplaces across Ontario to promote awareness of domestic violence and community supports for victims and perpetrators through distribution of Neighbours, Friends, and Family materials and information sessions.” (2013-19)

“Employers should also be required to provide training to all employees on recognizing the warning signs of domestic violence, as well as initiating the appropriate responses when they do recognize warning signs or witness incidents. Managers and supervisors should receive additional training in providing appropriate assistance to victims or co-workers who report concerns.” (2014-07)

Conduct broad public education accessible to neighbors, families, and friends

There was a total of 12 recommendations pertaining to the education of family members, neighbors, and friends stressing the importance of education surrounding warning signs, as well as encouraging individuals to report cases with identified risk factors. These recommendations emphasized the importance of individuals needing to understand the dynamics of DV as well as the gravity of the consequences if forms of abuse are not reported. For example:

“There is a continuing need to better educate family members, friends, and colleagues who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence. Public education should include action plans for persons who encounter individuals involved in domestic violence, and in particular address the increased risk associated to separation or pending separation and workplace stalking issues. In particular, this education should include a methodology to identify the risk factors for potential lethality and the specific steps to take when they are identified.” (2015-07; 2015-08; 2015-17)

“Friends, family, and neighbors of victims, or potential victims, should be encouraged to reach out to police and victim services agencies whenever they observe warning signs of domestic violence in a relationship. Public information should include ways to contact police or victim services for advice and support in non-emergency situations, and could be communicated through online sources, brochures, and public presentations.” (2016-01; 2019-04)

Education for separating couples

Six recommendations highlighted the importance of educating couples in the midst of separation, or divorce, regarding the potential of violence in such situations. Recommendations further stress and encourage couples, and individuals close to the couple, to seek assistance when and if they identify potentially abusive behaviour from either partner:

“Existing public education campaigns and programs for divorcing couples and their friends and family should highlight the potential for escalating violence in these circumstances and should encourage help-seeking for individuals experiencing high conflict divorce, as well as risk assessment and risk management for individuals expressing suicidal or homicidal thoughts.” (2015-04; 2019-08)

Education specific to educational institutes

The remaining six recommendations were directed to educational institutions and professionals, suggesting the incorporation of education on DV within school curriculum, as well as facilities on campus available for students. These recommendations highlighted the importance of early identification and intervention to mitigate long-term effects and habits. For example:

“The Ministry of Advanced Education and Skills Development should ensure that dating violence prevention programs in schools and post-secondary institutions include the links between mental health problems and intimate partner violence and should include discussion on how these problems may result in future violence by both males and females.” (2016-13)

“It is recommended that the Ministry of Education encourage school boards to make professional development and distribution of resource material on domestic violence a priority. Ontario has available materials ranging from educators’ resource guides to curriculum material on domestic violence, consistent and integrated basis. (E.g., Handbook for Educators, Choices, 4th R).” (2016-13)

“Ensure that educational programs are implemented for adolescent students to help them identify abusive and controlling behaviours in the context of both platonic and romantic relationships. These programs should also help students identify these behaviours to allow for intervention or safety planning. In particular, students should receive education on the issue of blackmailing-over-text in the context of suicide threats so that they will be encouraged to seek the assistance of adults.” (2014-16)

AREA 2: CASE REVIEWS

Recommendations specific to case reviews included the following:

- 26 recommendations for case reviews in total. Of these:
 - 19 recommendations were made for internal reviews
 - 7 recommendations were made for broader, more holistic reviews

Twenty-six DVDRRC recommendations focused on the need for reviews of critical incidents and DV deaths within a service or organization. Many of these recommendations (n=19) discussed the need for internal reviews within an organization or service to evaluate a service's role by reviewing a homicide case. Other recommendations (n=7) focused on broader reviews that were either community-based or involved multiple agencies.

Eight internal review recommendations were directed toward child welfare services, recommending retrospective examination of the provision of services and assessment of risk. An example of this type of recommendation is:

"Children's Aid Societies should be strongly encouraged to conduct an internal review whenever a domestic violence death occurs in a family that had received services of the Society within the preceding 12 months of the death, and where domestic violence issues had been identified." (2012-19)

At times, internal reviews were also directed at specific services that were involved with the family as well as toward specific areas of focus (n=8), for instance:

"The hospital involved should conduct an internal review of the services provided to the perpetrator. This review should include, but not be limited to: An evaluation of the psychiatric assessment conducted on the perpetrator particularly as it relates to his history of domestic violence and suicidal/homicidal ideation. An evaluation of the discharge process and whether the history of domestic violence was considered and whether safety planning for the family could have been completed." (2016-03)

Other recommendations specific to agencies that were involved with the family addressed the following:

- Police services should conduct an internal review of the specific case to ensure policies, protocols, and procedures were followed
- Office of the Children's Lawyer (OCL) should complete an internal review of their assessment of the individuals involved

Other recommended reviews were focused on certain types of service delivery and as “lessons learned” to improve and enhance future service response:

“Probation services should review this case as part of an examination of community corrections’ strategies in dealing with chronic offenders with problems related to domestic violence, addictions and poverty.” (2018-05)

“Obstetrical care providers are encouraged to utilize this case report and information contained within the DVDRC annual report for educational opportunities to reflect the significant risk that pregnant mothers face with domestic violence and domestic homicide.” (2020-07)

A recommendation specific to broader case reviews pertained to the coroner conducting an internal review in collaboration with other agencies:

“The regional supervising coroner for the area where this homicide-suicide occurred should conduct a review of the circumstances surrounding these deaths with the local agencies involved.” (2019-01)

Overarching reviews were also recommended for services to address identified issues noted from knowledge gained evaluating previous homicide cases. A good example of this was found in a recommendation provided to Correctional Services Canada which identified specific aspects to consider:

“Correctional Services Canada should conduct a lessons-learned case review of the circumstances surrounding this case including: reviewing their policies related to this case with a view to enhance counselling and monitoring of high-risk offenders, especially those deemed “dangerous offenders” involved in intimate relationships including random visits to the home, drug and alcohol testing and interviews with their intimate partners regarding their safety; role of child welfare services with a registered dangerous offender; protocols to alert police in the community, and alert CAS when a person with dangerous offender status has access to children.” (2020-01)

Often there was an emphasis within these ‘lessons learned’ recommendations toward the need for a multidisciplinary approach. Specifically, two recommendations discussed having a cross section of services involved as a significant step in holistically reviewing a homicide while also intentionally building partnerships to close gaps in services that may have otherwise led to missed opportunities:

“The police service involved should organize a community review of the homicide with appropriate professionals and community members to examine strategies to prevent a death in similar circumstances in the future including enhanced collaboration with friends, family, neighbours, as well as professionals in social service, health and corrections.” (2018-05)

“It is recommended that there be a province wide review of cases deemed to be at high-risk for further domestic violence and how they are treated at bail hearings” (2016-07)

Overall, the points that are emphasized by the review recommendations are:

- Reviewing strategies toward the assessment and management of risk as well as safety planning
- Reviewing how an organization identifies and differentially responds to high-risk offenders as well as chronic experiences of DV
- Continued review and education around coercive control in the context of DV
- Increasing understanding of missed opportunities to help further develop policies and procedures around DV

Implementing reviews to ensure appropriate service provision often requires a need for service coordination among agencies involved with families, which is the focus of the next section.

AREA 3: SERVICE COORDINATION

Twenty-five recommendations were made outlining the need for further service coordination.

Recommendations for Coordination/Collaboration included the following:

- 13 recommendations for utilization of services and referrals
- 1 recommendation for co-location of services
- 5 recommendations for collaboration/case management
- 6 recommendations for consideration of intersectional factors

Collaboration through co-location of services

The DVDRC made one call for the development of family resource centres and co-located services. This recommendation advises several provincial Ministries to consider further partnerships to develop co-located services to increase access for victims and families:

“The Ministry of the Attorney General, Ministry of Community Safety and Correctional Services and the Ministry of Children and Youth Services should consider expanding collaborative family violence resource centres throughout the province where victims would have a choice to access services at a single location.” (2016-05)

Collaboration through service utilization and referral

There were several recommendations (n=13) that called for more consistent utilization of existing services and making appropriate referrals. These recommendations highlighted how collaboration aids in ensuring client needs are being accounted for, including those related to DV.

These recommendations did not advise the development of new services, but rather for prompting referrals for victims. Specific points of focus were as follows:

- Addictions counsellors collaborate closely with the VAW sector
- Police should be reminded to immediately refer all victims of DV (male and female) to Victim Services to ensure timely intervention and assistance
- Police and other front-line workers (health/educational/social) be aware of the resources available in their respective communities to address issues of family breakdown, conflict, and mental health, and to make referrals when necessary
- In high-risk cases involving female perpetrators with substantial violent histories, serious substance abuse problems and emotional instability, referrals should be made for treatment and supervision.
- Professionals should be reminded to refer to CAS when concerns about child exposure to DV are identified

Collaboration and coordination as a necessity for high-risk and complex cases

Five collaboration recommendations discussed the need for a coordinated response to high-risk DV situations. These recommendations referenced further development of high-risk committees or more intensive service/supervision, including specifically identifying sectors needing better coordination. Two recommendations were made around working with cases with complex problems and/or many risk factors. For example, it was recommended that CAS should work collaboratively with other agencies to share information and collaboratively plan for addressing concerns.

“In conjunction with other agencies, should develop a protocol for working with parents experiencing mental health issues which could include a collaborative case conference for information sharing.” (2013-04)

One recommendation also emphasized the importance of working closely with specialized DV services for those who may not have the expertise to adequately address DV, for instance:

“We would not expect addiction counsellors to become experts in domestic violence work, but we would recommend that they collaborate closely with the VAW sector in their community.” (2016-02)

Other key points addressed by these recommendations include the following:

- Joint training initiatives to showcase a case management model within an integrated services approach.
- All emergency departments in hospitals should have access to mental health crisis support workers that can engage with patients involved with substance abuse with consideration of the safety of support people and intimate partners and/or family members. This would likely require more liaisons with external agencies.
- Having a panel of experts from family law, child welfare, judicial officers, police, and mental health to discuss issues related to DV cases.

There were two recommendations that focused specifically on the need for greater collaboration between justice partners and PAR for managing high risk situations. The first was directed at PAR, reminding them to *“immediately notify the police, the referral source, the victim and the perpetrator when there is evidence of heightened/high risk.”* The second was to police for involving PAR:

“Police services are reminded that when intervening in incidents involving violence against children where there is also a history of domestic violence, the perpetrator should be referred to Partner Assault Response (PAR) programs for risk assessment and risk management on a voluntary basis.” (2015-04)

A second concerned the need to develop appropriate treatment and more intensive supervision for women perpetrators with substantial violent histories, serious substance abuse problems and emotional instability.

The inclusion of intersectional identification and the need for collaboration

Collaboration recommendations uniquely discussed intersectional factors needing consideration to work effectively across systems and services. Six recommendations made clear suggestions for

collaboration, referral, and/or need coordination with culturally appropriate services (i.e., Indigenous, immigrant, LGBTQ+, racialized/marginalized communities). Included were four recommendations that identified the need to include culturally diverse partners in service delivery both locally and beyond. A good example of this type of recommendation described the need for further collaboration between police and healthcare providers with culturally appropriate services:

*“Police services are encouraged to work more closely with culturally appropriate healthcare and social services systems in order to address alcohol and substance abuse issues in a more holistic manner. Such an approach may include inviting community elders to assist with the process.”
(2019-02)*

Overall, these recommendations called for further consideration of cultural and intersectional identities in the response to DV situations. Specific points to consider:

- Honoring the calls to action that are laid out in the Truth and Reconciliation Commission of Canada report
- Need for increased culturally appropriate resources for DV services
- Referrals to culturally appropriate mental health services
- Police services to work more closely with culturally appropriate healthcare and social services systems in order to address alcohol and substance abuse issues in a more holistic manner. This may include inviting community elders to assist with the process.
- Cross-cultural and cultural competence training and the need for workshops developed and delivered by trained experts from the cultural communities being served
- Outreach by the Ministry of Citizenship and Immigration and OCASI with new immigrants who may be experiencing mental health, physical health and social consequences arising from their recent immigration to Canada
- Communication between local law enforcement or social service agencies and federal immigration authorities regarding information specific to DV occurrences involving immigrant applicants and/or their families or sponsors.

AREA 4: RISK ASSESSMENT, RISK MANAGEMENT, & SAFETY PLANNING

As described earlier, there were many recommendations for training and education which included enhanced recognition and awareness of risk factors for DV across service providers, workplaces, education settings, and for neighbours, friends, families, and diverse communities. These training recommendations often highlighted the need for clearer processes around risk assessment, and importantly, appropriate follow-up (i.e., safety planning and risk management strategies). One good example of these recommendations was found directed at the child welfare sector:

"It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies provide enhanced training on a standardized risk/danger assessment tool and enforce the use of this tool in all cases where domestic violence and harassment are present. Once the level of risk has been identified for the victim, an adequate safety plan must be implemented. As well, it is essential that contact be made with the perpetrator to assist in the risk assessment and risk management process." (2008-01; 2015-03)

There were 23 recommendations focused specifically on the need for standardized tools and processes for risk assessment, risk management, and safety planning in DV cases. For the purposes of this project, the category of risk assessment pertains to risk assessment implementation, procedures, strategies/tools, identification of high-risk cases, including a consideration of children at risk. Risk management, which is perpetrator-focused, is characterized by programs, resources, monitoring, and/or services to address perpetrator needs. Conversely, safety planning consists of interventions specific to children and victims, as well as programs and strategies that enhance safety in families.

Recommendations for risk assessment, risk management, and safety planning included the following:

- 9 recommendations for risk assessment/management, and/or safety planning by probation/parole officers
- 6 recommendations for risk assessment/management, and/or safety planning by police
- 3 recommendations to family courts/lawyers/Ministry of Attorney General
- 2 recommendations for risk management and intervention by PAR agencies
- 2 recommendations to the Ministry of Child and Youth Services for child welfare workers
- 2 recommendations specific to risk assessment and risk management and safety planning that were general and intervention among other agencies and individuals
- 1 recommendation specific to risk assessment among social workers
- 1 recommendation for school professionals to engage in risk assessment, risk management, and safety planning

Enhancing risk assessment and risk management by probation/parole agencies

There were 9 recommendations on risk assessment and management that were made specifically to probation/parole agencies. These recommendations addressed the need for utilizing specific risk assessment tools, as well as monitoring the perpetrator's compliance with conditions and intervening if necessary. Recommendations also addressed the need to engage collateral contacts (e.g., victim) in monitoring the perpetrator's progress. The following are examples of some of these recommendations:

"Probation officers should utilize a common risk assessment tool as it relates to woman abuse and lethality. Although probation officers routinely use the LSI tool, often the dynamics and issues related to abusive relationships are not identified or dealt with, in any involvement. The explanation for this is that the focus of the intervention is on 'criminal behaviour.'" (2008-02; 2017-03)

"Conditions of probation should include regular monitoring of the offender's compliance with conditions, specifically reporting requirements and counseling conditions. Supervision would benefit from ongoing collateral contacts to confirm the status of the offender's situation and the credibility of self-reported information. When the offender has failed to meet the terms, progressive enforcement must align with level of risk. When repeated verbal or written cautions fail to bring about change, a fail-to-comply charge should be pursued." (2012-10)

One of these recommendations was targeted towards female perpetrators:

"As in cases involving male offenders, parole and probation cases involving women perpetrators of crime should apply a supervision strategy that includes: identification of the level risk to others posed by women with a history of antisocial behaviour; identification of the factors associated with their risk to others, and offender participation in interventions and management strategies that address these risk factors. Factors related to the offender's self-esteem and victimization should be a focus of intervention only in so far as they are formulated as clear contributors to criminal behaviour." (2012-06)

Enhancing risk assessment, risk management and safety planning by police and associated services

Six recommendations on risk assessment, risk management and safety planning were made to police officers and associated justice services. One of these pertained to having a mandatory risk assessment for all DV calls. Two recommendations in this area called for the activation of a Victim Services/VCARS as well as working in collaboration with MAG/Crowns upon release of the perpetrator. Three recommendations had an intersectional focus, geared specifically towards Indigenous communities. These called for the need to identify, monitor, and manage high-risk Indigenous cases, including having a dedicated police unit in these communities.

Enhancing risk assessment, risk management, and safety planning with others

The remaining 11 recommendations in this category were addressed to a range of both general (e.g., all social workers) and specific (e.g., family law lawyers) professionals in the field. Underlying these recommendations is the sense that social service professionals should, in general, have the ability to recognize any DV-related lethality risk and then bring in others for a more fulsome assessment and

response. As an example of this kind of general recommendation, a recommendation was made for school professionals to enhance safety through the following:

“School professionals should be trained to actively pursue information from other professionals inside and outside the education system, as well as collateral sources” (2016-04)

Two recommendations were made for lawyers and family courts to conduct risk assessments. These included the following:

- Triaging for an initial assessment of cases in family courts to inform the degree of urgency needed to hear the matter
- Consideration of specific risk factors by lawyers

Other themes that emerged targeted the following:

- Use of the DVSR in identifying risk factors and as a way of mitigating future risk
- Risk management of the perpetrator by PAR programs through the provision of support and interventions (e.g., counselling).
- Enhanced training for child welfare workers on DV risk assessment
- Routine screening and thorough risk assessment that is followed by risk management and safety planning
- Removal of firearms from individuals going through separation and showing signs of depression, or suicidal/homicidal ideation
- Special funding to help support the development and implementation of risk assessment, risk management and safety planning processes.

AREA 5: POLICY, PROGRAMS, AND GUIDELINES

There were several recommendations (n=31) that pertained to enhancing policy, programs, and guidelines at various agencies that come into contact with victims and perpetrators of DV.

Recommendations specific to policy, programs, and guidelines included the following:

- 18 recommendations for policy development to address DV
- 5 recommendations specific to legislation amendments
- 8 recommendations for improvement of funding and program development

Policy development for addressing DV

A majority of these recommendations (n=18) identified a need for policy development specific to ensuring victim safety and enhancing perpetrator accountability and risk management.

- Protocol between police and crown counsel to ensure appropriateness of prospective sureties and to ensure they are informed of their responsibilities and liability in the event of breach of duty
- Development of a protocol between the CAS and local mental health services for coordinated service provision when working with parents experiencing mental health difficulties
- The Minister of Public Safety to require a signed medical waiver by applicants applying for a firearm Possession Acquisition License (PAL) as well as more stringent restrictions for those applicants who had previous licenses revoked or removed
- Policies, procedures, [and training] for police services on strategies to deal with reluctant victims of DV based on a mandatory risk assessment for all DV occurrences
- Policy/protocol for victims, potential victims, and family members to access information on prior convictions of violent offences for individuals they are currently dating or residing with. An advisory panel can be considered to implement this policy which is known as a Domestic Violence Disclosure Scheme in other jurisdictions.
- Guidelines for First Nations Police Services when responding to chronic DV
- The Canadian Radio-television and Telecommunications Commission (CRTC) to consider the reduction, management or elimination of websites that are published to inform people how to commit suicide or homicide

One recommendation specific to policy/protocol development in this area focused on the need to review any existing protocols and procedures to ensure their appropriateness:

“It is recommended that the protocol for identifying appropriate forensic psychiatrists who conduct court-ordered mental health assessments be reviewed, particularly for accused persons demonstrating a history of mental instability, suicide attempts, and threats to commit suicide or to kill others. In addition, the process by which such mental health assessments occur should also be reviewed to determine if such assessments include collateral information so that more than just the perpetrator’s accounts and self-reporting are considered. Collateral information sources should include, at minimum, the victim’s accounts of violent and abusive behaviour by

the accused, given that significant research has shown that abusers often minimize or deny their violence.” (2012-19)

Five recommendations were for policy, practice, and program changes relevant to family law:

- Policy for lawyers to ensure awareness of risk and safety issues in DV cases
- Litigants to complete an “Assessment of Conflict Form” in court which can provide information that can be further assessed by risk assessment tools
- Family law lawyers to consider different ways of serving and communicating family court documents and serving papers in person in cases of DV
- Appointment of an Amicus Curiae (lawyer as friend of the court) in child custody cases involving a self-represented litigant that might have significant parenting outcomes
- Including mandatory segment on potential risk of lethal violence in criteria for determining financial grants specific to training and public education
- Convening an expert panel on the process to change custody from one parent to another after a trial

Two recommendations focused on the need for policies within workplaces to address DV.

- Policies within workplaces to address DV including increased awareness and training for employees and managers, and response to direct threats of DV, safety planning for victims and risk management for perpetrators, and reviewing compliance with the provisions of the Occupational Health & Safety Act
- The Ministry of Labour to require the adoption of “Progressive Accountability” policies in the workplace to hold perpetrators accountable for their abuse by making continued employment contingent on behaviour change

Three specific recommendations were made specific to legislation amendments and included the following:

- Consideration by the federal Minister of Justice on whether first-degree murder charges should be expanded to include murder committed by individuals declared as a dangerous offender, under long-term supervision and in violation of supervision terms
- Legislation development that would allow potential DV victims and their family members to apply for access to information about intimate partners where there are violence concerns
- Consideration by the federal government of possible amendments to the Criminal Code of Canada to include homicide of domestic or intimate partner as automatic first-degree murder charges in cases involving prior convictions of DV or pattern of abuse

Improved funding/program development

There were eight recommendations that targeted the allocation of funding and/or providing specific programs or services. These addressed the following:

- Provision of long-term mental health resources to support mental health patients by the Ontario Ministry of Health and Long-Term Care
- The Ministry of Indigenous Affairs, Indigenous Services Canada, and Office of the Chief Coroner to provide adequate resources to ensure victim safety and reduce perpetrator risk
- Implement educational programs for students to help identify abusive behaviours
- Evidence-based program interventions/case supervision strategies for female perpetrators
- Provision of funding and resources to create joint training opportunities for those working in mental health agencies and violence against women services to ensure a more integrated and holistic response

SUMMARY

The aim of this report was to summarize recommendations made by the DVDRC committee in the reviewed between 2010 and 2020 in cases that involved dependent children. Of the 219 cases reviewed over this period, 55% or 120 cases, involved 308 dependent children, 24 of whom were killed.

A total of 239 recommendations were made in these 219 cases. The most common recommendations focused specifically on the need for further education and training (including specific training, broad education and public awareness, and intersectional considerations). Other major identified themes were a need for internal and broader case reviews (involving single and multiple agencies); service coordination (including utilization of services, co- location of services, collaboration/ case management, and intersectional considerations); policy programs and guidelines (including DV-specific policy development, legislation amendments, and improved funding and program development); and increased risk assessment, risk management and safety planning (primarily pertaining to parole/probation, and police).

The next critical step for DVDRC work is to determine the extent to which recommendations for change have, and have not, been implemented and then, if necessary, to map out a process for implementation. For all except a very few policy-related recommendations, such review requires the collaboration and consideration of sector partners. This is because determining whether the recommendation has been met is often not easily accessible to those outside a particular sector. For example, a recommendation cited earlier in this report was for *“ongoing training for police on the appropriate response to DV cases that involve child custody and access”*. Determining whether or not this recommendation was implemented needs discussion with police as to whether such training is available at all, whether it is accessible and universal, and whether it is deemed effective by those who attend the training or in independent research.

Part Two of this report focuses specifically on the child welfare services in Ontario; describing and analyzing recommendations made to this sector for change. It reports on the analysis of the recommendations and responses by the provincial steering committee to test the extent of actual implementation of these recommendations as well as barriers to successful implementation.

PART 2: CHANGES NEEDED IN CHILD WELFARE SERVICES FOR CHILDREN LIVING WITH RISK OF DOMESTIC HOMICIDE

INTRODUCTION

Child welfare services in Canada have an important role to play in responding to risk to children exposed to domestic violence (DV). A substantial proportion of children who come to the attention of child welfare services in Canada do so because of their exposure to DV (Fallon et al., 2015; Trocmé et al., 2010). Ontario's most recent incidence study of reported child abuse and neglect (OIS) documents that, in 45% of cases, child exposure to DV is the primary substantiated form of maltreatment (Ontario Incidence Study of Reported Child Abuse and Neglect, 2018). In families who come to the attention of child welfare for other forms of abuse and neglect, DV is identified as one of the most co-occurring experiences, thus compounding deleterious effects (McTavish et al., 2016). In Ontario, for example, the most common primary caregiver risk factor is being a victim of DV (53% of families) (Ontario Incidence Study of Reported Child Abuse and Neglect, 2018). Finally, longitudinal studies have shown that, for families involved with the child welfare system, the presence of DV is associated with a greater likelihood of re-referral (Casanueva et al., 2009; English et al., 2005; Kohl et al. 2005).

At the extreme end of DV are homicides perpetrated by intimate partners. Domestic Violence Death Review Committees (DVEDCs) have continued to highlight the role professionals have in intervening and preventing domestic homicides. Reviews show that many families were involved with community service providers, including child welfare, prior to the homicide. In Ontario, more than one in five of domestic homicide cases with dependent children had prior documented involvement with CPS (Olszowy, Jaffe, & Saxton, 2021). DVEDC's have recommended that service providers enhance how they intervene considering potential missed opportunities. As outlined in Part 1 of this report, many previous DVEDC recommendations have focused on changes needed in the child welfare system's ability to recognize and respond to DV. Recommendations have consistently highlighted enhancing education/training, service coordination, case reviews, policies, programs, and guidelines. Likewise, recommendations have called for further consideration of the potential missed opportunities for improved risk assessment, safety planning and risk management strategies.

Although there have been past improvements in child welfare standards in recognizing the risk to children exposed to DV, more needs to be done (Olszowy, Jaffe, & Saxton, 2021). Commentators have pointed to challenges associated with a lack of ongoing training on DV-related issues, poor maintenance of collaboration with community partners, lack of involvement with fathers who may have perpetrated DV, inconsistency in practice, as well as challenges emerging from complex families and high caseloads (Hazen, Connelly, Kelleher, Landsverk & Barth, 2004; Humphreys, C., Kertesz, M., Healey, L., & Mandel, D. (2019); Humphreys, C., Diemer, K., Bornemisza, A., Spiteri-Staines, A., Kaspiw, R., & Horsfall, B. (2019); Jenney et al., 2014; Nixon, Bonnycastle & Ens, 2017; Scott, Thompson-Walsh & Nsiri, 2018). A recent report by Women's Shelters Canada highlights numerous child welfare practices that unfairly penalize women/survivors of violence including relying on/requiring mothers, as primary caregivers, to protect children from exposure to domestic violence and failing to engage and hold father perpetrators responsible (Women's Shelters Canada, 2022). Despite these challenges, the child welfare system plays a critical role in addressing DV violence in families. Likewise, they are a fundamental community partner in identifying and responding to families at high-risk of repeated exposure to DV and homicides.

Two fundamental positions are central to consideration of change within child welfare – the legislative context of child welfare work in Ontario and a commitment to self-determination of Indigenous Peoples.

Legislative Context of Child Welfare Work in Ontario

It is important to situate work to review implementation of DVDRC recommendations in the context of changing child welfare legislation in Ontario. On April 30, 2018, the Child, Youth and Family Services Act (CYFSA) came into force and repealed the Child and Family Services Act, 1990 (CFSa). The aim of this act is not to punish or hold accountable parents who may have maltreated their children, but rather to protect children and promote their welfare. There is a presumption that the best interests of children is promoted by their being cared for by parents or relatives and there is an onus on the child welfare system to justify intrusions into parental care.

The CYFSA brought in a number of changes, many of which focused on making child welfare practice and service delivery consistent with Canada's ratification on the United Nations Convention on the Rights of the Child (UNCRC). The preamble to the CYFSA also acknowledges the unique and evolving relationships between Ontario and First Nations, Inuit, and Métis peoples.

The guiding principles of the UNCRC are non-discrimination; devotion to the best interests of the child; the right to life, survival, and development; and the right to participate and be heard. When the State intervenes with the family unit in the child welfare context, the child interpretation and enforcement practices of the child welfare law have to respond within the framework of the Charter of Rights and Freedoms. Although the UNCRC is not directly referenced in the child welfare legislation, the Supreme Court of Canada has clarified in various cases that children's rights, and attention to their interests, are central humanitarian and compassionate values in Canadian society and the international instruments should be considered as the tool of interpretation of domestic laws in the child welfare context. Subsection 74(3) of the CYFSA includes the importance of preserving a First Nations, Inuk, or Métis child's cultural identity and connection to the community as a specific stand-alone consideration within the list of general factors relevant to determining what order is in the child's best interests.

The UNCRC changed the way the world sees children. Children are now seen as individual rights-holders, particularly as emphasized in Article 12 that the children's voice needs to be heard in child welfare proceedings and their views to be considered when adults are making decisions that affect them, in accordance with their age and maturity. The Convention underlines that children are holders of their own rights, and not dependent on their race, colour, sex, language, religion, political or another opinion, national or social origin, disability, property, birth, or other status. In turn, the Convention attaches the responsibility on duty bearers, including families and caregivers to realize children's rights and makes the governments signatory to the convention accountable for protecting children's rights.

The Supreme Court of Canada (SCC) has recognized that the child welfare proceedings engage the children's Charter rights noted in UNCRC for example, children's rights under Article 2 of CRC are protected by S. 15 of the Charter right that guarantees the equal protection of law. The SCC has also recognized that child welfare proceedings engage children's s. 7 interests under the Charter. The UNCRC Article 12 is part of due process as defined in S. 7 of the Charter- the right to life, liberty, and security of the person.

The UNCRC is the world's most supported human rights treaty. However, it is important to note that UNCRC is criticized for being based on Western Euro-centric values. In view of that, it is crucial for the Ontario child welfare system to recognize additional human rights instruments, such as the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) while dealing with the Indigenous communities and children as the larger collective rights.

In addition, The Sustainable Development Goals (SDGs) were adopted by all United Nations Member States, including Canada, in 2015. The SDG's aim to end poverty, reduce inequality and build more peaceful, prosperous societies by 2030. There is a growing awareness within the international community that the SDGs cannot be achieved without the realization of child rights. In the context of children and realizing the SDG goals, there is a greater need to capture the experiences of children and youth in decision-making within the child welfare system - including children with multiple identities such as children with disabilities, living with HIV/AIDS, Indigenous background, refugees, internally displaced persons, and migrants.

Given these shifts in legislation and children's rights, there are multiple challenges for the child welfare system to reach out to disadvantaged children who are at risk due to long-standing barriers including poverty, discrimination and marginalization, armed conflicts, humanitarian crisis, global migration and refugee crisis, and gender gaps.

Self-Determination of Indigenous Peoples in Child Welfare

The second overarching theme and commitment that guided our consideration of the implementation of DVDRRC recommendations was recognition of self-determination of Indigenous Peoples. As recognized by the steering committee, the DVDRRC itself has not been led by, had consistent participation of, or were engaged with Indigenous leaders or Elders in reviewing deaths and developing recommendations. As such, the DVDRRC has been limited in the extent to which it has considered the needs and realities of Indigenous families involved with the child welfare system and, recommendations outlined herein cannot be directed or imposed on Indigenous Child Well-Being agencies.

Canada's colonial history makes it especially important to recognize and support Indigenous self-determination. A commitment to avoid imposing recommendations on Indigenous Child Well-Being agencies is based in a recognition that the rights of Indigenous Peoples of Canada have been repeatedly violated by governments and through Canada's child welfare system. Violations include the injustices of residential schools, the sixties scoop, birth alerts and the millennium scoop. These harms continue. Indigenous families continue to face significant inequalities and are disproportionately in contact with child protective services. Indigenous children and families continue to experience substantial harm under the guise of child welfare. As one example, data from the 2016 census shows fewer than eight per cent of Canadian children under the age of 15 are Indigenous, but Indigenous youth make up more than half the children under 15 in foster care. These disparities are rooted in longstanding structures, processes, and policies within, and outside of, the child welfare system that adversely impact Indigenous communities and peoples. In 2016, the Canadian Human Rights Tribunal officially recognized that the federal government discriminated against Indigenous children by underfunding an on-reserve child welfare system that paid little attention to the consequences of removing Indigenous children from their homes. The tribunal recognized that Canada's actions led to "trauma and harm to the highest degree, causing pain and suffering."

Advocates and leaders from Indigenous communities have been clear that a necessary step to addressing and redressing harms is transformational change in child welfare, including the right of Indigenous communities to establish and maintain their own child welfare agencies. Child welfare services, processes, systems, and discussions need to be fundamentally reframed to incorporate Indigenous worldviews and approaches. The primary factor then becomes taking continued steps toward empowering Indigenous communities and services to develop their own pathways to assess and respond to the needs of Indigenous children and families. A summary of recommendations of some of the many reports that have called for change is provided in Table 1. The steering committee asserted that such changes must be enacted as a foundation for any considerations from DVDRC recommendations and from this report.

Table 1 Summary of Recommendations from Critical Reports for Indigenous Peoples of Canada

| | |
|--|--|
| <p>Truth and Reconciliation Commission of Canada</p> | <p>The Truth and Reconciliation Commission of Canada (TRC; 2015) provided directions for child welfare as part of their calls to action. The TRC asserted that the number of Indigenous children and youth within the child welfare system is a “growing crisis” needing to be addressed. TRC highlighted some of the challenges that impact effective services, including those associated with underfunding and jurisdictional disputes. The TRC endorsed the need for child welfare mandates to focus on social determinates of families’ health and well-being and not simply child risk. There were specific calls for reducing the number of Indigenous children in care through supporting culturally appropriate services. The TRC called for affirming the rights of Indigenous led child welfare agencies and increasing resources and access to culturally appropriate solutions to family healing. The TRC also made calls to action to ensure child welfare workers across Canada be properly educated and trained.</p> |
| <p>Ontario Human Rights Commission Report: Interrupted childhoods: Over-representation of Indigenous and Black children in Ontario child welfare</p> | <p>In 2016 the Ontario Human Rights Commission (OHRC) undertook an inquiry into the involvement of Indigenous and racialized children and youth in the child welfare system. It found that across Ontario there was disproportionately high incidence of Indigenous and black children coming into the care of Children Aid Societies (CAS). Among the OHRC recommendations was a call to the Ontario government, MCYS (now the MCCSS), OACAS, and CASs to fully implement the TRC calls to action. OHRC also called for the government to require all CASs to collect and share human rights-based data. Their recommendations also extended to anti-racism training for all child welfare workers and on providing culturally competent services to Indigenous families. OHRC called for continued partnership with Indigenous communities across all work that unfolds (i.e., trainings, service development and delivery)</p> |
| <p>Ontario Indigenous Children and Youth Strategy (OICYS)</p> | <p>In 2017 the Ontario government in collaboration with Indigenous partners has provided a strategic framework called the Ontario Indigenous Children and Youth Strategy (OICYS). This framework is designed to enhance support for programs, policies and services that impact Indigenous children, youth, and families. As part of this ongoing strategy, the OICYS is working toward child welfare services that are community-led and preventative based. Furthermore, this framework is working toward supporting Indigenous communities to implement their own models of child welfare that incorporate Indigenous laws and worldviews. The intended purpose of this shift is to improve services and meet the needs of Indigenous families while also enabling Indigenous communities to have greater authority over child and family services.</p> |

| | |
|---|---|
| <p>Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls</p> | <p>The inquest into the missing and murdered Indigenous women and girls identified the child welfare system as a tool used by the government to oppress, disrupt, displace, and destroy Indigenous families and communities. The 2019 MMIWG report also was clear that the apprehension of Indigenous children is a form of violence against children and represents the worst form of violence against mothers. MMIWG noted that the policies, laws, and services used by the established child welfare system are not based in Indigenous laws, values, and worldviews which makes such a system ineffective at addressing the needs of Indigenous families. Consequently, to improve the system the MMIWG report called for transformational change, replacing the current child welfare system with one that was based in respect for Indigenous peoples and recognizes, promotes, and supports the notion that Indigenous peoples are in the best position to make decisions regarding Indigenous children.</p> |
| <p>Agreement-in-Principle with the Assembly of First Nations, the First Nations Child and Family Caring Society, the Chiefs of Ontario and the Anishnawbe Aski Nation</p> | <p>January 4, 2022, Canada announced that it had reached an Agreement-in-Principle with the Assembly of First Nations, the First Nations Child and Family Caring Society, the Chiefs of Ontario and the Anishnawbe Aski Nation on the long-term reform of the First Nations Child and Family Services Program. The aims of this reform are to better support Indigenous child and family services agencies in providing culturally based, substantially equal family supports, and to reduce the number of Indigenous children in care. Provisions include expanded eligibility under Jordan's Principle, funding for prevention services to build on multi-cultural strengths and to support Indigenous adults aging out of the child welfare system up until their 26th birthday. Critically, that agreement would ensure that funding to First Nations child and family services agencies, are established, managed and controlled by First Nations and delegated by provincial authorities. At the time of writing this report, effects to finalize this agreement and implement changes are ongoing.</p> |

Purpose of Part Two

Using the existing evidence-base of domestic homicide death review recommendations to guide a cohesive systemic change process, our aim was to identify and analyze the barriers to implementation of past recommendations to MCCSS and child welfare services over the last 2 decades. We embarked on this work with the knowledge that the child welfare sector is in the process of prototyping new projects that will address many issues identified in the recommendations. The analysis will inform the design of a blueprint for implementation in child welfare agencies across the system. Our aim is to help consider how systemic change in how we recognize and respond to DV within the child welfare sector can be a contributor to better supporting families, reducing the number of children in need of protection returning to care, while ultimately saving lives.

The project aimed to support child welfare redesign pillars:

1. Enhancing child, youth and family well-being across ministries and human services sectors that address complex challenges while keeping children safe in family-based settings. DVDRC recommendations provide evidence-based direction on how to enhance child, youth, and family well-being across sectors.
2. Improving accountability and sustainability through development of an *implementation blueprint* that will identify the most strategic recommendations for the child welfare sector with a pilot project design for the second and third phase of the project. The blueprint created will also include identification of meaningful indicators for systematic data collection that will qualify success over time.

GATHERING MANY VOICES: WHO CONTRIBUTED TO THIS PROJECT?

The central goal of the current project was to understand how Ontario DVDRC recommendations (see Part 1) are being implemented. To understand whether recommendations have been sufficiently implemented, and if not, to understand the barriers and propose solutions, it is necessary to consider the experience of service providers, families, and others working within the system. Thus, a critical step in this project was to bring together a working group with firsthand experiences with the realities of the role of, and for, child welfare workers and that communities, families, survivors and other service providers face in interacting with the child welfare system.

This project was co-led by the London Family Court Clinic (LFCC) with the Centre for Research and Education on Violence Against Women and Children (CREVAWC) with strong support from the Ontario Association of Children's Aid Societies (OACAS), and the Ontario Association of Interval and Transition Houses (OAITH). More than 20 Ontario experts came together on the project steering committee. These experts brought extensive experiences from a variety of disciplines, organizations in multiple roles in front-line service, supervisory responsibilities, and academic research. They included representatives from the Association of Native Child and Family Services Agencies of Ontario (ANCFSAO), the Ontario Association of Children's Aid Societies (OACAS), from the Child and Youth Death Review and Analysis Committee, and from WomenatthecentrE, a survivor organization. The steering committee also drew on the expertise of 4 members from Child and Family Services for 3 regions, 4 members from CASs from different areas of the province, a Men's service provider, a family law specialist, and expert consultants in diversity and family law.

Together with the leadership team, the steering committee collaborated to review, refine, and attempt to reach consensus on the roadmap to improving child welfare response to child exposure to DV. Our project team also endeavored to apply an intersectional understanding to our work. Applying an intersectional lens to research and policy means taking action to ensure that diverse experiences and interests are reflected in internal operations, structures, and systems. This approach is beyond simply accommodating people and moves towards putting and/or changing structures that are inclusive to all. Our team and working group strove to apply intersectionality as part of a fundamental mindset and in considering the possible implementation and impact of these recommendations on equity-seeking communities (Simpson & CRIAW, 2009).

STRUCTURING OUR CONVERSATIONS

In early discussions, the leadership and steering committee quickly recognized that answering the question: “has recommendation X been implemented” was not straight-forward. Although there are a few DVDRC recommendations that call for discrete actions (e.g., change in a specific policy) that can be easily tracked, many more concern broader changes in practice (e.g., improved training) that require more nuanced consideration. To support such analysis, a four-part structure was used to examine these recommendations and to consider solutions (see Figure 5). Steps of the process are outlined as follows:

Recommendation: The first step of our work was to gather and summarize the recommendations from the DVDRC that were specifically relevant to the child welfare system. Following the structure of the broader summary of recommendations from the DVDRC as summarized in the report “*Investigating Child-Specific Recommendations from the Ontario Domestic Violence Death Review Committee*”, recommendations within the five broad categories of: professional education, case reviews, service coordination, risk assessment, risk management, safety planning, policy, programs, and guidelines were presented and considered together.

Response: The second step was to consider responses provided to the Ontario DVDRC by the province (i.e., MCCSS) and individual child welfare agencies in response to the recommendation. Recommendations from the DVDRC are advisory but are generally responded to (around 80% of the time) by the recipient with a short letter indicating that the recommendation has been implemented, under consideration, rejected (due to flaws or lack of resources) or already in place.

Reality: We next engaged the steering committee in a discussion of the “reality on the ground”. In other words, regardless of the response provided to the DVDRC about the recommendation, what was the experience of committee members with regards to whether the recommendation had been implemented? Specific details of the reality of recommendations are detailed below; however, there were also some overarching themes about the reality of work with DV in child welfare that were shared among the multi-disciplinary steering committee members.

Roadmap: Finally, our steering committee charted steps that might be part of a roadmap to change that would allow for the implementation of DVDRC recommendations. For this report, we start with a more granular and specific review of DVDRC recommendations and how they might be implemented (i.e., roadmap). At the end, we present a more holistic view of how child welfare services might engage in a process of change.

Figure 5: Overview of Components for Conversation Roadmap



Twenty-two meetings took place between January 10, 2022 and November 2, 2022. Meetings were conducted in a combination of ways. There were four meetings involving executive team members, seven meetings with the complete steering committee, and 11 meetings with various individuals from the steering committee. At each executive and steering committee meeting, the authors provided regular reports from research findings and there were large group and small group discussions to process the information with a view to making recommendations for action required. Several drafts of reports were shared, and feedback thoroughly reviewed. Group members further shared potential conflicts of interest and limitations in their ability to endorse certain plans of action.

RESULTS

Review of DVDRC recommendations, response, and potential roadmaps change often touched on similar points and themes (see Figure 6). These themes were overarching in that they were relevant to each of the discussions that followed. They included recognition that: 1) change is needed; 2) survivor and service-user voices are critical advisory of change; 3) child welfare should have strength in recognizing and responding to DV; 4) an intersectional, gender-based, equity lens is needed in understanding and responding to DV; 5) strong, collaborative relationships are needed with community-based DV services; 6) complex cases need collaborative work; 7) child welfare practice in domestic cases should involve all members of the family; 8) no one size fits all communities. These overarching themes are relevant to all recommended actions.

Figure 6: Overall Themes of Steering Committee Discussions

CHANGE IS NEEDED

Steering committee members from within and outside of child welfare services were aligned in their view that significant improvements were needed in child welfare service work to address child exposure to DV.

SURVIVOR AND SERVICE-USER VOICES ARE CRITICAL ADVISORY OF CHANGE

Steering committee members highlighted the fundamental need for those with lived experience being key voices in any change.

CHILD WELFARE SHOULD HAVE STRENGTH IN RECOGNITION AND RESPONDING TO DV

Steering committee members were in agreement toward the fundamental role the child welfare system has in effectively addressing DV.

AN INTERSECTIONAL, GENDER-BASED, EQUITY LENS IS CRITICAL

DV must be understood with an intersectional and gendered lens, recognizing the role of structural violence in DV prevalence and in the experience of those living with DV.

STRONG COLLABORATIVE RELATIONSHIPS AND COMMUNITY-BASED AGENCIES

Child welfare agencies are often the largest providers of services to families experiencing DV and are very likely the only service being provided to children living with DV. The strength of child welfare is identifying children at risk and advocating for children's safety and well-being through family and community collaboration and courts as needed. To do good work within child welfare, it is critical for agencies to have strong, collaborative partnerships with community agencies, including agencies that serve diverse populations, that can provide families with strength-based and trauma and violence informed prevention and intervention.

COMPLEX CASES NEED COLLABORATIVE WORK

There is a shared perception that the complexity of problems being faced by families in child welfare services are increasing. To address this complexity, stronger connection points are needed to support collaborative case work across mental health, substance use, and criminal justice services.

ADDRESSING THE ENTIRE FAMILY

The steering committee agreed that further effort is needed in addressing the entire family system, including fathers who have perpetrated DV. There was agreement that child welfare workers need further support to hold fathers accountable while pushing for change. It has been made clear that responding to DV effectively needs to include addressing the entire family system.

NO ONE SIZE FITS ALL COMMUNITIES

Although there was broad agreement on the need for change, steering committee members were also quick to recognize specific strengths, limitations and barriers within their own communities. There was a shared understanding that change would need to be done at a local level, through building relationships locally, and by addressing the necessary change points in that community.

A particular point of emphasis by the steering committee was the need for an intersectional, gender-based, equity lens. Of particular concern is the recognition of diverse Canadian communities and recognition of multiple cultural perspectives. Multiculturalism is a core Canadian value reflected in the Canadian Constitution and the Constitution protects diverse traditions and recognizes the value of interdependence. Canada is committed to recognizing the rights of individuals to follow their customs and traditions provided it does not interfere with other people's legal rights. There is a growing awareness in Canada around intercultural perspectives and how diverse communities lead to distinct points of view around raising children and parenting practices. However, the courts have noted that children who are disproportionately represented in the child welfare system are black, Indigenous, or otherwise racialized; they are from families marginalized by poverty, mental health, addiction, physical disability and/or trauma. (*Children's Aid Society of Peel v. T.R.*, 2022 ONCJ 268 (CanLII)).

Canada's colonial past that substantially impacts the Indigenous communities resulting in inter-generational trauma is relatable for many immigrants and refugees coming to Canada from geographies with a colonized past. In view of that for the child welfare arena, the impact of colonization on diverse communities needs to be understood in a larger context, as colonization could result in the dehumanization of people in child welfare from marginalized communities.

The impact of intersectional identities and resulting oppression should be a crucial consideration for the child welfare system. Who is oppressed is often connected with people's identities- such as gender, race, sexual orientation, class, ability, or immigration status. For example, refugees coming to Canada from war-torn countries, with a history of exposure to civil disruptions carry their trauma within themselves. The child welfare system needs to factor in the impact of disruption in their social functioning resulting from such exposure and its effects on the sense of well-being of refugee families in child welfare.

SPECIFIC AREA 1: PROFESSIONAL EDUCATION

RECOMMENDATION

Over the past 10 years, one of the most frequently made recommendations of the DVDRC is for professional training. Ten separate recommendations have been made for enhanced training on DV within child welfare services with the earliest in 2013 and the most recent in 2020. Recommendations for enhanced training of child welfare workers on DV have been directed to agencies and organizations specializing in victim and family protection such as the OACAS, Ministry of Children and Youth Services and the Ministry of Children, Community and Social Services. Recommendations often highlight specific areas requiring enhanced training; particularly, risk assessment, dynamics of DV, and effective intervention. Examples of specific recommendations include the following:



“It is recommended that the Ministry of Children and Youth Services update and enhance the training available to all CAS’s regarding assessing potential for domestic and intimate partner violence and ensure that it reflects the most recent literature and best practices. It is recommended that the training of front-line CAS workers and supervisors include training on issues related to intimate partner violence.” (2015-03)

“Staff of Children’s Aid Societies should be made aware of the links between DV and domestic homicides that may impact their clients and place families at risk, with a view to supporting evidence-informed practice in this area. The OACAS should consider integrating knowledge about this link into training materials for new and ongoing staff training.” (2015-09; 2015-12)

“It is recommended that the Ontario Association of Children’s Aid Societies (OACAS) work with the Association of Native Child and Family Service Agencies of Ontario to ensure that all child welfare workers that may work with Indigenous families receive training on how to effectively respond to Indigenous families that have experienced and/or are experiencing DV. The training should be offered on a regular basis to ensure that all relevant staff can receive it.” (2016-09)

RESPONSE

Most of the recommendations from the DVDRC on the need for enhanced professional education have received responses of “under consideration”. Responses generally agree that professional training is important and valuable and then outline the programs that are available from OACAS in this area. Responses also generally provide a reminder that OACAS and the more recently formed ANCFSAO are both membership organizations that serve as a resource to child welfare agencies. These organizations do not have a mandate to ensure that all workers in the sector receive training however, one of the main services they offer to their members is the development and hosting of training. All the trainings offered by OACASs is 100% funded by MCCSS.



There are few older training programs referenced in earlier responses that are no longer available (e.g., *Critical Connections: Where Woman Abuse and Child Safety Intersect* published in 2010 and

Working with First Nations, Inuit and Metis Families who have experienced Family Violence, developed in 2012).

The most recent responses to recommendations for training within child welfare reference the following two training opportunities.

OACAS Child Welfare Pathway to Authorization (CWP2A)

Developed in 2018, this training supports (primarily) new child welfare workers in gaining the knowledge fundamental to their work. Although it is not mandatory, most new child welfare workers are directed to complete this training. The CWP2A training reviews the information in the eligibility spectrum and practice standards on child protection work with children exposed to DV. Topics covered include screening for DV, addictions and DV, and the impact of DV on children.

Collaborating to Address the Intersection of Intimate Partner Violence (IPV)/ Violence Against Women (VAW) & Child Safety.

This training was developed in 2018 in part as a response to recommendations of the DVDR. Training development included provincial representatives from VAW sectors and women's shelters including Luke's Place, Barbra Schlifer Commemorative Clinic, METRAC, Springtide Resources, South Asian Legal Clinic of Ontario, Ontario Coalition of Rape Crisis Centers, Ontario Network of SADVTC's Women's College Hospital, CREVAWC, OCASI and Action Ontarienne contre la violence faite aux femmes, as well as consultation with subject matter experts Dr. Peter Jaffe and Maureen Reid. Development included consultation with Indigenous stakeholders. The revised curriculum teaches learners that DV can comprise of any behaviour, whether acute or chronic, within an intimate relation that causes harm and provides behavioural examples of types of physical, sexual, and psychological violence. There is also a dedicated section explaining coercive control and lethality risk factors; training also offers opportunities for learners to participate in exercises which provide a greater comprehensive understanding and a practical application of coercive control. This training was developed with initial online learning components and a two day in-person experience shared by child protection and VAW partners.

REALITY

Steering committee members strongly endorsed the continued need for training in DV within child welfare services. They noted that many CAS cases involve DV as a substantiated concern or a complicating risk factor. There was a consensus among steering committee members that child welfare workers need to be skilled in practicing in this area. It was also the consensus of the steering committee that the overall level of training on DV within child protection services needs to be enhanced. They noted that most new child welfare workers get some training though the Pathways to Authorization resource; however, they felt that there was a need for longer, more focused, ongoing, and more comprehensive training on this topic. They had positive reports on the 2-day Collaborating to Address the Intersection of Intimate Partner Violence (IPV)/ Violence Against Women (VAW) & Child Safety training but noted that it had not been offered for a couple of years (due to COVID) and that, even when it was offered, it was only accessed by some child protection agencies and workers. They also noted that, although a training structure that brings together VAW and CAS workers for training was a strength in many ways, it has also created barriers. The reality is that, in an average year, CAS's typically have many more new staff that require training than community-based agencies. Requiring joint participation of the VAW sector, who might not have the same level of requirement in terms of training, has sometimes placed an unreasonable demand on community partners.



Who provides training to child welfare workers?

It is important to understand the reality of training within child protection. Child protection agencies are autonomous organizations with their own Board of Directors. Most, however, are members of either OACAS or ANCFSAO. OACAS and ANCFSAO have multiple functions; however, one of the main services they offer to their members is the development and hosting of training. Member agencies can access training for their staff at no additional cost. Not all the training done by any one child welfare service is linked to these agencies; however, OACAS and ANCFSEO are important resources for training.

What is needed in training?

Steering committee members had many recommendations for improving training. General themes of discussion around “what is needed” in training in DV within child protection agencies are as follows:

Mandatory and monitored. The committee identified the clear need for training in DV to be mandatory for all working in child protective services. There was consensus that, given the vast number of trainings within child protection, many do not voluntarily complete DV training. It was recommended that MCCSS legislate DV training as an essential component of child protection work. It was also agreed that language around mandatory should be explored as this type of training should build and enhance upon child protection practices not simply be a “check box.”

Practical. The committee discussed the need for training to include opportunities for “hands on” learning with clear applications to everyday practice. DV-focused practice sessions, coaching, shadowing of VAW protection workers, and case review were all highlighted as valuable practical learning opportunities. The committee noted that there has been a general sense of training fatigue within child protection services and that training that has clear elements of practicality and reflect the real-world context of child protection will be most useful.

Sustainable. The committee identified challenges around increasing sustainability of learning/training. They discussed the reality of staff turnover, position changes, and new hiring practices can often directly diminish how training competencies are implemented and maintained. Accordingly, the committee agreed that effort should be taken to better address how to maintain skills practice and development. Ongoing training requirements were recommended.

Incorporating supervisors and managers. The committee was clear in their direction that training needs to be done at the level of supervisors and managers and not just at the level of front-line workers. The committee discussed the importance of supervision and of the skills of supervisors and managers in DV risk assessment, management, and safety planning. The committee highlighted that supervisors and managers who are trained in DV will be better positioned to support front line staff.

Community focused. The committee highlighted the significance of recognizing the unique needs of the communities being accounted in any new training. They discussed the challenge of balancing a standardized training with a core curriculum while also fostering flexibility to

address diverse needs within a community. The committee identified new training should provide steps that individual CASs can take to enhance their ability to identify their own community needs and how best to respond to DV within their own context.

Intersectional. The committee discussed how trainings have often separated material on intersectionality and DV. They indicated that they perceived the need to embed intersectional and gender-based understanding into DV training with practical steps to address the realities of Indigenous and equity-seeking populations. The committee spoke clearly on ensuring new training needs to include an intersectional framework that recognizes and accounts for the impact of systemic racism, colonialism, ableism, and other systems of oppression.

Trauma-and violence-informed. The steering committee highlighted how training should provide core information on the impact of trauma on the individual, families, child development, and larger systems. Trauma-and violence-informed approaches in child welfare and service delivery should also be included in training. Further development of awareness and acknowledgment toward the role trauma can play in service-users' lives, as well as staff providing services, is also fundamental in any future training development.

Collaborative. The committee identified the importance and challenges in increasing collaboration through training. They discussed the need for training to provide a framework to increase coordination and intentional pathways (i.e., community of practice, conferences, etc.) to maintain connection and further opportunities to collaborate. Collaboration within an agency was also highlighted; more specifically, that legal departments and other relevant staff within an agency be part of collaborative training opportunities to enhance shared understanding and language.

Accessible. The advancement of online learning platforms and video conference systems provides an excellent opportunity to expand access to training and communities of practice. These new ways of working lend to the ability to foster learning more widely across the province with less cost. Shifts to virtual spaces have allowed for connections across communities and professionals at a rate never possible before.

Addressing the Needs of the Entire Family System. The steering committee also noted problems with the historic focus of CAS on addressing the needs of mothers as caregivers. While the needs of mothers remain a necessary element to be addressed, the needs of fathers have often been overlooked, particularly when DV is present. Child protection workers are at a very important position to recognize the risk and needs of both caregivers and take effective action to address these. The committee discussed how child welfare workers are at the intersection of fatherhood and violence and should be able to leverage their position to work directly with fathers who are putting their children at risk due to their use of DV to set and monitor goals for change in abusive behaviour. However, many child welfare workers lack the skills and training toward working directly with perpetrators, the assessment and management of risk and needs of perpetrators, and awareness of perpetrator services.

ROADMAP

Committee discussions outlined the following specific actions as a roadmap to implementing DVDRRC recommendations.

SPECIFIC ACTION 1

MCCSS to mandate 20 hrs. of initial training and 6 hrs. of ongoing professional education (on a three-year cycle), for all child welfare workers.

It is recommended that MCCSS create a mandate requiring that all child welfare workers in the province of Ontario receive a minimum of 20hrs of training on DV within 6 months of hiring and 6 hours refresher every 3 years thereafter. At least 25% of the training should be done with or by community partners and another 25% be done as part of practice over time (e.g., coaching, individual file/case review). Core curriculum should include:

- Recognizing dynamics and patterns of DV including coercive control.
- Assessing level of risk in DV cases
- Understanding how systemic factors, oppression, colonization, and inequities influence the ways that people experience violence, interpret violence, and seek help.
- Role of child welfare/the CYFSA/CLRA and community partners in working with families impacted by DV
- Highlights from the literature and Lessons learned from DVDRRC cases involving children
- Skills for recognizing and accounting for the impact of systemic racism, ableism, and other systems of oppression. Training should have practical steps to minimize the barriers that many face and should incorporate the voices of equity seeking populations.
- Recognizing and documenting the consequences of DV for children including risks of lethal violence to children and parents.
- Skills for compassionate engagement with all members of the family
- Skills to set and follow up on child protection goals that focused on the abusive parent and are aimed at ending their use of abusive behaviour, including their use of coercive control
- Skills to contribute to safety planning with survivor parents and with children
- Ability to document in ways that make patterns of abuse clear and visible and aligns with governing legislation including Part X of the CYFSA
- Understand how and when to refer/access and work collaboratively with VAW, men's and culturally based services in the community
- Deep consideration of the tension that can exist between using a risk/safety lens and an approach focused on collaboration and healing



SPECIFIC ACTION 2

Review and update online components of OACAS's 2018 Collaborating to Address the Intersection of Intimate Partner Violence (IPV)/ Violence Against Women (VAW) & Child Safety training. Consider providing flexible options for training with/by community-based agencies

As noted, the steering committee had generally positive evaluations of OACAS's 2-day Collaborating to Address the Intersection of Intimate Partner Violence (IPV)/ Violence Against Women (VAW) & Child Safety training. This training is very likely to be accessed by child welfare services as part of meeting mandatory initial professional training requirements (Specific recommendation 1).

It is important that this training, like others, are reviewed regularly (on a three-year cycle) to ensure it is adequate and updated to maintain best practice standards in the field and recent research and findings from the Domestic Violence Death Review Committee and Child Death Review Committee. Accordingly, it is recommended that a review as well as update of the 2018 curriculum is undertaken.

The mix of online and in person activities in the existing training should also be reviewed and considered. As noted, the requirement of in-person VAW/CAS training collaboration has been a barrier in some communities. Updating the 2018 curriculum should consider multiple options for meeting the proposed requirement having 25% of training done with or by community partners. Options could include co-training days, having community leads be part of leading practice sessions, shared training across child welfare and community partners on practice improvements, secondment from or co-facilitation with VAW service providers, tours of local VAW services and opportunities for less experienced workers to shadow more experienced workers on complex DV cases. Involvement of VAW service providers was seen as an important advantage in training and funding should be provided to facilitate such work in local community contexts (e.g., to support backfilling of VAW staffing during training time).

SPECIFIC ACTION 3

Require 6 hrs. of DV specific training for new supervisors/managers. This training could be part of OACAS's supervisor/manager advanced training offerings

Six hours of required advanced training should be developed and offered to child protection staff moving into supervisor and manager-level roles. This training should include:

- Consideration of community factors, including specific community challenges and needs steps that individual CASs can take to enhance their ability to use best practices within their communities.
- Training in how to support front-line workers in developing effective skills in working with perpetrators including how to manage high-risk or difficult to serve perpetrators of DV as well as strategies to support staff in doing so.
- Training in how to support front-line workers in clearly articulating child protection concerns related to DV risk, safety and child impact; set goals to reduce risk, increase safety and address

impact on children, monitor progress towards these goals and judge when case closure is warranted.

- Reflections on lessons learned from cases of DV-related deaths in families involved with child welfare services
- Leadership in how to foster collaboration and coordination between services, including frameworks to increase collaboration and may provide intentional pathways (i.e., community of practice, conferences, etc.) to maintain connection and further opportunities to collaborate.

SPECIFIC ACTION 4

MCCSS to mandate 20 hrs. of initial training and 6 hrs. of ongoing training (on a three-year cycle), for all child welfare legal counsel

Every CAS has legal counsel to help inform and advise social workers about potential court proceedings and preparing the case and witnesses for court when needed. Regarding DV, a CAS's legal counsel plays a critical role in consulting and advising on managing cases involving high risk dynamics. It is important to include them in DV training for all staff at the outset of their careers with CASs and on an annual basis. This training could be part of lawyers' ongoing professional development requirements.

To develop this training, it would be important to consult with CAS lawyers' provincial association to address and to align with their needs and mandate (Ontario Counsel for Children's Aid Societies (OCCAS)).

There are many complex issues in these cases that require ongoing legal education and close collaboration with CAS workers as well as community agencies that can address risk assessment, safety planning and risk management. There is also a need for clear policies and practices based on case law, community resources, access to justice and an understanding of the role of the CAS in protecting children from DV. A particularly complex issue which needs to be addressed is looking at cases from the point of view of the CAS protection mandate compared to private family law proceeding over parenting decision-making and parenting time. Although a CAS action will be case specific, there are many gray areas in which a victim may be involved in multiple court proceedings such as child protection, parenting and criminal proceedings with significant delays to decisions and resources. For example, if the victim parent was unable, for whatever reason, to seek appropriately protective court orders via the CLRA, then an assessment would be needed on whether the risk to the child could be sufficiently mitigated in some other manner short of a CYFSA Application/order. If it could not, then a CYFSA Application would be brought. Such an application would likely seek a Supervision order with the victim parent, or another kin person depending on the circumstances, with restrictions on access to the abuser or alleged abuser. Initial and ongoing education for child welfare legal counsel should address these types of issues.

SPECIFIC ACTION 5

Provide direction and support OACAS (and potentially other organizations) to develop advanced training offerings (recommended 6 hrs. per module including a minimum of 2 hrs. practical “hands-on” learning) on the following specific topics:

- a) Engaging fathers who perpetrate DV to manage risk, promote accountability and prompt change;
- b) Expanding recognition of survivor strategies, including survivor strategies used by children and their impact;
- c) Collaboration in complex cases with co-occurring DV and serious mental illness, including substance use;
- d) Culturally integrated models of practice, including newcomer, Black and Indigenous families and
- e) Working with families involved in multiple family and criminal court proceedings.

These advanced modules could be used to meet 3-year training review requirements.

While having a required core DV training for child welfare workers is an essential baseline, there is also a recognition of the need for other advanced training in addressing DV in the context of child welfare. Although some of this training may be centrally developed and offered (i.e., through OACAS), other aspects of training might be best developed and offered with the unique needs of communities across Ontario in mind. For example, training on collaboration on cases involving co-occurring DV, serious mental illness and substance use might be best offered as a collaborative case-review co-training day, with local representatives from these service agencies. Support should be provided to ensure these types of advanced training are accessible, potentially with a combination of online learning and in-person learning. Development of advanced training modules should include the voices of survivors and of the members of the community of families being served. This work is necessary to ensure that practice reflects the reality and lived experience of the families being served by child welfare agencies. Because one focus of these advanced trainings is community collaboration, community members should be involved. Early on it may be important to develop external training teams to partner with internal implementation leads from within the agencies to deliver trainings.

Advanced trainings modules should be guided by community needs and be shared across the province. The sharing of training opportunities and materials will strengthen collaboration across agencies/organizations which will increase sharing of expertise and foster communities of practice. Additionally, these advance modules could aid in the continuous review of DV training to ensure training needs are being addressed while also sharing best practices from across the province.

Core areas of focus for training:

Area 1: Engaging fathers who perpetrate DV to manage risk, promote accountability and prompt change

Advanced training on working with fathers who perpetrated DV should include the following: strategies to engaging difficult to reach DV offending parents; advanced risk assessment; practice

in setting goals focused on managing and reducing risk of perpetration; collaborative work with community-based services to perpetrators; and managing high risk and potentially lethal situations.

Area 2: Expanding recognition of survivor strategies, including survival strategies used by children and their impact

Advanced training should foster awareness of how survivors of DV utilize strategies to cope with violence. An understanding toward how these survivor strategies exist in the context of violence and in the protection of children and victims is vital. Training should emphasize that survivors are not helpless victims of DV, but rather implement strategies to survive the violence they experience. Likewise, that these survivor strategies can directly impact children as well as how services (i.e., child protection) is delivered to families. This also includes developing the structural barriers that many women face when seeking support, including women from marginalized communities. Training should focus on how to support victims of DV; support her understanding of what she has experienced, the impact of coercive control, helping foster understanding that the responsibility to change behaviour is on a perpetrator of violence and not the victim. Collaboration with shelter services and services for children exposed to domestic violence should be emphasized.

Area 3: Collaboration in complex cases with co-occurring DV and serious mental illness, including substance use

Advanced training should provide further education around how to support families with complex needs. This should include practical steps and skills to support families experiencing co-occurring DV, addiction concerns, and mental health needs. Training should aim at increasing skills for child welfare professionals to identify significant factors (i.e., addiction, mental health, etc.) that may contribute to DV and pathways to address them. Workers should gain practical experience in collaborating with addictions and mental health service providers.

Area 4: Culturally integrated models of practice, including practice with newcomer, Black and Indigenous families

Training should focus on developing a deeper understanding of culturally integrated models of practice. It should help develop workers' appreciation and understanding of different worldviews of practice that foster cultural humility, client centeredness, and how to increase the delivery of, or access to, services that respect and appreciate client diversity and represented cultures. Training should also clearly show how cultural biases and restricted access to cultural relevant services can maintain and grow the current disparities within the child protection system. Emphasis should be placed on previous work that has been completed examining marginalized populations, including racialized and Indigenous families and the CIFSR model of intervention with immigrant and refugee families. Central to this type of training is incorporating practical steps toward connecting families of diverse backgrounds to organizations that represent diverse communities, including new immigrant and refugee populations services, and to working alongside community partners to manage risk, ensure safety, and address the impact of DV on children.

Area 5: Focus on families involved in multiple family and criminal court proceedings

Training should focus on the unique issues facing victims of DV and their children involved in multiple court proceedings. It is critical for CAS to have a clear mandate in protecting children and advocating for their safety until such time that there is a safety plan in place for the victim parent and a risk management plan in place for the offending parent. Even though the CAS may consider the victim parent to be a protective parent, there may be a need for ongoing involvement and even supervision until there is a clear court order that determines parenting decision-making and parenting time. There is a tendency to assume parents will work things out through private family law proceedings but access to a judicial decision may be slow and the victim parent and child may remain in harm's way. In a similar vein, the offending parent may be before the criminal court for an extended period pending adjudication and sentencing. The need for safety does not end during these proceedings. As well, even in the face of a finding of not guilty, there still may be enough evidence for the family court to make a finding about DV on balance of probabilities that will require ongoing support from the CAS and community partners.

SPECIFIC AREA 2: RECOMMENDATIONS FOR CONDUCTING, SHARING AND LEARNING FROM REVIEW OF DV-RELATED DEATHS

2A - INTERNAL CASE REVIEWS

RECOMMENDATION

Eight DVDRC recommendations focused on the need for reviews of critical incidents and DV deaths within child protection services, recommending retrospective examination of the provision of services and assessment of risk. Such recommendations reflect the reality that even when children are not direct victims of DV homicide, they witness/experience the horrific events and their aftermath. Children suddenly lose one or both parents, and their lives are changed forever. Recommendations for conducting and learning from review of cases are sometimes directed to CAS/OACAS in general and sometimes to specific CAS agencies. An example of this type of recommendation is:



“Children’s Aid Societies should be strongly encouraged to conduct an internal review whenever a domestic violence death occurs in a family that had received services of the Society within the preceding 12 months of the death, and where domestic violence issues had been identified.” (2015-12)

Another example for a specific focus for an internal review is:

“The CAS involved with the family should conduct an internal review to examine its provision of services and assessment of risk for this family prior to the homicide” (2011-24)

“The Children’s Aid Society (CAS) involved with this family should conduct an internal review to examine its assessment of risk, not only for child abuse or neglect, but also for intimate partner violence” (2015-03)

RESPONSE

Recommendations for reviews of critical incidents of DV deaths within child protection services were met often with an assertion that a process already exists for these reviews. Specifically, responses state that: *“In situations where ... an adult, parent or caregiver has been killed or seriously injured as a result of domestic violence, CASs are required to conduct a child protection investigation in accordance with Ontario Child Protection Standards, 2007”.*



Response in cases where reviews are recommended for individual agencies were generally met with a short summary saying that a review was completed. An example is as follows:

“We made our assessment with the tools and knowledge we had at the time. Giving the information we had, we think our assessment of risk was appropriate – things escalated in the days before the mother’s death, and we responded to the best of our ability. After reviewing the file, there could have been more engagement and participation in the family planning -

something that at this point with SOS could be possibly. I also think that we could have worked more closely with collaterals.”

“Given the information we had at the time and our knowledge of the family **we don’t feel** that there was any way we could have predicted lethal domestic violence. We agree with the Domestic Violence Review that workers/supervisors could benefit from more knowledge and training about domestic violence (and having more tools to do this).”

Another example is:

“The supervisor and worker reviewed the file together as part of formal supervision. The results from this review were formally presented to the director of Intake and Assessment Services in a work plan.”

REALITY

Even with a broad steering committee, it was difficult to fully ascertain what was taking place with death reviews in Ontario. What the committee was able to identify were challenges emerging from differences in how ministry standards and best practices are being implemented across agencies in the province. There are several processes that currently exist that may initiate and/or request an internal review. The first is connected to the Ontario Child Protection Standards and sets out the roles, responsibilities, and requirements for CAS when a child death has occurred. The other two are related to death review committees that work directly with the Office of the Chief Coroner (OCC). Table 2 summarizes these three processes in more details.



Table 2: Summary of Current Internal Reviews Processes

| PROCESS | AUTHORITY | WHAT IS THE MANDATE | HOW RESULTS ARE SHARED |
|--|---|---|--|
| Internal review by a child welfare service | Ontario Child Protection Standards (2007) | In March 2006 the then Ministry of Children and Youth Services, and the Office of the Chief Coroner (OCC) for the Province of Ontario, issued a joint directive that sets out the roles, responsibilities and requirements of the OCC and CAS when a child fatality has occurred (see appendix X). As part of this process CASs are directed to initially complete a Serious Occurrence Report and file a Contentious Issue Report (CIR). Within the CIR, CASs provide a deidentified summary of the case and action being taken by the society and the regional office. Additionally, CASs are required to complete a case summary using the Child Fatality Case Summary Report template. The case summary includes the society’s determination as to whether the child died under questionable circumstances and/or as a result of abuse, mistreatment or parental negligence/neglect. CASs then forward copies of the report to the regional office and to the Chair of the Paediatric Death Review Committee (PDRC). The Directive allows for the OCC to convene a PDRC and for the PDRC to in turn require a Children’s Aid Society to undertake a comprehensive internal review of their involvement in, and management of, the child’s case. This directive requires CASs to notify the local coroner and the ministry immediately whenever they have knowledge that: <ol style="list-style-type: none"> 1. a child who received service from the society up to the time of his or her death, dies 2. a child who received service from the society at any time in the 12 months prior to his or her death, dies | No public reporting despite directive for the ministry and the Office of the Chief Coroner to establish and release a public report card on child deaths |

| | | | |
|--|------------------------------------|---|---|
| <p>Child and Youth Death Review and Analysis Team (CYDRA)/ formerly the Paediatric Death Review Committee -Children Welfare (PDRC-C)</p> | <p>Office of the Chief Coroner</p> | <p>The Chief Coroner's child death review process is currently undergoing major transformation. In the interim, the former PDRC-Child Welfare committee has broadened to include other systems like education and health under the name PDRC-Children and Youth.</p> <p>There are two interim Pediatric Death Review Committees for Children and Youth (PDRC-CY) one that is non-Indigenous and one that is Indigenous specific. Interim review processes are not child welfare specific but applicable to child deaths in a range of circumstances. Transformation will include the development of a new review process, called the Child and Youth Death Review and Analysis (CYDRA) and separate process for Indigenous. It is envisioned that CYDRA will include several review options depending on the need. These may include Local Death Review Tables, use experts for reviews if needed, as well as more reviews under a similar process to the PDRC. As part of collaborative transformation, the coroner's office is working with First Nations (where asked) to develop local protocols for child and youth death review.</p> <p>As transformation is taking place, the Joint Directive is in place (which is a process used when there was child welfare involvement within 12 months). This process involves a request to access the internal review done by the CAS agency providing service to the family. In cases where such review has not been done (e.g., in a case that falls outside the legislated mandate) and where no internal review had been completed, the PDRC may request an internal review by the child welfare agency involved with the family.</p> | <p>No public reporting</p> |
| <p>Ontario Domestic Violence Death Review</p> | <p>Office of the Chief Coroner</p> | <p>The mandate of the Ontario DVDRC is to assist the Office of the Chief Coroner in the investigation and review of deaths that occur in the context of DV, and to make recommendations to help prevent deaths in similar circumstances. Note that this includes the death of children in the context of DV. The DVDRC is also undergoing transformation with new leadership and new committee members being selected.</p> <p>If there has been CAS involvement in the family in which there was a DV homicide, the DVDRC can make a request to access the internal review done by the CAS agency providing service to the family. In cases where such review has not been done (e.g., in a case that falls outside the legislated mandate) and where no internal review had been completed, the DVDRC may request an internal review by the child welfare agency involved with the family. This review is then considered alongside other information as part of reviewing the death and making recommendations for prevention of future deaths.</p> | <p>Public report of limited information</p> |

Strengths & Challenges for Internal Reviews by CAS/CYDRA

CASs value completing their own internal reviews for potential lessons to be learned. Broadly these reviews provide a deeper understanding of areas where improvements are needed within a specific agency. There are also particular strengths for CAS completing their own internal reviews. For instance, any CAS review would include individuals who were directly involved in the case. These individuals can provide the clearest information toward what took place and identify through their experiences the challenges they face within their roles. These reviews are by their very nature child protection focused. They may also include those who work in the community and therefore have a greater awareness of factors that are vital in understanding the broader context of any case. Additionally, given that reviews take place within an agency, any identified need can be immediately and efficiently addressed. External reviews can often be a drawn-out process, however with a CAS completing their own internal reviews there are mandated timelines which increase both the speed at which they are completed as well as their relevance.

Some challenges identified for internal reviews within CAS emerged from a lack of updated guidelines. The last guidelines for internal death reviews were provided in 2005 by the OACAS supported Child Death Review Task Force. The final report by this Task Force laid out guiding principles, best practices, considerations for CAS, and sample processes for internal reviews. While this work product was an expansive report, it is unclear how these guidelines have been, and continue to be, applied across the province by CASs. Shortly after this report the MCCSS and Office of the Chief Coroner gave a joint directive in 2006, which is described in the table above. In this joint directive, the standards and mandate for child protection agencies to conduct internal reviews is provided. These standards outline specific requirements for the process for a review to be requested and initiated.

Although the basic requirements from the 2006 joint directive continue to be followed, committee members noted that some of the steps are rather prescriptive, and many steps within these standards do not provide detailed guidance. This lack of detailed guidance has led to inconsistency across the province toward how CASs are undertaking internal reviews. Indeed, the steering committee commented that many CASs have developed their own processes around conducting internal reviews to correspond to ministry requirements; with some agencies having a more comprehensive process than others. The committee also indicated that at times these standards are used as “checklist” requirements to be completed to ensure compliance with ministry standards. A concern raised by the committee is how this ‘checklist’ approach can leave little opportunities to learn from tragedies and limit sharing about missed opportunities for wider change across the child protection sector. Other challenges arise when reviews use a process that is not trauma and violence informed – where it becomes a significant source of shame and secrecy for the workers involved.

A final challenge identified is a lack of sharing of recommendations for improved practice from any internal reviews across child welfare services. While CASs continue to follow mandated requirements for internal review processes, unfortunately the valuable information learned from these reviews is neither readily accessible nor widely available. The lack of sharing was made clear from the steering committee discussion which indicated that reviews are generally not shared as a learning process across CASs despite there often being common issues on training, policy, and practices/ collaboration. Even if there was a desire to share thoroughly de-identified reviews there is currently no mechanism within CAS or across CAS agencies for sharing the lessons learned from these reviews.

There is no overarching support, governmental or otherwise, that may aid in providing a mechanism to increase potential sharing of information. This lack of centralized support greatly limits public oversight of whether learnings from tragedies lead to changes in policy and practice.

Strengths & Challenges for PDRC/CYDRA

It is important to highlight that the PDRC/CYDRA under the Office of the Chief Coroner (OCC) is currently going through a transformation to become more transparent, community engaged, and trauma and violence informed, with the first priority being child death reviews within Indigenous communities. Given this ongoing transformation, and until these changes become publicly available and finalized, it is difficult to judge the extent to which the changed process aligns with the recommendations for the DVDRC. Nonetheless, we have been able to have some joint discussions on areas of shared priority. One of the strengths of the PDRC/CYDRA is their close working relationship with the child welfare system. They are in the unique position, as laid out in the Joint Directive by the OCC and MCCSS, to provide request for internal reviews to CASs. Likewise, the provincial standards ensure that PDRC/CYDRA requests are followed by CAS. As such, the PDRC/CYDRA has the authority to request the completion of an internal review from a CAS and require it be returned. This level of authority is not shared with the DVDRC who have no mandated authorities. Accordingly, the PDRC/CYDRA's ability to consistently identify where reviews are needed, ensure they are completed, and provide recommendations places them in an excellent position to help shape the review process.

In our view, there is a problem in lack of public sharing of de-identified PDRC/CYDRA reviews and recommendations. It is impossible to find current information on any accessible websites. This problem needs to be addressed as it goes to the core of transparency and accountability. These reviews can provide fundamental information that may aid in addressing gaps in services and training.

There are encouraging new initiatives and plans that have not been finalized or publicly shared which may move the transformed PDRC/CYDRA reviews to a more broad-based and multi-agency local review rather than a provincial review per se in some cases. We fully support this new direction.

Strengths & Challenges for DVDRC

The Ontario DVDRC was the first of domestic homicide review committee in Canada. For nearly two decades the DVDRC has reviewed deaths and provided recommendation to foster change across systems. Extensive research has been published from the DVDRC data base and annual reports on multiple areas including child homicides. While there have been changes in how the DVDRC reports their reviews and recommendations, one of the strengths of the DVDRC has been its commitment to ensuring information is shared with the public through the OCC website. However, more recently it has been noted that previous reports have become increasingly more difficult to access. Therefore, consideration should be taken toward how reports are being shared publicly and ensure they are accessible since many sectors count on this information that is utilized in annual training (e.g., police, probation, crown attorneys, VAW agencies, professional colleges).

In some cases that are reviewed, the DVDRC may benefit from an internal review that they access as part of their information gathering. In other cases, the DVDRC suggests internal reviews by different agencies including the CAS after their comprehensive domestic homicide review or even suggest that the case be used for training purposes. At this point in time, a CAS will not complete an internal

review when one or both caregivers die in the context of a domestic homicide if the children survive. The DVDRC does get file information from a CAS if they have had significant contact with the family prior to the homicide. This information may be relevant and important toward developing directions on how to intervene more effectively with children and parents at risk in these families.

Collaboration between DVDRC and PDRC/CYDRA

When a child dies in the context of DV, there may be reviews completed by the PDRC/CYDRA and the DVDRC. These cases are managed on an individual basis but there are no guidelines on how the 2 committees collaborate or share information. In some cases, there may be 2 different reviews with perhaps a different focus and in some cases, there are reviews by one committee shared with the other in advance. Overall, there appears to be inconsistent coordination between the DVDRC and the PDRC/CYDRA other than an overlapping member in some cases when children are killed but not if their parents are killed with prior CAS involvement. Consideration should be given to enhancing coordination between the DVDRC and PDRC/CYDRA and how to increase synergy between the two in their efforts to prevent child homicides – especially now as these committees are both undergoing major transformation.

ROADMAP

SPECIFIC ACTION 1

Extension of the mandates of the PDRC/CYDRA and for internal CAS reviews to include cases where a parent has been killed in a domestic homicide

In our view, PDRC/CYDRA and internal CAS reviews need to expand to review cases of child and/or parent death in the context of DV to better understand risk factors and potential missed opportunities to intervene by a CAS and their community partners. Children’s exposure to a parent’s homicide and the devastating impact of this event on children’s well-being must be seen as very significant for child welfare and community partners. This information will better inform training, policies, and practices on an ongoing basis.



SPECIFIC ACTION 2

Enhance coordination between the DVDRC and the PDRC/CYDRA for homicide reviews in the context of DV and CAS involvement

In Ontario, some deaths are already reviewed by the DVDRC and the PDRC/CYDRA (specifically, all cases of a DV homicide that involves the death of a child and some additional cases chosen for review by the PDRC/CYDRA when CAS is involved). It is not clear if these review processes are consistently coordinated or shared. With an expanded mandate for the PDRC, the number of reviews that fall under the mandate of both the DVDRC and the PDRC/CYDRA will be increased so this enhanced coordination will be critical.

The DVDRC and PDRC/CYDRA committees are distinct, with overlapping but differing areas of expertise. In cases in which a review by both committees is warranted, this review should happen on a collaborative basis. It is hard to find any public reports about either committee, annual reports or how these committees are working together. It is easier to find surviving family members publicizing their stories and demanding system changes. Processes and policies should be developed to create a mechanism for joint PDRC/CYDRA and DVDRC reviews and public sharing of deidentified cases on an annual basis. Children and their parents continue to be killed without any ready access to information about lessons learned for the public and different service sectors.

From our review of the DVDRC recommendations and responses, we would also suggest that that recommendations be written more clearly in term of expectations or explicit outcomes so change can be assessed. From a review of past recommendations, it is helpful if a clear rationale for recommendations as well as references to promising practices (if any) in Canada are included by the DVDRC to support implementation.

SPECIFIC ACTION 3

Increase information sharing of PDRC/
CYDRA Reviews

A public website through the Office of the Chief Coroner should provide updated annual reports and updated non-identified reviews as part of a process of transparency and accountability. We recognize that the process of de-identifying cases can be complex and ideally will involve permission from surviving family members and community engagement.

SPECIFIC ACTION 4

MCCSS and the OCC to develop and share a set of
best practices for internal review within child welfare
agencies

As noted, although some child welfare agencies have developed model policies and procedures for comprehensive review and sharing of information, other agencies lack such detailed guidance. It is recommended that MCCSS develop and share such guidance. Included in this guidance should be the specification that internal reviews attend to four core areas, listed as follows:

Risk assessment, risk management, and safety planning. An examination of how the organization took steps to assess and respond to risks in the case reviewed should be a focal point. Likewise, reviews should work to identify tricky issues or components around assessment and management of risk, including unique factors in the case.

Focus on improvement. Internal review process should be rooted in identifying actionable areas where improvements may be made. Each review should end with at least one area where concerted effort will be placed to make improvements and/or changes to better address identified needs.

Coordination and collaboration. An examination of efforts to coordinate and collaborate within cases reviewed should be a focus. Reviewing the potential barriers toward collaboration as well as opportunities to explore to further develop collaboration between services within the community.

Transparency and accountability. Internal reviews should be completed with transparency and accountability as core tenets. To aid in transparency, it is recommended that continued effort be taken to update/provide clear guidelines and standards of practice. Considerations should be taken toward creating clear pathways for this information (de-identified) to be shared (i.e., website, annual reports, centralized sharing repository etc.). The mandate for reviews should include cases in which a parent was killed but children survived since these tragedies have a major impact on children's well-being.

SPECIFIC ACTION 5

Ensure transparency, accountability and information sharing of internal reviews by child welfare agencies

Internal reviews should be completed with transparency and accountability as core tenets. To aid in transparency, it is recommended that continued effort be taken to update/provide clear guidelines and standards of practice. Considerations should be taken toward creating clear pathways for this information (de-identified) to be shared (i.e., website, annual reports, centralized sharing repository etc.).

Although the DVDRC and PDRC/CYDRA review processes are both valuable for learning, internal reviews by CAS happen faster and are more focused on the specifics of CAS policy and practice (CAS reviews are faster since PDRC/CYDRA and DVDRC reviews are delayed until all matters are settled by the criminal justice system). Currently, there is no consistency in how the results of these internal reviews are shared. In the best-case scenario, agencies themselves have developed strategies to share information on lessons learned in staff training and development. However, in many other cases, there is no consistent sharing of information. There is considerable opportunity for further development around how CAS internal reviews are utilized to aid in addressing gaps in services across the child welfare system.

Our steering committee suggests that OACAS and ANCFSAO work with their members to develop a process of sharing de-identified internal reviews (recognizing the challenges with de-identification) with them so that they can consolidate lessons learned across all reviews on an annual basis. This process could culminate in an annual report by OACAS and ANCFSAO to its member on key areas that need to be addressed to enhance services (i.e., gaps in services, risk management, safety planning, community engagement, coordination). These areas can be disseminated across CASs in Ontario so that learning from internal reviews is shared and more appropriately addressed/considered.

2B - SCENARIO-BASED “LESSONS-LEARNED” WORKSHOP DAYS FOR CHILD WELFARE AND COMMUNITY PARTNERS

RECOMMENDATION

Several DVDRC recommendations have called for a ‘lessons learned’, multi-disciplinary approach to share learning from DV related deaths. Two specific recommendations discussed having a cross section of services involved as a significant step in holistically reviewing a homicide while also intentionally building partnerships to close gaps in services that may have otherwise led to missed opportunities. DVDRC recommendations note that reviews with case scenarios based in part on repeated themes and missed opportunities to assess risk and intervene can provide rich professional education.



RESPONSE

Responses to recommendations for review are generally supportive of the need and value of learning from prior tragedies. This model of learning was most-clearly supported in a 2012 response from OACAS to a recommendation for review which stated:



“... endorsed a ‘lessons learned’ review process that would be convened by the coroner’s office and include both CASs and other relevant community partners. Such a process would ensure a broad analysis of the circumstances under review by capturing the perspective of all relevant stakeholders”

REALITY

Steering committee members generally agreed that having an opportunity to review DV related death scenarios, in detail, in collaboration with community partners, was an excellent way to learn. Some committee members recalled past workshop days set up in this manner following major inquests.



Steering committee members also identified some of the challenges that often emerge when using details of cases as a means of addressing gaps and/or learning. These include:

Information sharing. The committee discussed considerations around sharing potentially identifying information to uphold applicable privacy legislation while also allowing organizations to participate in reviews. They highlighted that domestic homicides are often identifiable given their nature, media coverage, and the communities that are often affected. Therefore, even when cases are redacted or anonymized, they are-likely still identifiable.

Ownership of information. The committee also discussed the challenge that emerges in respecting the choice of those impacted about sharing any information. The committee discussed considerations needing to be made around whose story is being told, how it is

being told, and honoring all the people impacted by the tragedy.

Trauma-and violence-informed approaches. The committee was clear that any approach to review DV-related deaths needs to be trauma-and violence-informed from its development, in the delivery, and in its aftercare. Reminders were provided around considerations toward (re)traumatization of those closely involved in these cases, the communities have been impacted, and the impact of those listening to the details of these tragedies. There was also a call to ensure recognition and acknowledgment toward the presence of trauma and the role trauma can play in how individuals engage with the materials.

Defensiveness and blaming. The committee discussed the need to ensure that workshops foster collaboration rooted in constructive discussions of the cases. There were some concerns that review of prior cases, even using a “lessons learned” lens, lead to blaming of systems and/or professionals and to high levels of defensiveness. The committee highlighted that the utility of these type of workshops would be diminished if workshops had a blaming or shaming feel. Care would be needed to ensure that reviews offered opportunities for open discourse of the real challenges service providers face.

Leadership and community. The committee discussed the logistical aspects of workshops, including who might lead these workshops. They discussed the need to incorporate voices and leadership from the community. They also highlighted the need to provide space and voice to those living in the community.

In problem solving around steering committee members’ concerns, several options were discussed. One idea that received endorsement was moving away from using actual cases and instead designing “lessons learned” review days based on scenarios created from an amalgamation of themes that are common across DV-related deaths. These amalgamated case scenarios can continuously be updated to incorporate current and/or unique challenges that arise for communities across the province. The creation of situation-based scenarios can be used to stimulate discussion centered around collaborative workshops focused on enhancing knowledge by examining lessons learned from tragedies.

ROADMAP

SPECIFIC ACTION 6

Consider funding a scenario-based “lessons-learned workshop” in communities across Ontario to contribute to ongoing learning and enhance collaboration.

Given the endorsement of the steering committee and of the broader representatives of the coordinating committees across Ontario, we decided to use this as an opportunity to outline a process and run a test day with the Windsor Coordinating Committee. The overarching goal of this workshop was to examine the implementation of longstanding DVDRRC recommendations for increasing robust community coordination, collective risk assessment, ongoing and targeted risk management, clarity, and accountability on information sharing on high-risk cases. In doing this, the workshop examined a worst-case outcome in a composite case to identify challenges, strengths and missed opportunities for intervention at individual, organizational and community levels.



Materials for this day were developed collaboratively with representatives from the Windsor Coordinating Committee and three working group members from this team. Effort was placed on ensuring that the day included members from a wide section of community and organizational leaders to ensure representation at different levels of professionals (i.e., front-line, managers, executives). Having a wide section of participation was aimed at providing an opportunity for the community partners to discuss issues and solutions that go toward a whole community response.

Trauma and violence informed practice was a consideration for all parts of planning. Connections between violence, trauma and the negative impacts on individuals, families and communities was included in the workshop materials. The day was structured to include time to process the experience. An additional room was booked to provide a quiet space for workshop participants.

The trial workshop, entitled “Preventing Femicide: Developing a Community Response in Windsor/Essex” was held on Nov 9th, 2022. There were over 150 attendees from multiple agencies. Conducting this trial workshop helped to examine how to effectively balance discussion around a case and its core issues while also solution oriented. Aspects like timing, length/detail of information, and discussion format were explored. Considerations were taken around effective use of targeted questions, intentional opportunities for discussion, and action-oriented planning.

Ninety-six percent of the participants in the Windsor event rated it as excellent or good and 92% reported that they were leaving with next steps for their organization. Participants’ indicated that they valued the opportunities to connect with other service providers in their region and that participating in this event helped them to set priorities for community development.

We need to have a “follow up” - need to set up a table of leaders to continue this work (community coordination)

It was smart to deliberately place individuals at each table. Having varied perspectives made the conversation flow easily

You need to organize more training like this

This session has given me a vision for how to bring this forward

The realization that so many agencies are not working with one another and families are overwhelmed with the amount of agencies they are working with. We need to do better.

Word about this event has spread and, already, other communities in Ontario are reaching out to request facilitation of a similar day.

SPECIFIC AREA 3: SERVICE COORDINATION: COLLABORATION AND COORDINATION IN HIGH-RISK AND COMPLEX CASES

RECOMMENDATION

Lack of coordination and collaboration across services is very frequently identified by the DVDRC as a contributing factor to DV homicides and the committee has many recommendations for improved practice in this area. Over this review period, six recommendations for greater coordination and collaboration were explicitly directed to CAS and Ministry of Children, Community and Social Services (MCCSS; formerly the Ministry of Children and Youth Services). Specifically, recommendations made over the past 10 years direct CAS to refer to high-risk case management, in cases with multiple risk factors like alleged child abuse, parental alcoholism and DV and called for greater collaboration between CAS and other partners to better manage factors (i.e., mental health) that may increase risk:



“In order to address the need for improved service coordination in cases where a parent’s adult mental health is a concern, it is recommended that MCYS require that CASs, in collaboration with mental health services in their communities, develop a protocol for working with parents experiencing mental health difficulties. Such a protocol should, at minimum, outline the importance of discharge planning when patients are leaving the hospital to resume their parenting role. In addition, a protocol could include a collaborative case conference format which will assist with critical and dynamic information sharing allowing for a more coordinated service response, enhancing safety for children in these cases.” (2013-04)

Recognizing the need for cross-agency work, a further recommendation made specifically to child welfare service was to develop processes to work collaboratively with other agencies to share information and collaboratively plan for addressing concerns.

Additional recommendations made by the DVDRC are for a broad coordinated response to high-risk DV situations. Child welfare is included in the broad group to which these recommendations are directed, though they may or may not be explicitly named. In these broad recommendations, the DVDRC has called for further development of high-risk committees and coordinated services. An example of such a recommendation is as follows:

“It is recommended that once a case has been identified as a high-risk case, then there must be a systems response so that the case can be actively managed. This would require that the justice partners involved with the case meet to discuss management options and strategies. Such dedicated teams already exist in parts of Ontario and should be the model for other communities to follow.” (2013-01)

RESPONSE

From the handful of recommendations directed to child welfare and children’s services, DVDRC received four responses. Two of the responses outlined organizations’ agreement with the recommendation for greater collaboration, while also providing detailed accounts of steps they took to implement change



within their organizations. Respondents report that they have initiated symposiums focusing on collaboration between child welfare and adult mental health services in order to develop intersectional collaborative strategies and best practices. Other agencies highlighted that some recommendations may be best suited to be redirected to either a different colleague within the agency, or to an entirely separate agency.

REALITY

Communities across Ontario recognize the need for collaboration and coordination in response to high risk and complex DV cases. Most, although not all, communities have at least one organized process for collaboration and coordination. A general concern that permeates virtually any discussion of both collaboration and coordination surrounds issues of privacy and information sharing. One steering committee member expressed that “everyone means well, but no one is working together out of fear of the other agencies, crossing boundaries, confidentiality...” It is important to note that in 2016, the Office of the Information and Privacy Commissioner of Ontario outlined a detailed process to address concerns regarding sharing of information in high risk situations. This information has been presented more recently as part of a 2019 PHIPA Connections Summit. Box 1 briefly summarizes this process. It was notable, however, that even among the highly experienced members of the steering committee, knowledge of the existence and details of these guidelines was inconsistent. For some members, these guidelines were well known, while others were unaware of this resource.



Collaboration in cases where families are involved in family or criminal court

Although coordination was a concern in high-risk cases in general, steering committee members identified particularly acute concerns regarding coordination in recognizing and responding to child exposure to DV in families involved with the family and criminal court systems. A critical need to improve coordination with cases involved in multiple courts and court proceedings was discussed. Children living with DV may enter the justice system through reports to CAS, parenting disputes under the CLRA or as victims or witnesses to DV through criminal proceedings. These legal systems often operate in silos and do not share information that could be critical for risk assessment, safety planning or risk management.

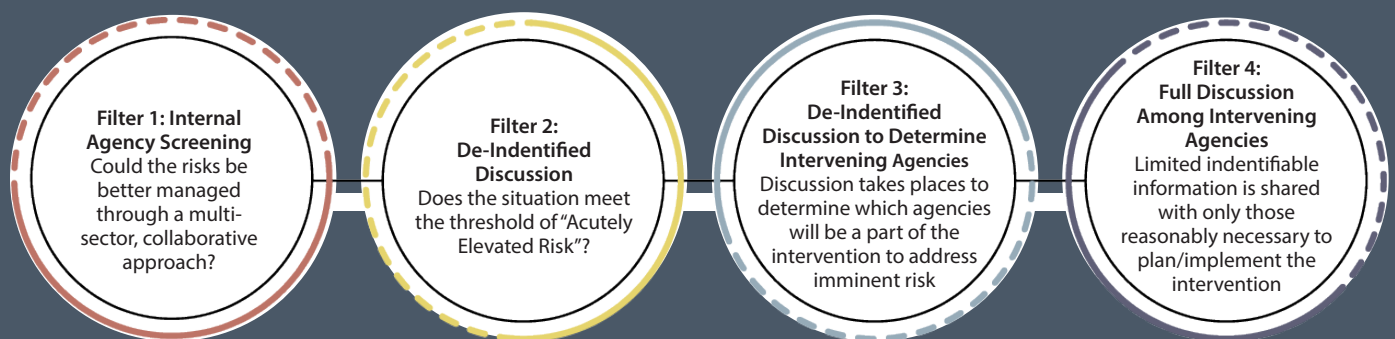
CAS have a critical role in high-risk cases in protecting children and advocating for their safety until such time that there is a safety plan in place for the victim parent and a risk management plan in place for the offending parent. Even though the CAS may consider the victim parent to be a protective parent, there may be a need for ongoing involvement and even supervision until there is a clear court order that determines parenting decision-making and parenting time. There is a tendency to assume parents will work things out through private family law proceedings but access to a judicial decision may be slow and the victim parent and child may remain in harm's way. In a similar vein, the offending parent may be before the criminal court for an extended period pending adjudication and sentencing. The needs for safety do not end during these proceedings. As well, even in the face of a finding of not guilty, there still may be enough evidence for the family court to make a finding about DV on balance of probabilities that will require ongoing support from the CAS and community partners. It is clear that child protection work in service of child safety cannot wait until courts have heard and made decisions and that such work often benefits from collaboration with other service providers.

The Office of the Information and Privacy Commissioner of Ontario outlined processes to address concerns about sharing of information and to facilitate collaboration to reduce serious harms. A first series of presentations on this topic were done in 2016. <https://www.ipc.on.ca/resource/the-privacy-protective-roadmap-issues-and-solutions-in-the-context-of-a-collaborative-service-delivery-development-the-situation-table/>

Subsequently, a manual was written and released by Dr. Russell to provide easy to use information and guidance for such multi-agency processes that includes these and other guidelines. <https://ckfirst.ca/wp-content/uploads/2016/07/Situation-Table-Manual-Dr.-Hugh-Russell.pdf> . A more recent summary of this information was presented by legal counsel for the Commission at a PHIPA Connections Summit <https://www.ipc.on.ca/wp-content/uploads/2019/12/2019-12-04-phipa-summit-situationtable-panel-web.pdf>

As outlined in the guidance documents from the Information and Privacy Commissioner, information sharing concerns can be addressed using the *Four Filter Approach* (see figure 7). Descriptions of each filter is as follows:

Figure 7: Thunder Bay, Ontario: Four Filter Approach for Situation Tables.



Filter 1: Internal Agency Screening

This step encourages internal communication within community services and agencies regarding specific, potentially high-risk cases. Agencies are expected to thoroughly analyze and decide whether a certain case may benefit from a single agency focusing on their protection and improvement, or a coordinated community response.

Filter 2: De-Identified Discussion

This step involves a discussion with all members of the Situation Table regarding the case. While specific and identifiable information is concealed, certain facts are shared. For example, gender and age-ranges are provided, and, if relevant, previous criminal involvement, while concealing the type of crime. This method allows for the members at the table to deem a case appropriately and accurately as high-risk and needing immediate attention, while ensuring the privacy and confidentiality of victims at the early stages of intervention. While definitions of high-risk and Acutely Elevated Risk (AER) may differ slightly across communities, the overarching definition surrounds the idea that AER refers to "a situation negatively affecting the health or safety of an individual, family, group, or place

where there is a high probably of imminent and significant harm to self or others” (CMHA Thunder Bay, n.d., What is Acutely Elevated Risk section).

Filter 3: De-Identified Discussion to Determine Intervening Agencies

Next, the table discusses which service providers would be most appropriate to provide assistance for a case deemed as high-risk. The filter approach continues at this step with de-identified information throughout the table’s discussion.

Filter 4: Full Discussion Among Intervening Agencies

In the final step, the agencies finalized from Filter 3 remain at the table to receive case information and history related to the issue and risk at hand. The agencies are then tasked to plan a beneficial and appropriate response with the aim of protecting victims and vulnerable individuals involved.

Other considerations outlined include strong governance, information sharing agreement and transparency.

Models of collaboration

In terms of what is available in communities to bring people together to share information and coordinate on case planning, the two most common models of collaborative response in Ontario are High Risk Justice Committees and Situation Tables. These are described first, followed by briefer discussions of two less common models, Multi-Agency Risk Assessment Conferences and the Collaborative Community Response for Children Living with DV model. In reviewing these models, it is useful to clarify that there are also several broader community initiatives that bring agencies together to improve response to DV in their community that are not client-based (i.e., where planning is not for individual cases). These committees are often named Coordinating Committees to end DV or Domestic Assault Response Teams (DARTS). An example of the work done by these types of teams is outlined by Peel Region, which has recently commenced a four-year initiative aiming to increase collaboration and connectivity among service providers and agencies in the community. Termed “Peel’s Community Safety and Well-Being Plan (CSWB)”, the project aims to have continuous function by addressing areas of community concerns to proactively plan and implement factors leading to long-term change.

High Risk Justice Committees

High risk justice committees are a part of Ontario’s DV court policy and procedures. As such, they are presumably available in all 54 of Ontario’s DV court jurisdictions. The aim of these committees is to review and manage high-risk DV cases that are currently in the criminal justice system. Cases identified as high risk can be provided with additional monitoring, proactive management and additional outreach and support to victims. Members of high-risk justice committees typically are the police, Crown, and Victim Witness Assistance programs. These services are all “part” of the DV court system and, therefore, are able to readily share information without using a filter process (as outlined in Box 1). Most communities also include child welfare services within these committees.

Commentary from the steering committee

The steering committee identified two major problems with high-risk justice committees. First is that, in most communities, these committees involve criminal justice partners and exclude community partners. Shelters, multicultural service agencies, addictions services, men's intervention providers, and sometimes, child welfare services are, at best, secondary partners brought in for specific cases. These partners are not able to refer high risk and complex cases to the table. The second problem relates to the very "justice oriented" way that these committees function. Perhaps in part because they are led by justice partners and mainly involve members of the justice system, there is concern from community partners that cases are not reviewed with a lens of survivor safety, but with one of justice accountability. As a concrete example, because of the presence of the Crown and police, if the committee learns of a criminal offense committed (e.g., a breach of conditions), the police may have to act unilaterally to respond to that offense even if it might be counter-indicated for victim safety. steering committee members further mentioned that victims were often reluctant to engage with high-risk justice committees because they were fearful of police laying charges.

Situation Tables

A second common collaboration structure in Ontario is a "Situation Table". A situation table refers to a process where participants across agencies work together to reduce the chances that an individual will experience harm from a combination of risk factors that heighten the chances of imminent victimization. It is a strategic alliance of human services, guided by common principles and processes in order to mitigate risk situations in a timely manner. Situation Tables aim to connect several service providers throughout communities. Communities may differ in the number and forms of services involved due to various factors; however, the objective is to include as many social service providers in order to maximize community protection and coordination. Common service providers involved in situation tables include both municipal and provincial law enforcement, probation, school boards, healthcare units, child welfare and victim's agencies, and counselling services. While approaches to privacy may differ depending on the community at hand, many situation tables require confidentiality agreements for representatives from services involved either prior to joining the table, or at the beginning of each meeting.

Commentary from the steering committee

Steering committee members who sat on situation tables often found them to be efficient and effective. Members of Situation Tables identified that, through the process of collaborating on individual cases, systems and structures were put in place that were helpful in the future. As such, one "success" of situation tables is for there to be lower numbers of referrals as each agency becomes more knowledgeable about options and strategies for dealing with high-risk cases.

Despite these strengths, committee members identified several challenges to situation tables as a response to high risk and complex DV situations. Most importantly, steering committee members noted that situation tables have been set up with a range of purposes, only some of which include DV, and which rarely have an exclusive focus on DV. Some situation tables are very police focused, others have a focus on mental health, addictions, or high-risk situations with youth. Reflecting their different mandates, some situation tables include CAS agencies and others (e.g., Situation table on addressing high risk in adults vulnerable due to homelessness and addiction) may not. In smaller communities, having a general situation table may be efficient, as the agencies are likely to be coordinating and collaborating on a range of issues (e.g., high risk DV, complex youth issues).

In larger communities, the proliferation of situation tables has sometimes become a challenge. When a community has many situation tables all requesting CAS participation, it can be difficult to adequately staff each one. A final concern about situation tables is that they seldom have processes in place to involve or include the person whose safety is at stake as a participating member.

Multi-Agency Risk Assessment Conference

Another model of collaboration that has been used in DV cases is a Multi-Agency Risk Assessment Conference (MARAC). Originally developed and used in the UK, a MARAC is a gathering with representatives from local community services surrounding high-risk domestic abuse cases. Agencies involved in MARAC meetings include police services, healthcare services, child protection, probation services and more. The primary purpose of a MARAC is to share information regarding high-risk DV cases for community services to plan and implement a coordinated response to protect the adult victim. While the victim is not present throughout MARAC meetings, an Independent Domestic Violence Advisor (IDVA) attends and participates on their behalf. In most cases, victims are aware of their case and information being shared at local MARACs, however in cases where the victim is not willing to be referred to a MARAC, the service provider representative may make the final decision on sharing their information, based on the severity of the situation and the level of risk the victim is facing. In addition to risk management of the offender and safety planning for the victim, a goal of a MARAC is to support children through their coordinated response for the adult victim. The most common referrals to the MARAC in the UK are from police services, IDVAs and health professionals, however any community service representative can refer a case deemed as high-risk to their community.

The Woman Abuse Council of Toronto (WomanACT) began a four-year project in 2019 aiming to evaluate the MARAC model within a Canadian context. The goal of their project is to assess the implementation of MARAC within one rural and one urban city in Ontario, in order to analyze its functionality among Canadian service providers working on reducing cases of high-risk DV. Researchers from the University of Guelph are working alongside this project to evaluate its implementation and success.

Collaborative Community Response for Children Living with DV

A final model of collaboration outlined by the steering committee members is the Collaborative Community Response for Children Living with DV (CCRCDDV) in London Ontario. CCRCDDV is a multi-agency model organized and led by child protection. The CCRCDDV response aims to allow case risk assessment by multiple agencies and systems, to plan and implement a coordinated response to ensure victim protection. Information sharing and response plans were shared among the services involved, as well as with the family involved. Agencies and services involved include CAS, police services, woman's advocate, probation, parole, and more. Case conferences additionally included the victim, certain family members, friends of the victim and perpetrator, and in some cases involved the perpetrator himself. Notable in this model is that CAS played a lead role in managing coordination. As the leader in this regard, CAS gained knowledge of a range of community services and of various methods and processes that could be applied, as appropriate, to deal with other situations as well. The CCRCDDV response has been in place for several years in London however, community members note that it has been more and less active over time.

General concerns and comments

In addition to the strengths and challenges already identified, steering committee members outlined several other issues that are worth considering in improving collaborative work. The first issue is inconsistent membership. Steering committee members have varying experiences; in some communities, collaborating tables were functioning well, in part due to stable membership. Other communities have had trouble maintaining membership due to various reasons, the main one being COVID and subsequent challenges in staffing which have highlighted the challenge of maintaining membership. Having strong, consistent relationships between CAS and VAW service providers were identified as critical.

A second challenge is consistent funding. It was noted that many collaborative tables are underfunded and that, although members endorse the value of this work, it can be difficult to fund the time necessary for staff from various agencies to participate.

Third, steering committee members shared that the lack of common understanding and assessment of DV-related risks and of factors that denoted escalation was a concern. This concern is highlighted in the recent Inquest into the deaths of Carol Culleton, Anastasia Kuzyk and Nathalie Warmerdam. Specifically, recommendation 41 is to:

Investigate and develop a common framework for risk assessment in DV cases, which includes a common understanding of DV risk factors and lethality. This should be done in meaningful consultation and collaboration with those impacted by and assisting survivors of DV, and consider key DV principles, including victim-centered, intersectional, gender-specific, trauma-informed, anti-oppressive, and evidence-based approaches.

Finally, it was noted that for families involved in criminal or family court, coordination is often more difficult (though just as, if not more, necessary). Barriers include heightened concern about information sharing, concern about being called into court to testify, and concerns about becoming drawn into being part of an adversarial, rather than a problem-solving, process.

ROADMAP

SPECIFIC ACTION 1

Spread information about information sharing guidelines and protocols

Although guidance has been available from the Office of the Information and Privacy Commissioner of Ontario on sharing of information and facilitating collaboration to reduce harm since 2016, even in the highly experienced group of steering committee members, this information was not universally known. This is problematic because any conversation about collaborating to address DV inevitably begins with concerns about sharing information. There is a need for more systematic sharing of information about guidance provided by the Office of the Information and Privacy Commissioner. This recommendation aligns with the Inquest into the deaths of Carol Culleton, Anastasia Kuzyk and Nathalie Warmerdam recommendation 78 to the Information and Privacy Commissioner of Ontario, that they should be Recommendation 78:



“Working together with the DVDRC, justice partners and DV service providers, develop a plain language tool to empower DV professionals to make informed decisions about privacy, confidentiality, and public safety.”

SPECIFIC ACTION 2

Provincial leadership to clarify and enhance the use of high-risk committees for DV situations

For our second recommendation, the committee endorsed the recommendation from the Inquest into the deaths of Carol Culleton, Anastasia Kuzyk and Nathalie Warmerdam on the need for provincial leadership to clarify and enhance the use of high-risk tables. They note that, in some communities, the combination of the high-risk Justice and situation tables have been effective, and that child protection feels confident in how to proceed to address high risk situations. In many other communities, however, there is a disconnect between justice and community players, mainly due to an unclear understanding, and utilized process, to problem solve for high-risk DV situations. For this reason, Renfrew inquest recommendation on this topic duplicated as follows:

Recommendation 44. Clarify and enhance the use of high-risk committees by:

- a. Strengthening provincial guidelines by identifying high-risk cases that should be referred to committee,*
- b. Identifying and including local DV service providers that are in a position to assist with case identification, safety planning, and risk management. Consideration should be given to including DV service providers supporting perpetrators,*
- c. Ensuring that involved DV service providers at high-risk committees are given the necessary information to facilitate their active participation, subject to victim consent where applicable.*

SPECIFIC ACTION 3

Provincial leadership to develop policies and practice regarding coordination of legal proceedings and services for children exposed to DV in multiple court actions

This issue may be best managed by an inter-ministerial committee made up of the MCCSS and MAG to review current policies and practice that create silos among the public and private family law proceedings and criminal proceedings that prevent information sharing and interventions to promote safety and risk management. A lack of a timely and coordinated access to justice for children puts them at risk.

SPECIFIC AREA 4: RISK ASSESSMENT, SAFETY PLANNING, AND RISK MANAGEMENT

RECOMMENDATION

Several recommendations were made by the DVDRC on enhancing risk assessment, risk management, and safety planning strategies. Often these recommendations combined risk assessment, risk management and safety planning into a single recommendation. This combination emphasizes the need to recognize how risk assessment should be used to inform risk management and safety planning strategies.



Closer examination of these types of recommendations directed to the child welfare system found that risk assessment, management, and safety planning recommendations were framed in two different contexts. The first, included recommendations that directly addressed the need to enhance risk assessment, safety planning or risk management approaches. One example of this type of recommendation was provided to the Ontario College of Social Workers and Social Service Workers:

“Social workers should recognize the risk of domestic homicide for victims of domestic violence. Members should be mandated to complete a risk assessment when clients disclose violence and provide safety planning” (2020-07)

The second framework of these types of recommendations was aimed at making changes and improvements toward training in risk assessment, risk management and safety planning. This type of recommendation included additional training and assurances toward improving approaches being taken to assess and address risk of DV. One example of this type of recommendation was provided to the MCCSS and OACAS:

“It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children’s Aid Societies provide enhanced training on a standardized risk/danger assessment tool and enforce the use of this tool in all cases where domestic violence and harassment are present. Once the level of risk has been identified for the victim, an adequate safety plan must be implemented. As well, it is essential that contact be made with the perpetrator to assist in the risk assessment and risk management process.” (2015-03)

RESPONSE

Responses to risk assessment, risk management and safety planning recommendations often indicated that the recipient was considering the recommendation or that the recommendation was already in place. The latter was particularly true when recommendations were placed in the context of training.

The Ontario College of Social Workers and Social Service Workers indicated that they published the recommendation toward the need to recognize and respond to risk for domestic homicide in their e-bulletin. As part of that publication, the college also highlighted the responsibilities of their membership through their professional obligation, ethics, and standards.



REALITY

Existing standards for child welfare practice do explicitly recognize child exposure to DV as a child protection concern. The Eligibility Spectrum was designed to assist child welfare workers in making consistent and accurate decisions about a child or family's eligibility for service at the time child welfare becomes involved in keeping with their mandate under the CYFSA. The most recent revision of the Eligibility Standards was published in 2021. A specific category of concern under the Eligibility Spectrum is "Child Exposure to Partner Violence." Child protection workers are advised to consider several factors when investigating and making decisions about child exposure to DV. These include directions to:



- Consider violence between partners or between a parent/caregiver and their partner
- Use a gender-based and intersectional analysis to understand the relationship between intimate partners, each partners' access to resources, their activities, and the constraints they face relative to one another
- Use a broad definition of exposure that includes direct exposure but also hearing about the violence, feeling tension in the home, being denied care because of impact on the victim parent, having their relationships with victim parents and supportive adults undermined, being enlisted by the abusive parent to align against the other parent, etc.
- To consider the duration frequency, intensity, developmental stage in which the exposure to the violence occurs, cumulative exposure over developmental stages, and resiliency and protective factors that may be present
- To be attentive to the likelihood of co-occurring forms of maltreatment
- To consider children's protective mechanisms, as well as protective factors in children's environments
- To consider risk factors for lethality that have been identified by the DVDRC

Additional categories of Eligibility include "Child Exposure to Adult Conflict" and "Caregiver Causes and/or Caregiver Response to Child's Emotional Harm or Risk of Emotional Harm". The first of these refers to violence within the home that occurs between adults, whose relationship is something other than partners/parents. The second includes emotional harm resulting from patterns of negative behaviours or repeated destructive interpersonal interactions by the caregiver to the child including spurning, terrorizing, isolating, exploiting/corrupting, and denying emotional responsiveness. This category of Eligibility may be considered when a child is exposed to, and significantly impacted by, adult conflict (as opposed to partner violence).

In addition to considering child exposure to partner violence as part of the Eligibility Spectrum, partner/adult conflict is considered as a single item as part of the Ontario Safety Assessment, which is designed to help determine the immediate danger to a child and the Ontario Family Risk Assessment tool to organize the information according to constructs that identify families which have low, moderate, high or very high probability of future abuse or neglect relative to other families. Finally, in the Family and Child Strength and Needs Assessment, which is a tool completed on every case receiving ongoing protection services at the time of transfer and again every six months, one area

for consideration is partner/adult relationships. Child protection workers are asked to consider this area and to indicate, as a risk, the presence of physical violence and/or controlling behaviour. It is important to note that not all these instruments are used consistently across the province.

Despite the inclusion of DV in the standards for practice in Ontario's child welfare service and in many of the tools designed to aid in worker decision making, steering committee members shared many concerns about the quality and consistency of DV assessment and conceptualization within child welfare services. Some of the concerns noted by committee members included the following:

- Failure to follow best practices for assessing DV (e.g., interviewing partners together rather than separately, making victim blaming statements)
- Frequent misidentification of DV as instances of bidirectional couple conflict (e.g., describing concerns about conflict following an arrest of a perpetrator for a DV-related assault)
- Failure to recognize DV-related risk and DV-related risk escalation (e.g., failing to recognize and respond with urgency in cases with many indicators of lethality)
- Equating separation with safety; closing cases based on a separation of mother and father without recognizing the increased risk for DV victimization associated with separation
- Closing cases based on the protective action of the non-offending parent even when level of DV offending risk is high and no risk management has been put in place with/for the perpetrating parent
- Failure to set and monitor goals associated with change in the perpetrating parent, and then failure to follow-through on expectations
- Insufficient time spent with victim parents to support their understanding of the violence, coercive control, and abuse that they have experienced
- Failure to share risk assessment information across service agencies
- A tendency to automatically characterize cases involved in family court as conflict, and not DV, without first completing a DV assessment
- Limiting consideration of DV risk factors to cases presenting with child exposure to DV as a primary substantiated concern, thereby missing DV risk factors in other cases
- Missing intersectional risks and opportunities to work collaboratively with diverse communities

The wide gap between the expectations outlined as part of the child welfare standards and the reality of practice is of considerable concern. Training alone may not be sufficient to scaffold and support better practice. Child welfare service providers may also need, and benefit from, the use of a semi-structured and empirically supported risk/threat assessment guide to support professional judgement on the level and nature of DV-risk and impact and on how to use this information to guide work to reduce abuse and manage risk with perpetrators, increase safety with non-offending parents, and advocate for children impacted by DV exposure. Universally, it is critical to recognize risk assessment as not an end, but rather, a starting point to guide the response. In other words, it is not enough for child welfare to verify abuse or risk – they need to specify action and support families in making changes that will reduce abusive behaviour, manage vulnerability, address DV impact and, generally, to connect families in high-risk situations to needed services and interventions.

The committee identified several important aspects that need to be considered when developing risk assessment, risk management, and safety planning:

Tools should be evidence-based. The Committee asserted the need for a new assessment tool to be evidence based. Given the heterogeneity and complexity of cases presenting to child welfare services, the need to consider intersectional risks, and the critical need to link assessment of risk to actions that reduce risk, increase safety and address impacts, tools based on structured professional judgement are likely to be of most value. The SAFeR, RIA, and B-SAFER were identified as potential resources to consider in tool development.

Assessment should focus on patterns of history and ongoing abuse used by the perpetrating parent to control and harm the non-offending parent and children and on necessary steps to manage and change risks associated with DV perpetration. A key problem in current practice is failure in directing child protection practice (i.e., assessment, goals, monitoring) at the parent who is engaged in domestically violent behaviour. A new process should support workers in articulating patterns of abusive behaviour, setting expectations for change in abuse directed at the abusive parent and implementing strategies to manage and respond to DV-related risks directly with the perpetrating parent. Child protection workers should be supported in clearly assessing and articulating the differences between relational conflict and DV. For perpetrators involved in the criminal justice system, assessment should include consideration of already completed assessments of risk for re-offending.

Assessment should include the protective strategies and safety needs of the non-offending parent and any actions needed to reduce vulnerability and increase safety. A second area of assessment should be identifying both the protective strategies being used by the non-offending parent and the vulnerabilities that might need to be addressed to support safety. This area of assessment should be based on an understanding that the safety of children is intrinsically connected to the safety of their non-offending parent. Assessment in this area should clearly articulate how the victim parent is working to keep themselves and children safe and what is needed to support safety. Consideration should include co-occurring concerns such as those associated with mental health, substance use, pre- and post-migration trauma, systemic violence, and racism as potential vulnerability factors and should outline steps and supports needed to address these vulnerabilities. Proposed actions should include supporting a victim parents' understanding of what they have experienced and its impact. As part of these responses, referrals facilitated to community-based DV services will often be warranted.

Assessment should include consideration of the needs of the child exposed. Child protection has a critical role, and unique position, in identifying children's needs and advocating for services and resources focused on children and that might address the impacts of DV exposure. Child welfare workers are needed to advocate for children in schools, community centres and programs, and within the child mental health system. Child welfare workers also often also support children through facilitating access to childcare and to helping their non-offending caregivers access housing and support for basic needs.

There should be continued recognition that cases of child exposure to DV can present as an immediate and acute safety concern. Child exposure to DV is often characterized as a longer-term, less acute concern. There are, however, cases of child exposure to DV that present as immediate safety issues, such as instances when one parent is immediately in need of safety.

Child protection workers need to have the understanding and ability to identify as well as appropriately address these immediate risks and needs.

There needs to be awareness of patterns of abuse, protective strategies and impacts in diverse families. Indigenous, Black, racialized, immigrant, refugee and other diverse families from equity-seeking populations experience a number of specific risks related to family violence. In the context of immigration, for example, men and women might be hesitant, or unable, to access services due to factors such as, but not limited to, a lack of information about Canadian criminal and family laws, fears of deportation and financial dependency, or a lack of access to culturally and linguistically appropriate services (Ahmad et al., 2009; Okeke-Ihejirika et al., 2020). Individuals who experience colonization and racism might be justifiably hesitate to share information with child welfare services. Risk assessment, when done without an appreciation of violence in diverse families, can result in an underappreciation of the unique risk factors, inherent strengths, and barriers to accessing services. An example that combines both the need to be aware of DV risk in cases presenting with other concerns and the need to be aware of culturally-based risk factors are situations of Afghan and Syrian refugees being reported by schools for a range of concerns and where exposure to DV is being under-recognized.

Acknowledgement of Assessment Limitations. The committee was clear in highlighting limitations that exist within risk assessment strategies. They discussed the need to acknowledge the reality that no perfect assessment tool exists to measure the risk of DV. Likewise, there is no valid tool that can predict homicide for children within the context of DV. The committee also noted that tools may miss important risk factors and protective strategies used by diverse, equity seeking populations and often contain cultural biases/prejudices. Structured professional judgement, as opposed to actuarial item-based risk assessment, helps address some of these concerns, though when using such tools, good training and strong supervision are critical.

Acknowledgement of time needed to monitor and respond to the success, or failure, of outlined plans to reduce or manage ongoing abuse by the perpetrating parents, increase safety in non-offending parents and address impacts on child of exposure to DV. One of the key concerns in responding to cases of child exposure to DV is having the time needed to monitor and respond to the success of outlined plans in reducing and managing risk. Under the current model of service, initial involvement with child welfare services is meant to be investigative, and thereby, it is time limited (specifically for 45 to 60 days). During that time, the responsibilities of the child welfare worker is to make three decisions: whether the child protection concern should be verified, whether the child is in need of protection, and to determine what services should be provided to the family. Unless a case is transferred to ongoing services, no additional follow-up is possible.

The current model/standards of CAS practice means that child protection works are not able to follow-up on whether recommended changes were made, recommended services were accessed or to follow rapidly changing dynamic risk for DV. The limited follow-up time is especially concerning when the timeframe for child welfare involvement is considered. Child protective services very often become involved immediately following an arrest for a DV related offense. At that point in time, offending parents are often subject to bail conditions and no-contact orders. Criminal court and family court may both be involved. Offending parents may be waiting for, or enrolled in, a Partner Assault Program and victim

parents may be accessing services from a Victim Witness Assistance program. This is a time when a high number of professionals and systems are involved, and families' situations are rapidly changing. Concerns were raised toward the limited role child protection that can take place within a short-time frame of many of these cases, despite real risks being present. Likewise, with their limited timeframe of involvement, it is unclear how CAS can contribute to following-up on recommendations which can lead to potential gaps that have significant risk. Notwithstanding comments around the need for a fundamental change of the child welfare system; there were also identified need toward ensuring increased time is taken DV is identified within a family within a child protection context, and the potential need for maintaining an open child protection file to ensure pathways to respond to needs are taken/maintained.

ROADMAP

SPECIFIC ACTION 1

MCCSS should support the development and dissemination of a child welfare guide to comprehensive risk assessment in cases involving child exposure to DV. This assessment should identify:

- a) Patterns of abuse and coercive control used by the perpetrating parent to harm the non-offending parent and children, including risk for lethality
- b) The safety needs and safety strategies being used by the non-offending parent; and
- c) The impact of DV exposure and the associated needs of the child exposed.

All of these questions need to be answered with a consideration of the intersectional realities of children's lives. Assessment of patterns and ways of creating safety must include consideration of the cultural and religious practices around parenting and take into account the specific context of certain factors that could enhance the risk for the children involved (for example, customs of child marriages, family honour, son preferences, forced marriages, demand for dowry, female genital mutilation)

MCCSS can contribute to improving practice by developing, and then expanding standards and requiring the use of a structured decision guide. This guide would support comprehensive assessment of risk associated with DV and would support child welfare workers in outlining required actions to intervene early to prevent ongoing abuse perpetration and escalation, reduce vulnerability and increase safety for the non-offending parent and identify needs and advocate for services needed to address the impact of DV on children.



SPECIFIC ACTION 2

MCCSS should support the development and dissemination of guidelines for managing risk and promoting safety in cases where DV has been identified or suspected. Such guidance should include strategies to prevent and address ongoing perpetration and escalation of abuse with the offending parenting, support safety needs of the non-offending parent and children, and advocate for children's access to services and resources that can help address the impacts of DV exposure.

Following clear formulation of risk, child welfare workers need to be able to outline a clear and comprehensive plan to reduce and/or manage ongoing abuse, increase safety, and address the needs of children exposed. This process should exist from the start of contact and persist across service delivery and should include how to increase assurances that progress is taking place. At minimum, MCCSS and CASs should ensure that they have processes in place for each step, including around:

1. Monitoring risk, safety and child need while implementing intervention plan
2. Clear plan toward coordinating and collaborating with community-based services
3. Mechanisms to monitor and document change in the abusive parent

As part of this process, CAS should evaluate if the usual amount of time taken for files with DV is effective in addressing needs. It is suggested that further review specifically on the logistical needs for files where DV is a factor are being appropriately accounted for. It is difficult to say with certainty that limitations in timing for these types of cases have impacted response effectiveness. There is a complex balance that arises out of keeping an open file to ensure all needs identified in the family are being addressed or closing a file once child protection needs are considered no longer. In many cases, there is a revolving door where the file is opened again when a new child protection concern is identified and in need of investigation. This leads to an ineffective use of resources and continues to allow for underlining needs for the family to persist, which can increase the potential risk and harm.

SPECIFIC ACTION 3

Consider alternate models of collaboration between child welfare and community-based DV services as part of child welfare redesign

With a comprehensive assessment and clearly articulated plan for change, child welfare may be better positioned to broker deeper and more meaningful collaborations with community-based service providers. Specifically, child welfare may take on the role of assessing level of risk and need, setting out aims for service, passing the case to community-based services and then stepping back into a monitoring and support role. A collaborative model like this recognizes that having a large proportion of cases of child exposure to DV substantiated at intake and then closed within 45 to 60

days, without any possibility of meaningful monitoring and follow-up on change, is an inefficient and ineffective use of resources. An alternate, collaborative child welfare-community based service model places CAS in the position of being a central player in the development of intervention plans and brokers within the community space. In other words, CAS should increase their ability to develop comprehensive plans to address the needs of a family and work with community-based services to ensure families are receiving services.

To become more effective in managing DV files, CAS should consider alternative pathways to case management (see Figure 8). In this model, child welfare workers continue to close cases where there is no risk and continue to work actively with cases that are at high risk for imminent and lethal abuse.

In other cases, child welfare can play a middle role, assessing patterns of risk, safety and child needs and then passing files to community-based services. To ensure progress, child welfare can retain a monitoring role until family safety needs are met. This model includes the following:

Decision around opening files. Rather than either opening the file to ongoing service or closing the file entirely, there is a middle ground where a focus on case planning and management is undertaken. This middle pathway could include a set of treatment targets that are laid out by CAS and brokered with community partners.

Coordination with services. CAS should be a core service within a community and effort should be made to foster relationships with other service providers. Through these relationships CAS should look to improve their role in managing risk and safety by identifying needs and having appropriate referral pathways to address these needs. As part of this role, CAS could also come in to advocate for the child and the non-offending parent and children affected in other processes, with facilitated referral and with family court.

Monitoring role. Child protection workers could shift their functions towards a monitoring force taking on a check-in role on a predetermined schedule (i.e., every 6 months). Unlike most service providers, given their mandated authority, child welfare can leverage their position to continue to monitor in the background. If things are going well, then the file can be closed. If not, they can come back in, re-assess risk and needs, and set out a new plan with perhaps greater involvement.

Figure 8. Alternative Pathways to Case Management for CAS

Case is closed: No ongoing pattern of abuse AND no concern about vulnerability AND no child needs related to impact

Case is monitored by CAS: pass to (not pass-off) community-based services and/or private family law proceedings

- ✓ Low to moderate risk of ongoing abuse
- ✓ Low to moderate concern about vulnerability
- ✓ Low to moderate concern about impact

Case is open - managed: High risk of ongoing abuse OR high levels of concern about vulnerability OR high concerns about child impact

WHERE DO WE GO FROM HERE

As reported in part one of this report, the Ontario DVDRC has provided many recommendations aimed at the child welfare system. The challenge being faced is not one associated with not knowing what to do, it is a challenge with implementing these recommendations into practice. Barriers to implementation and translating research into practice is not a new phenomenon and not one limited to child welfare services. Researchers and practitioners alike have noted challenges with implementing and sustaining new practices and have established that traditional approaches to implementation (e.g., disseminating information through training alone) leads to predictable results of a modest uptake between 5-15%, which is rarely sustainable (Fixsen & Blase, 2015)

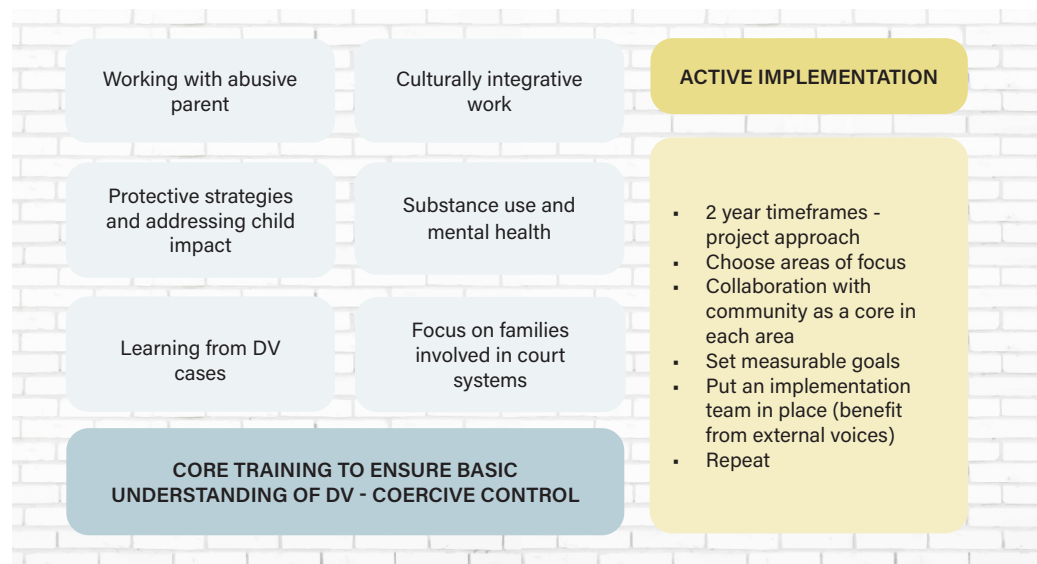
Given the challenges that arise with implementation, this project focused on providing specific and clear actions that can aid in implementation of the recommendations in five areas: professional training, case review, scenario-based learning, collaboration, and risk assessment, management and safety planning. This final section summarizes actions that can be taken. It begins with a consideration of actions that might be taken by CAS agencies independently and autonomously as part of their overall efforts to improve service quality. Following this section, broader recommendations for change – those that would require community or government action – are summarized.

Roadmap for change within child welfare agencies

Review of DVDRC recommendations and consultation with our steering committee on their implementation identifies a need for substantial development of services associated with child exposure to DV within child welfare services. There are many recommendations for improvement, in many different areas.

Figure 1 below identifies areas of recommendation change within child welfare agencies and Table 1 summarizes key action in each area. A foundation for change is core training to ensure basic understanding of DV. For there, we have outlined numerous areas of change. Each area represents core recommendations and related components be used as guides for communities to

determine where they currently are within the implementation of these recommendations based on their needs. Each component is a fundamental recommendation to enhance how child protection is addressing DV, and together providing an overall approach that holistically address violence for the family.



**CORE TRAINING TO ENSURE
BASIC UNDERSTANDING OF DV
- COERCIVE CONTROL**

- Recommit to the OACAS training modules or another training system to solidify skills of all frontline staff and all supervisors/managers
- Ensure training of managers and supervisors on DV cases
- Review how agency leaders are connected to leaders; are CAS leads connected with leads for shelters, services for children exposed, men's service, health service, and any leads for cultural organizations addressing DV
- Ensure that the agency is an active participant in coordinating committees and on high-risk collaborative tables

Focus on engaging with perpetrating parents as a source of risk to children

- Implement whole agency training on working with perpetrators
- Implement opportunities to practice working with DV perpetrators
- Review and strengthen the relationship between child protection and agencies in the community that work with perpetrators
 - Review number and nature of referrals to the program
 - Review communication between the program and the agency
 - Review ways in which agency and program work together to manage risk
 - Develop a MOU or a "practice map" to outline processes for referral, communication, and collaboration
- Review and strengthen collaboration and information sharing with police and with probation so that information about risk is shared and to ensure collaborative risk management
- Develop or strengthen a collaborative process for working together with high risk, complex cases, including those with fathers who are who are difficult to engage

Focus on culturally integrated work

- Implement whole agency training on culturally integrated work
- Implement opportunities to practice working in a culturally integrated manner
- Review and strengthen the relationship between child protection and agencies that specialize in working with diverse communities
- Review and strengthen the relationship between child protection and agencies that specialize in working with diverse communities
 - Review communication between the program and the agency
 - Review ways in which agency and program work together to manage risk
 - Develop a MOU or a "practice map" to outline processes for referral, communication, and collaboration
- Develop or strengthen a collaborative process for working together with high risk, complex cases

Focus on mental health and substance use

- Implement whole agency training on complex cases
- Implement opportunities to practice working with complex cases
- Review and revise protocols for working together. Where are the gaps (e.g., release from mental hospital) and how can they be filled?
- Bring together internal leads from MH and substance use services to create a referral map – how can connections be made? Who are the connectors for the various systems?
 - Develop a MOU or a "practice map" to outline processes for referral, communication, and collaboration
- Review and strengthen collaboration and information sharing agreements with MH and substance use services
- Develop or strengthen a collaborative process for working together with high risk, complex situations

Focus on protective strategies and addressing child impact

- Implement whole agency training focused on survivor strategies
- Implement opportunities to practice identifying protective strategies and impacts on children
- Review and strengthen the relationship between child protection and VAW agencies
 - Review number and nature of referrals to the program; pay particular attention to referrals for children exposed
 - Review communication between the program and the agency
 - Review ways in which agency and program work together to manage risk
 - Develop a MOU or a "practice map" to outline processes for referral, communication, and collaboration
- Develop or strengthen a collaborative process for working together with high-risk cases

Focus on families involved in court systems

- Implement whole agency training on the ways in which families can be involved in multiple court proceedings and prevent working in silos.
- Implement opportunities to collaborate with different justice partners (family lawyers, police, crowns) on enhancing opportunities to share information and manage safety of victim parent and children as well as interventions with offending parents.
- Organize joint training programs
 - Engage in community reviews of de-identified domestic homicide cases to examine lessons learned
- Develop or strengthen a collaborative process for working together with high-risk cases to include family lawyers and CAS counsel.

Learning from DV cases

- Initiate a continuous case review/learning process - develop a culture of learning from mistakes
- Revise internal review process to make learning visible to all
- Regularly profile and review best practice and practice to be improved
- Participate in community scenario review processes
- Have a strategy to pull out and then learn from child death review committee reports

Our recommendation is for child protection agencies to identify priorities for change and then systematically implement changes in these areas. It is likely impractical to implement all changes simultaneously. Moreover, as has been emphasized throughout this document, the specific needs of each agency and each community are likely to differ.

The Active Implementation Framework (AIF) is one tool that might provide guidance toward developing a plan that is both realistic and sustainable. The AIF was developed from a synthesis of implementation research from broad fields and focused on how to make use of effective innovations in enabling contexts (Fixsen, Blase, Metz, & Van Dyke, 2015; Metz et al., 2015). The AIF has been proven effective in fostering the implementation of evidence-based practices within large systems, including the child welfare system. Fundamentally, the AIF model recognizes that implementation is a process involving multiple decisions, supports, actions, and interdependencies; thereby implementation should never be viewed as a one-time event. Accordingly, the AIF stages are non-linear and often occur simultaneously (Blanchard et al., 2017). It directs agencies to engage in iterative change processes such as: exploration, installation, initial implementation, and full implementation. Each of the implementation stages has specific functions that are important to consider for the success of a new approach. Equally important is the recognition that these stages of implementation should be viewed as additive and dynamic. For example, a CAS may move from between full implementation back to initial implementation in the midst of high levels of staff turnover and/or changes in resources; a CAS may also have to repeat exploration when there is new leadership or policy changes (Fixsen & Blase, 2016).

The literature is clear that implementation is a process that takes two to four years to complete in most provider organizations. Training alone, although important, will not create the change needed in practice. Also needed are clear goals for change, monitoring of progress, and changes in practices around collaboration.

How can the province support change?

The fundamental change required in the way in which child welfare agencies recognize and respond to DV is not likely to be achieved without provincial leadership. It is recommended that MCCSS consider ways to ensure commitment to a change agency and to a process of monitoring this change. Likewise, commitments and plans should have a clear communication strategy to help

maintain progress toward meeting implementation goals. Given the complexities that are inherent in sustaining implementation, there is a need for some level of Ministry support to ensure ongoing communication. More specifically, there should be infrastructure in place to foster continued dialogue and support can take place between CAS and policy makers. By having this continued communication problem-solving can take place around the challenges of policy and practice gaps and more effective implementation strategies and support can be offered and accessed.

Provincial leadership can also strongly encourage community involvement in change processes. Such involvement is critical, especially if revised models of practice having implications for referrals to, and communication with, community-based service providers. There is significant expertise in communities on addressing DV, and community members will be extremely valuable members of a team working to implement change.

CHILD WELFARE CANNOT DO THIS ALONE: IMPROVING OUTCOMES FOR CHILDREN EXPOSED TO DV WILL REQUIRE MULTIPLE CHANGES ACROSS MANY SYSTEMS AND NEEDS PROVINCIAL LEADERSHIP

The focus of this report was on recommendation made to MCCSS and to child welfare service on changes needed to better respond to lethality risk in children exposed to DV. It is worthwhile to note that, even with this narrow focus of review, there were several recommendations that require collaboration and leadership with and from other agencies and organization. A few of these additional recommendations are worth highlighting.

Collaboration and coordination

The first is the need for provincial leadership on collaboration and coordination in high risk and complex cases. MCCSS could take a leadership role in three ways. They can spread information about processes for collaboration. They can coordinate and share information across communities about processes that are in place. Finally, they can make sure that there is an inclusive process, in every community, to review high risk DV cases. This recommendation arose in review of changes needed within child welfare services (i.e., that CAS refer to and use such processes) but goes beyond child protection practice. The call for provincial leadership in this area aligns with recommendations from the Renfrew inquest.

Creating guides for assessing, and responding to, DV related risks

Given the proportion of cases that come to the attention of child welfare services as a result of child exposure to DV, frontline workers should be skilled in conducting such assessments and then collaborate with community-based interventions that can work with perpetrators to manage and reduce the risk, improve safety for adult victims and children and facilitate access to therapeutic supports for children impacted by DV. Changing the way child welfare recognizes and responds to families where there has been child exposure to DV needs to begin with changes in standards of practice and in the tools, guides and resources that support practice in DV. In brief, this committee recommends that the Ministry re-evaluate risk assessment and safety planning policies for DV within child welfare standards. New tools, designed to assess the dynamics of risk, should be developed for use with all cases where there are concerns about DV. Such tools and resources should begin with a clear assessment of risk for DV, including consideration of police-based risk assessments that are

ofttimes associated with the initial referral, and continue to clear recommended actions to manage risk, promote safety and facilitate child access to therapeutic support.

Ensure that lessons learned from DV and child homicides are more readily available and are used to continuously improve response

Review of recommendations and their implementation identified a couple of policy changes that could increase the capacity of Ontario-based service providers in child welfare, and in other agencies, to learn from tragedies. We recommend a review of the internal review process within child welfare agencies, more transparency in recommendations and enhanced coordination between the DVDRC and the PDRC/CYDRA for homicide in the context of DV and CAS involvement.

We also recommend that the province consider investing in an annual community education process to share information from DVDRC and PDRC/CYDRA reports. We used a small part of the funding from this grant to outline a process and run a test education and problem-solving day with the Windsor Coordinating Committee. The overarching goal of this workshop was to examine the implementation of longstanding DVDRC recommendations for increasing robust community coordination, collective risk assessment, ongoing and targeted risk management, clarity, and accountability on information sharing on high-risk cases. In doing this, the workshop examined a worst-case outcome in a composite case to identify challenges, strengths and missed opportunities for intervention at individual, organizational and community levels. This process was well-received and viewed by the attendees as a valuable experience to learn and to connect.

CONCLUDING COMMENTS

Child homicides in the context of DV appear predictable and preventable based on the multiple known risk factors as well as systems and agencies involved with the family prior to the homicide. Most of the homicide reviewed by the DVDRC suggest many lessons that can be learned in terms of public education, professional development, and enhanced community collaboration. There are no quick fixes but some of the suggested fixes have been documented repeatedly across multiple DVDRC reports. The time for action is now. This report provides a roadmap to go from these ideas to implementation.

REFERENCES

- Alisic, E., Krishna, R. N., Groot, A., & Frederick, J. W. (2015). Children's mental health and well-being after parental intimate partner homicide: A systematic review. *Clinical Child and Family Psychology Review*, 18(4), 328–345.
- A. Metz, L. Bartley, H. Ball, D. Wilson, S.F. Naoom, P. Redmond. Active implementation frameworks for successful service delivery: Catawba County child wellbeing project. *Research on Social Work Practice*, 25 (4) (2015), pp. 415-422, [10.1177/1049731514543667](https://doi.org/10.1177/1049731514543667)
- Blanchard, A. K., Sangha, C. A. T. M., Nair, S. G., Thalinja, R., Srikantamurthy, H. S., Ramanaik, S., ... & Bruce, S. G. (2017). Pursuing authenticity from process to outcome in a community-based participatory research study of intimate partner violence and HIV vulnerability in North Karnataka, India. *Qualitative Health Research*, 27(2), 204-214.
- Bugeja, L., Dawson, M., McIntyre, S., & Walsh, C. (2015). Domestic/Family violence death reviews: An international comparison. *Trauma, Violence, & Abuse*, 16(2), 179-187.
- The Canadian Press. (2017). Quebec government to examine causes of domestic violence. CTV News. Retrieved from: <https://montreal.ctvnews.ca/mobile/quebec-government-to-examine-causes-of-domestic-violence-1.3697308?autoplay=true>
- Casanueva, C., Martin, S. L., & Runyan, D. K. (2009). Repeated reports for child maltreatment among intimate partner violence victims: Findings from the National Survey of Child and Adolescent Well-Being. *Child Abuse & Neglect*, 33(2), 84-93.
- Children's Aid Society of Peel v. T.R., 2022 ONCJ 268 (CanLII), <https://canlii.ca/t/jpq9b>, retrieved on 2022-11-23
- CMHA Thunder Bay. *Thunder Bay Situation Table*. (n.d.). Retrieved from: <https://thunderbay.cmha.ca/our-services/thunder-bay-situation-table/>
- English, D. J., Upadhyaya, M. P., Litrownik, A. J., Marshall, J. M., Runyan, D. K., Graham, J. C., & Dubowitz, H. (2005). Maltreatment's wake: The relationship of maltreatment dimensions to child outcomes. *Child Abuse & Neglect*, 29(5), 597-619.
- Fallon, B., Chabot, M., Fluke, J., Blackstock, C., Sinha, V., Allan, K., & MacLaurin, B. (2015). Exploring alternate specifications to explain agency-level effects in placement decisions regarding Aboriginal children: Further analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect Part C. *Child Abuse & Neglect*, 49, 97-106.
- Fallon, B., Filippelli, J., Lefebvre, R., Joh-Carnella, N., Trocmé, N., Black, T., ... Stoddart, J. (2020). *Ontario Incidence Study of Reported Child Abuse and Neglect-2018 (OIS-2018)*. Toronto, ON: Child Welfare Research Portal.
- Fixsen, D., & Blase, K. (2015). *Active Implementation Practice and Science*. Retrieved from: <https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-Briefs-1-ActiveImplementationPracticeAndScience-10-07-2016.pdf>
- Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2015). Implementation science: international encyclopedia of the social & behavioral sciences. In *International Encyclopedia of the Social & Behavioral Sciences* (pp. 695-702). Elsevier Inc.

- Hamilton, L. H. A., Jaffe, P. G., & Campbell, M. (2013). Assessing children's risk for homicide in the context of domestic violence. *Journal of Family Violence, 28*(2), 179-189.
- Hazen, A. L., Connelly, C. D., Kelleher, K., Landsverk, J., & Barth, R. (2004). Intimate partner violence among female caregivers of children reported for child maltreatment. *Child Abuse & Neglect, 28*(3), 301-319.
- Hester, M. (2007). *Making an impact: Children and domestic violence: A reader* (2nd Ed.). London, Philadelphia: J. Kingsley Publishers.
- House of Commons. (2015). *Promising practices to prevent violence against women and girls: Report of the Standing Committee on the Status of Women*. Ottawa, ON: Standing Committee on the Status of Women.
- Humphreys, C., Diemer, K., Bornemisza, A., Spiteri-Staines, A., Kaspiw, R., & Horsfall, B. (2019). More present than absent: Men who use domestic violence and their fathering. *Child & Family Social Work, 24*(2), 321-329.
- Humphreys, C., Kertesz, M., Healey, L., & Mandel, D. (2019). Shifting practice in domestic violence: child protection workers partnering with mothers. In *Intersections of Mothering* (pp. 194-205). Routledge.
- Jaffe, P. G., Campbell, M., Hamilton, L. H. A., & Juodis, M. (2012). Children in danger of domestic homicide. *Child Abuse & Neglect, 36*(1), 71-74.
- Jaffe P., Campbell M., Reif, K., Fairbairn J., David R. (2017) Children Killed in the Context of Domestic Violence: International Perspectives from Death Review Committees. In: Dawson M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.
- Jaffe, P. G., Dawson, M., & Campbell, M. (2013). Developing a national collaborative approach to prevent domestic homicides: Domestic homicide review committees. *Canadian Journal of Criminology and Criminal Justice, 55*(1), 137-155.
- Jaffe, P., Scott, K., & Straatman, A. L. (Eds.). (2020). *Preventing domestic homicides: Lessons learned from tragedies*. United Kingdom: Elsevier Science.
- Jenney, A., Mishna, F., Alaggia, R., & Scott, K. (2014). Doing the right thing? (re) considering risk assessment and safety planning in child protection work with domestic violence cases. *Children and Youth Services Review, 47*, 92-101.
- Jones, C., Bracewell, K., Clegg, A., Stanley, N., & Chantler, K. (2022). Domestic homicide review committees' recommendations and impacts: A systematic review. *Homicide Studies, 10887679221081788*.
- Kohl, P. L., Edleson, J. L., English, D. J., & Barth, R. P. (2005). Domestic violence and pathways into child welfare services: Findings from the National Survey of Child and Adolescent Well-Being. *Children and Youth Services Review, 27*(11), 1167-1182.
- Kuijpers, K. F., van der Knaap, L. M., & Winkel, F. W. (2012). Risk of revictimization of intimate partner violence: The role of attachment, anger and violent behavior of the victim. *Journal of Family Violence, 27*(1), 33-44.
- Lewandowski, L. A., McFarlane, J., Campbell, J. C., Gary, F., & Barenski, C. 2004. "He killed my mommy!" murder or attempted murder of a child's mother. *Journal of Family Violence, 19*(4), 211-220.

- McTavish, J. R., MacGregor, J. C., Wathen, C. N., & MacMillan, H. L. (2016). Children's exposure to intimate partner violence: An overview. *International Review of Psychiatry, 28*(5), 504-518.
- Nixon, K. L., Bonnycastle, C., & Ens, S. (2017). Challenging the notion of failure to protect: Exploring the protective strategies of abused mothers living in urban and remote communities and implications for practice. *Child Abuse Review, 26*(1), 63-74.
- Olszowy, L., Jaffe, P., & Saxton, M. (2021). Examining the role of child protection services in domestic violence cases: lessons learned from tragedies. *Journal of Family Violence, 36*(8), 927-939.
- Ontario Domestic Violence Death Review Committee (Ontario DVDRC). (2015). *Domestic Violence Death Review Committee 2012 annual report*. Toronto: Office of the Chief Coroner.
- Ontario Incidence Study of Reported Child Abuse and Neglect-2018 (OIS-2018). Toronto, ON: Child Welfare Research Portal.
- Reif, K., & Jaffe, P. (2019). Remembering the forgotten victims: Child-related themes in domestic violence fatality reviews. *Child Abuse & Neglect, 98*, 104223.
- Scott, K. L., Thompson-Walsh, C., & Nsiri, A. (2018). Parenting in fathers who have exposed their children to domestic violence: Identifying targets for change. *International Journal on Child Maltreatment: Research, Policy and Practice, 1*(1), 51-75.
- Simpson, J. (2009). *Everyone belongs: A toolkit for applying intersectionality*. Ottawa: Canadian Research Institute for the Advancement of Women (CRIAW).
- Statistics Canada. (2018). *Family violence in Canada: A statistical profile, 2017*. Statistics Canada, Catalogue no. 85-002-x. Ottawa, ON. Retrieved from: https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2018001/article/54978-eng.pdf?st=sRUW_OYL
- Storer, H. L., Lindhorst, T., & Starr, K. (2013). The domestic violence fatality review: Can it mobilize community-level change? *Homicide Studies, 17*(4), 418-435
- Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., & Black, T. (2010). *Canadian incidence of reported child abuse and neglect–2008: Major findings*. Ottawa, ON: Minister of Public Works and Government Services Canada.
- Women's Shelters Canada (2022). *Child Welfare Practices and Policies in Canada*. <http://endvaw.wpenginepowered.com/wp-content/uploads/2022/11/Child-Welfare-report-1.pdf>