

Utilizing Information and Communication Technologies for the Provision of Child Welfare Services During the COVID-19 Pandemic

Policy Brief



Policy Bench

**Fraser Mustard Institute for
Human Development**

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Acronyms

ADHD: attention deficit hyperactivity disorder

CAWS: Canadian Association of Social Workers

CBT: cognitive behavioural therapy

COVID-19: Coronavirus disease 2019

CYFSA: The Child, Youth, and Family Services Act

ICBT: internet cognitive behavioural therapy

MD: Maternal depression

PCIT: parent-child interaction therapy

PHIPA: Personal Health Information Protection Act

PPE: Personal Protective Equipment

RCT: randomized clinical trial

TF-CBT: trauma-focused cognitive behaviour therapy

VAV: video-assisted visitation

VC: Videoconferencing

Executive Summary

Issue: What is the evidence regarding utilizing information communication technology (ICT) to deliver child welfare services during the COVID-19 pandemic?

Background: The COVID-19 pandemic poses a range of unexpected and unprecedented challenges to families and child welfare services. The imbalance between increased need for children's support and decreased access to social services due to public health measures creates a gap in service delivery. Consequently, child welfare services transitioned from face-to-face to virtual services. This document investigates ICT usage in child welfare services, including various challenges before the pandemic.

Findings: A review of the literature on technology-assisted parenting services before the pandemic showed that robust evidence supports the feasibility, acceptability and efficacy of these services, given the availability of technological requirements. For other technology-mediated programs such as home visits and foster care services, the evidence is limited and inconsistent, but promising.

There is a dearth of evidence thus far to support the efficacy of ICT for both child welfare and mental health service provision during the pandemic. However, there are some initial reports from European countries during the COVID-19 pandemic, specifically after lockdown, which explored new initiatives for using ICT for child welfare service delivery, including challenges, recommendations, and lessons learned.

Policy Recommendations: the COVID-19 pandemic provides policymakers with a unique opportunity to re-think the strengths and weaknesses of current child welfare programs and plan for a more effective system that incorporates ICT in the implementation of services and programs. Based on the reviewed evidence, this brief presents recommendations in four core areas: First, the child welfare system should be scaled up based on the emerging needs through: a) improving virtual services, b) upgrading the research agenda, and c) enhancing information provision. Second, guidelines for the appropriate use of different digital technology platforms should be developed to help child welfare workers determine which platforms to use under which circumstances, and to highlight concerns related to privacy, security, confidentiality and safety. The third recommendation focuses on building capacity for child welfare workers to conduct virtual sessions successfully while managing the risks associated with virtual service delivery. Finally, there is a need for enhanced intersectoral collaboration to decrease the digital divide, improve current technical and technological requirements and develop alternative child maltreatment reporting channels.



1.0 Introduction

The COVID-19 pandemic presents unprecedented challenges to the world. Due to the actions taken by governments to control the spread of COVID-19, children are more vulnerable to increasing threats to their safety and wellbeing, such as maltreatment, gender-based violence, social exclusion and separation from caregivers (UNICEF, 2020a). According to the World Health Organization (2020), violence against children is the hidden crisis of the COVID-19 pandemic. Based on the available evidence (Sistovaris et al., 2020; The Alliance, 2020c), we expect intensified child protection risks, such as food insecurity, educational challenges, malnutrition as well as new emerging hazards to be added to the socioeconomic impacts of COVID-19. These new hazards include neglect and lack of parental care, mental health and psychological distress and increased exposure to violence and abuse. Some children are more vulnerable to these risks, particularly those without parental/family care, alternative care residents and children who recently left alternative care. A report by Raising Canada (2020) on threats to childhood in Canada and the impact of the pandemic highlighted in its executive summary that "... most of the top 10 threats to childhood identified in Raising Canada 2019 [the previous year's report] show signs they may be increasing – or are in danger of increasing – because of the effects of COVID-19¹."

During the COVID-19 pandemic, many services, including child welfare services, have dealt with transitions from face-to-face to remote service delivery using information and communication technologies (ICT).

This brief investigates the evidence for utilizing ICT to deliver child welfare services during the COVID-19 pandemic. It is organized in 9 sections: sections 1 to 4 review the use of ICT in the field of child welfare in general and the efficacy of these interventions. Section

¹ These top 10 threats to childhood in Canada are listed as: unintentional and preventable injuries, poor mental health, child abuse, poverty, infant mortality, physical inactivity, food insecurity, systemic racism and discrimination, vaccine-preventable illnesses and bullying (Raising Canada, 2020).

5 presents some of the best practices of utilizing ICT in mental health services and the implications for child welfare services. After a brief review of the effects of the pandemic on children and families in section 6, the experience of utilizing ICT for child welfare services during the COVID-19 pandemic is described in section 7. Finally, sections 8 and 9 summarize the findings and implications for policy.

The World Health Organization defined telehealth as "delivery of health care services, where patients and providers are separated by distance" (World Health Organization, 2016). Child welfare services benefit from technology in two main categories, described in sections 1.1 and 1.2: direct contact with clients and ancillary care to support administrative and quality improvement activities.

1.1 ICT for direct contact with clients in the welfare systems

1.1.1 Emails and text messaging

Common forms of ICT use by both service providers and clients include email and text messaging. Many service providers use emails for daily tasks such as communications with their clients, scheduling appointments, and delivering information. Text messaging is a comfortable means of communication for youth and young adults (Breyette & Hill, 2015). Text messages are also being used widely by care providers (Lustgarten et al., 2020). A survey among child welfare workers in the US (Breyette & Hill, 2015) revealed about 91% of the workers use emails and 65% of them benefit from text messages, for communication with their young clients. Almost two-thirds of the responders believe that emails and text-messages made their work with youth easier.

1.1.2 Phone and mobile applications

Mobile devices, such as smartphones, tablets and laptops are widely used by child welfare agencies during fieldwork for different purposes, such as case management, connections between foster youth and foster parents, and family visitations (Hughes, 2018)

Mobile systems/devices in the field: Child welfare workers can benefit from using mobile applications for different purposes, including family reunification efforts, training programs, and receiving and delivering data from child welfare cloud-based platforms. Moreover, some mobile apps provide assessment tools and resources for child welfare fieldwork. For example, a list of free mobile apps accessible for fieldwork is maintained by the Academy for Professional Excellence, a project by the San Diego State University School of Social Work² (Hughes, 2018).

Mobile apps for child welfare case management: In addition to fieldwork, other mobile applications can also be used for purposes such as preparing caseworkers for client visits,

² Academy for Professional Excellence: 26 free mobile apps are accessible from this link: [ICWA Guide Browser-Based App - Academy for Professional Excellence \(sdsu.edu\)](https://www.sdsu.edu/~apex/ICWA-Guide-Browser-Based-App-Academy-for-Professional-Excellence)

providing training materials for investigations in the field, and creating a secure and efficient way to conduct assessments and fill out forms³.

Mobile apps for foster youth and foster parents: these applications can deliver a variety of services, including connecting people to agencies, organizations and experts in the child welfare field near their locations and providing support to foster parents (Hughes, 2018). In this area, the pros and cons of smartphone technology are still under debate. Mobile phones can simplify youth reconnection with their families, facilitate prosocial skill learning, help children remain responsive and develop time management skills. In contrast, child welfare personnel have raised concerns about the use of mobile phones among children in foster care, including potential harm to youth-caregiver relationships and the creation of distrust when caregivers attempt to limit or control cell phone use (Alford et al., 2019).

1.1.3 Videoconferencing (VC)

Video-assisted visitation (VAV) is a VC practice to connect foster care children with their family members virtually to enhance reunification. The results of a survey of child welfare workers who engaged in family reunification programs in the US highlighted the advantages of this method for: strengthening teamwork, relationship maintenance, therapeutic values and overcoming distance barriers. However, about 30% of the respondents noted some disadvantages of VAV, including technological problems (such as access or difficulties with setting up technology and interruptions in audio or video service) and communication limitations compared with face-to-face communication (e.g. challenges related to the age of the child or being unable to conduct a thorough assessment). Limited attention spans among younger children may also hinder the use of VAV, as they may prefer to play instead of engaging in communication over the monitor (Quinn et al., 2015).

1.1.4 Online portals

Online portals are useful methods for providing resources and information in different areas of child welfare services. For example, iFoster⁴ is a non-profit American portal designed to fill the connection gaps between youth in the child welfare system and the other stakeholders such as external corporations, foundations and government agencies who can provide the resources to help them succeed. Fosterport Resource Portal, TeenParent.net and Foster Care to Success are other examples of online portals for foster care in the US (Hughes, 2018).

³ A list of available social work case management is accessible from this link: [Best Social Work Case Management Software 2020 | Reviews of the Most Popular Tools & Systems \(capterra.com\)](#)

⁴ <https://portal.ifoster.org/>



1.2 ICT for ancillary care in Child welfare

1.2.1 Cloud-based information system and case management tools

Many countries in North America and the European Union benefit from using large computer systems to manage child welfare data. Ontario implemented the Child Protection Information Network (CPIN) funded by the Ministry of Children, Community and Social Services to modernize and replace a myriad of information systems used by children's aid societies. In 2020, 39 Children's Aid Societies in Ontario use CPIN (OACAS, 2020). CPIN shares confidential child protection information securely; manages case files and finances; and tracks the protection services children have received anywhere in Ontario and their results (Ontario Ministry of Children, Community and Social Services, 2020). There are 12 Indigenous-led children's aid societies across Ontario that have control over child welfare services for Indigenous children and are not included in CPIN. Services for Indigenous peoples living on reserve are under federal jurisdiction, and the recent *Act respecting First Nations, Inuit and Métis children, youth and families*⁵ affirmed the right of Indigenous peoples to exercise jurisdiction over child and family services and deliver solutions that best suit their needs (Government of Canada, 2020).

⁵ The Act came into force January 1, 2020

The US has also initiated various cloud-based information systems, including the Comprehensive Child Welfare Information System (CCWIS) and others⁶ (Alford et al., 2019). CCWIS Final Rule was introduced in 2016 by the US government (Children's Bureau, 2017), to improve the quality of data collection across states, share efforts and access to data across agencies and tailor the new technology systems to each state's unique needs (Corrigan, 2019). Some states have implemented additional options for technological support, including video-assisted visitation in family reunification programs, apps with information about screening abuse, local and federal statutes for staff conducting home visits, and mobile options for documentation of case notes (Hughes, 2018). After initiating CCWIS, many states have benefited from its real-time analytics⁷. Various states in the US implemented a web-based system to store and analyze statewide child welfare administrative data⁸. Child maltreatment online reporting systems have online portals for receiving child abuse and neglect reports by various states⁹ (Hughes, 2018).

1.2.2 Interagency Data-Sharing Systems

Based on the Statewide Automated Child Welfare Information System (SACWIS) in the US, many states developed their own databases to share child welfare information. For instance, Denver and Colorado developed a Medical Passport System to share and track information on screening diagnostic and treatment appointments for children who enter foster care. Medical clinics and providers can also enter appointment information and visit notes directly into the system. As another example, Los Angeles County's Department of Child and Family Services (LA DCFS) developed an information sharing system between social workers and school districts. This system aimed to identify foster children and youth and provide them with the services they need for academic success (Hughes, 2018).

1.2.3 Social Media

Utilizing social media as a communication platform in public child welfare is still a new but popular practice, especially with the increasing use of smartphones. One US study from 2015 found that 12.6% and 44% of child welfare workers used social media directly or

⁶ For example, Statewide Automated Child Welfare Information System (SACWIS), National Child Abuse and Neglect Data System (NCANDS), Adoption and Foster Care Analysis and Reporting System (AFCARS), and Child Welfare Information Gateway (CWIG). Source: Alford et al. (2019).

⁷ For example, in Indiana, the new system's real-time analytics helps to measure the impact of agency initiatives —. After starting HMIS ClientTrack and DV ClientTrack in Indiana's Department of Child Services, they measure a decrease in stays under 15 days in foster care from 13.9% to 4.9% (Noveck, 2014), 2014). Child Welfare Services-California Automated Response and Engagement System (CWS-CARES) in California, is another example. All of Child Welfare Digital Services (CWDS) implementation related information and documents can be found here: <https://cwscms.osi.ca.gov/Portal/Digital-Services-Implementation-Portal>

⁸ Some examples are California's Child Welfare Dynamic Report System, Results Oriented Management (ROM) Systems, Texas' Data Enhanced Online Management Support (DEMOS) and Utah's Online Analytic Processing (OLAP). The Interstate Compact on the Placement of Children (ICPC) System is another cloud-based system to quickly place children across state lines. The National Electronic Interstate Compact Enterprise (NEICE) is a national electronic system for quickly and securely exchanging all the data and documents required for ICPC. <https://aphsa.org/OE/AAICPC/NEICE.aspx>

⁹ Arizona, Delaware, Georgia, Kansas, Kentucky, Missouri, Pennsylvania, and Texas

indirectly with clients, respectively (Breyette & Hill, 2015). In another study (Sage & Sage, 2016), only 20% of child welfare workers stated that they never used social media to look for client information. Child welfare workers have reported a number of uses of social media in their work. For example, through social media, child welfare workers may find kin for youth in care or have better access to children-in-care¹⁰ who are vulnerable to becoming disconnected, especially those who are harder to reach through traditional methods, such as runaway or homeless youth (Hughes, 2018). Child welfare workers also benefit from social media by improving communication with foster parents, attorneys, and co-workers. One survey of 171 child welfare workers in eight states in the US found that many workers used social media to search for clients and believe it is acceptable in some situations, such as locating a missing parent or being aware of client risk factors to complete a child welfare assessment¹¹ (Sage et al. 2017). One large study among Canadian and American social workers¹², including child welfare services (Mishna et al., 2019) found that a significant majority of respondents reported informal ICT use to interact with their clients (78% of the Canadian and 80% of the American sample). The most common reasons for using ICT were scheduling appointments, additional practical information/resources, check-in or brief updates and receiving additional therapeutic information. About 40% of the sample (39.6% of Canadians and 42.7% of the US participants) did not talk about informal ICT use with their supervisors or colleagues. These findings suggest that practices and policies among individual child welfare agencies and supervisors can influence the use and acceptability of ICT among workers, and point to the potential need for agency guidelines and training on the use of ICT such as social media (Sage et al., 2017).

Social media can also be an outlet for youth in foster care. Some of the benefits of social media for these youth include: self-expression of their feelings and ideas (e.g. by posting videos, blogs, and other digital venues); connecting with family, friends, and maintaining social ties; and finding support from peers through online community groups – which may

¹⁰ Children-in-care: children who are involved in the child welfare system “who have been removed from the care of their original families because of a situation where authorities have deemed their family unable or unfit to look after them properly. In some cases, children are voluntarily placed into care by their parents or guardians. Children can come into care for a variety of reasons including abuse and neglect, illness, death of a parent, addiction issues or conflict in their family, disability, or emotional problems. Some children are placed in care for very short time periods before being returned to their families, whereas others may spend many years in care. Children in care do not include children who remain with or are returned to a parent or guardian under an order of supervision.” Source: <http://mchp-appserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=103824>

¹¹ “Over half of workers (53%) stated that it was acceptable in some situations to search for a client on Facebook that the agency would like to locate, such as a missing parent and about half (49%) had done this. Likewise, 61% of the child welfare workers stated that it was acceptable in some situations to search for a client on a site like Facebook when the information might give insight into client risk factors and close to half (46%) had done this.” (Sage et al., 2017).

¹² The study was an online survey among social workers with direct client contact, with sample size of 2609 and 1225, across Canada and the U.S, respectively.



continue after they leave care and begin living independently (Child Welfare Information Gateway, 2017 and Hughes, 2018). Foster parents may also use social media and other online networks to keep in touch or share information with child welfare workers, other foster parents, or the youth's family members (Child Welfare Information Gateway, 2017).

1.2.4 Predictive Analytics

Different services, such as the health system and child welfare care, use ICT progressively to extract data patterns and trends from datasets and predict outcomes or assign risk categories to individuals or families. Predictive modelling helps to identify the most vulnerable children and their families to apply preventive interventions (Gillingham, 2016). Arranging predictive analytics enables child welfare services to use administrative data for many purposes, including supporting decision-making and improving policies (Casey Family Programs, 2018).

1.2.5 Emerging Technologies for Child Welfare Agencies

There are many new and evolving uses for ICT in the area of child welfare, including: data visualization software, document management systems, Internet of Things (IoT)¹³,

¹³ "IoT is the network of physical devices, vehicles, home appliances and other items embedded with electronics, software, sensors, actuators, and connectivity which enables these objects to connect and

location-based services/geofencing¹⁴, Business Rules Engines (BREs), blockchain and intelligent automation technologies, conversational artificial intelligence platforms, virtual reality, and call center technology (Hughes, 2018).

2.0 Advantages of ICT in Child Welfare Practice

2.1 Reduced barriers to access and increased likelihood of treatment attendance

Virtual or online treatment sessions can help to increase participation rates due to their greater accessibility and efficiency for families. Virtual visits can reduce travel costs and time, including time off from work to travel, planning for attendance, and implementing face-to-face interventions. These benefits are even greater for people living in more remote or rural areas (Nelson, Cain, & Sharp, 2017; Comer et al., 2017; Mishna et al., 2015 and Breitenstein et al., 2014). Video-assisted visitation also helps to increase the frequency of contact between foster children and their families in the reunification process and promotes relationship maintenance, especially for situations where face-to-face access is not possible due to distance (Quinn et al., 2015).

2.2 High acceptability and feasibility

Results of a survey by Breyette and Hill (2015) showed that about 72% of child welfare workers who participated in a survey believe that emails are easy to use and convenient for youth and 52% had the same idea about using text messages. Emails and text messages also support more straightforward documentation and scheduling for their younger clients. Videoconferencing facilitates contact for foster children during the family reunification process (Quinn et al., 2015).

Several studies of technology-assisted parenting interventions revealed optimized convenience, feasibility and acceptability for parents using technology (Hall & Bierman, 2015; Ondersma et al., 2017; Owen, 2020).

exchange data ... IoT uses in child welfare include... Google Glasses for child welfare home visits [to r]ecord assessments and living conditions so workers can accurately share what they saw;...[w]earables for medically fragile children: Monitor health vitals for children with health issues (e.g. diabetes, asthma); [w]earables for visiting workers (e.g. home health aides): Ensure visits are made and medication administered-potentially reduce fraud and abuse; [t]racking devices for transportation companies: Ensure children are safely and accurately shuttled to doctor visits and other appointments." (Hughes, 2018).

¹⁴ "Location-based service (LBS) can be defined as a service that integrates a mobile device location or position with other information to provide added value to a user... Geofencing combine awareness of the user's current location with awareness of the user's proximity to a location that may be of interest... LBS technology (via mobile gadgets such as smartphones or smartwatches) can assist caregivers and local child welfare services in monitoring children activity and even preventing potential crime against children. A child safety and tracking management system by using GPS and/or RFID (Radio Frequency Identification – Bluetooth, wifi, etc.), geo-fencing and an android/iPhone application offers a location-based application which can provide a real-time direct monitoring system to track the activity of child, location, and even enable real-time communications from child, child welfare services agency, and caregivers. The model can also locate missing children using geofencing and emergency messaging services." (Hughes, 2018)



2.3 Supporting ongoing child welfare programs

2.3.1 Parenting services and technology

A review of technology-assisted interventions for parents of young children identified two main categories of interventions (Hall & Bierman, 2015). The first group comprises internet-based platforms and web resources, commonly designed to deliver information to parents and enhance social support. Some examples are online discussion forums/groups, chat rooms, blogs, and social media.

The second group focuses on more interactive methods, such as mobile devices and video conferencing, which can be used to deliver individualized interventions and enhance parental engagement. Some studies have demonstrated that incorporating technology into existing parenting interventions could improve their efficacy (Carta et al., 2013; Sanders et al., 2012). However, there may be differences in receptiveness to technology among parents, which could limit their impact. In a review of technology-assisted parenting studies, Hall and Bierman (2015) concluded that parents with lower socioeconomic status are less interested in using the internet for receiving parenting information versus other forms of delivery. Only 45% of the participants in a survey indicated an interest in receiving parenting advice through the internet; mothers with higher incomes more often preferred receiving daily emails by the internet ($\chi^2 = 16.2$ $p < .001$) (Walker et al., 2012). The widespread use of cell phones across all income levels means that smartphone and mobile apps or text messaging interventions may have greater reach among younger parents.

SafeCare®¹⁵: A success story in technological adaptation in a parenting program

¹⁵ SafeCare® is an 18-week parent training program delivered via home visitation. It contains three, six-session modules that target risk factors for child physical abuse and neglect. These modules include (1) child health, (2) home safety, and (3) parent-child interaction. Each module includes six sessions and is structured based on an assess-train-assess approach. (Source: Self-Brown et al, 2017)

This care model was initiated as an evidence-based program four decades ago in Virginia and provided a framework for successful technological adaptation. The original program was delivered via home visitation and targeted risk factors for child abuse and neglect. For example, the focus of this program's child health component is to train parents to make effective decisions related to child health, prevent child illness and injury, and assist parents in seeking appropriate healthy treatments for children when a disease or injury occurs (Self-Brown et al. 2017).

Some of the technological adaptations (Guastafarro & Lutzker, 2019) in SafeCare include:

- i. Delivering the program through a tablet, web-based approach (Self-Brown et al., 2017)
- ii. Using slide shows or videos to reduce provider training time and in-home intervention time;
- iii. Adding daily use of phone calls and text messages to the protocols to maintain contact with a family between sessions to improve their engagement;
- iv. Using smartphones to deliver the program to reduce the face-to-face time for implementing some of the modules; this approach yielded similar results as the standard in-person delivery method for example, in lowering the household hazards (Jabaley et al., 2011). In one study, 371 low-income mothers participated in the SafeCare training model using either the standard approach or a technology-assisted version of the intervention using daily phone calls and text messages. The results demonstrated more frequent use of parenting behaviours and enhanced responsive parenting in the cellphone assisted group compared to the standard intervention group without a cell phone and the control group (Carta et al. 2013). Another study demonstrated significant long-term effects (over a 12-month follow-up period) for a cellphone supported version of the parent-child interaction model of SafeCare and a higher retention rate among participants in the intervention group than the traditional delivery method (Lefever et al. 2017).

2.3.2 Home visiting and technology

Home visiting programs for high-risk families may reduce child maltreatment and promote positive parenting outcomes, particularly for child neglect cases, which comprise the majority of child maltreatment cases (Chaffin et al., 2012). However, a difficulty in administering these interventions is getting families to remain in the program. One strategy to improve participation rates and reduce attrition is using cell phone reminders, and text messages to encourage ongoing involvement. In one study, the addition of cell phones to a home visitation intervention also increased both adaptive behaviours in children and growth in parenting, as more mothers in the cell-phone enhanced version of the program practiced newly learned parenting behaviours (Carta et al. 2013).

Early Childhood Home Visiting (EHV) is one of the most widely adopted and accepted programs for child maltreatment prevention in the US, with services for up to 550,000 families per year. The use of interactive technology to supplement EHV programs enhances the service providers' capacity without requiring extensive training or modification: In one

study, a multicomponent computer-based supplement was added to a home visiting program to deliver 20-minute sessions to mothers. However, despite good acceptability and feasibility of the software, there was no evidence that the technology-assisted version of the program significantly enhanced child maltreatment outcomes or risk factors (Ondersma et al., 2017).

2.3.3 Supporting foster children and parents

In Section 1.1.2 and 1.2.3, we explained the application of various mobile apps and social media for foster youth and parents' services. Videoconferencing can also facilitate contact during the family reunification process through improving "family bonding, reviving, family energy and connection" (Quinn et al., 2015).

A program from California called the '1 Laptop Program'¹⁶ demonstrates the benefits of having access to a home computer for youth in foster care. A series of studies to evaluate the program was conducted from 2013-15 among 730 youth in California (Placer County, Madera County and Los Angeles County) who received laptops through the program. The results showed that providing access to a computer at home led to significant improvements in grades and life satisfaction, as well as reduced depression. The qualitative results supported improved social connectedness, such as relationships with both families and friends, job search, enhanced communication with teachers, employers and lawyers, and looking for learning opportunities¹⁷ (Goldbach, 2016).

2.3.4 Reporting and disclosure of child maltreatment

Communication technologies are increasingly used to report child maltreatment. The reporting could be through phone or online portals, by schools and healthcare staff, neighbours or family members. Technology-facilitated approaches to maltreatment disclosure, such as text messaging and online communication, may be an important alternative approach for young people; however, few studies have examined these approaches (Cash et al., 2020). In addition to phone lines, some services in the US¹⁸ and

¹⁶ "The 1-Laptop program met the hardware and software requirements by partnering with the MAR (Microsoft Authorized Refurbisher) program to access low cost and durable, business-class laptops and free productivity software (Microsoft Windows and Office). iFoster also provided in-house Tier 1"

¹⁷ The youth reporting a program laptop reported better grades in school than youth who had computer access from another source ($t(48) = -2.40, p < .05$). The participants who had a program laptop reported significantly higher life satisfaction than those who did not report having a laptop from the program yet ($t(44) = -2.20, p < .05$) and their depression went down over time ($t(44) = 9.62, p < .001$). Also quality of relationship with biological parents improved over time ($t(42) = -2.50, p < .05$). Life satisfaction increased over time for the group who used program laptop ($t(41) = -5.11, p < .001$).

¹⁸ Crisis Text Line (CTL), launching in August 2013 in the US, was among the first to provide a free, 24/7 SMS line for in the United States. CTL's volunteer crisis counsellors help the texters with suicidal behaviour, bullying, abuse, and other crises. Other services, such as the 24/7/365 Crisis Hotline, Teens Helping Teens (TEEN LINE), and Mind Infoline, also provide SMS-based crisis services for young people contacting them, usually during limited hours or about limited topics. TEEN LINE is a peer-based education and support, non-profit, community-based organization. It helps distressed youth address their problems by using an

Canada¹⁹ offer SMS-based crisis lines to support youth, which allows them to contact counsellors through text messages to disclose maltreatment (Teenline, 2017, and Kids Help Phone, 2020).

One study by Cash et al. (2010) analyzed text messages sent by young people through a crisis service and found that text-based crisis services can effectively provide a safe and supportive environment for youth to facilitate maltreatment disclosure. The researchers identified two crucial points in maltreatment disclosure through text message conversations. First, crisis counsellors usually provide sympathy and affirmation after the initial disclosure. The next step and the most central point after disclosure is the discussion of mandatory reporting. Children are generally concerned about confidentiality and anonymity. Therefore, the counsellors should be trained to appropriately conduct the discussion through text messaging (Cash et al., 2020). Issues of confidentiality mean that disclosure by victims and research on maltreatment disclosure is uncommon (Schwab-Reese, et al., 2019). However, one review summarized some of the factors relevant to disclosure process, including “children’s age, gender, relationship to the offender, fear of negative consequences, perceived responsibility for the abuse, and characteristics of the abusive event” (Lev-Wiesel et al., (2019). Inadequate control over the disclosure process may inhibit disclosure of maltreatment, while perceived support by children and youth, and experiencing a sense of anonymity and confidentiality may facilitate disclosure (Ungar et al., 2009).

2.3.5 Intervention programs: counselling, trauma-focused cognitive behaviour therapy (TF-CBT) and parent-child interaction therapy (PCIT)

Videoconference is one of the most common forms of ICT use in delivering counselling services. Owen (2020) provided a number of reasons for receiving virtual counselling services for parents or caregivers of young children (0–8 years) who were referred through normal referral criteria to the clinicians as part of parenting services. These reasons include: family difficulties that impact caregiving, the child’s developmental or emotional challenges, having children with behavioural challenges, child or parental health issues, parental mood issues and post-natal depression and anxiety. Appendix1, provides a list of studies in which virtual counselling with parents was a part of the intervention.

Trauma-focused cognitive behavioural therapy (TF-CBT) is a structured components-based treatment protocol, targets children and adolescents with experience of traumatic events with emotional and/or behavioral problems. This treatment that includes both parent and child (Cohen et al.,2011). Based on the available evidence, TF-CBT remained the best-supported treatment for children following child maltreatment (Mavranezouli et al., 2020; Bennett R. S. et al., 2020). The evidence for online TF-CBT is limited, although

international hotline, community outreach and online support. Their main vision is providing support before problems become a crisis (Teenline, 2017).

¹⁹ In Canada, Crisis Text Line powered by Kids Help Phone provides 24/7 texting service for youth across Canada. They can connect with a trained, volunteer counsellor without any need to a data plan, internet connection or app (Kids Help Phone, 2020). Also, Good2Talk provides similar services in Ontario and Manitoba to post-secondary students.

promising. For example, one pilot study showed clinically meaningful changes in the symptoms after treatment, with low treatment attrition among children and adolescents ages 7–18 living in seven diverse communities across South Carolina (Stewart et al., 2020)²⁰. Another study on adjudicated youth in residential treatment facilities showed that a mix of online and face-to-face TF-CBT, compared with the online-only method, was associated with the significantly higher completion of the treatment and lower PTSD and depressive symptoms (Cohen et al., 2016).

Parent-child interaction therapy (PCIT) is another innovative parenting program for child externalizing behavior problems that has shown to be effective for parent-child dyads who have experienced maltreatment or are at high-risk of maltreatment (Thomas et al., 2012). One review showed positive evidence for online delivery of PCIT with an overall effect size larger than for online CBT, Triple P²¹-CBT, and psychoeducative interventions (Appendix 1) (Flujas-Contreras; García-Palacios & Gómez, 2019).

3.0 Challenges of ICT usage in child welfare Practice

3.1 Physical limitation

3.1.1 Access to reliable technology

Clients' access to a reliable and efficient internet connection and a technological device with adequate audio and video capabilities is one of the greatest challenges of ICT use for child welfare (Fisk et al., 2020; Hall and Bierman, 2015). Racine et al. (2020) discussed that access to the internet per se does not guarantee adequate and accessible technological support, specifically in more socioeconomically disadvantaged families.

Digital divide: Moreover, access to reliable technology is unequal across the population, resulting in what is known as the "digital divide." The digital divide is defined as "the gap that exists between individuals who have access to modern information and communication technology and those who lack access" (Steel, 2019) and is generally the result of cultural or socio-economic factors (Badillo-Urquiola et al., 2019).

In Canada, about one in 10 Canadian households do not have internet at home and should rely on mobile internet or available services in workplaces, schools and libraries. Moreover, people living in rural and remote areas and Indigenous people have disproportionately affected: Only 41% of connected rural households have access to the minimum speed targets²². This access is even less (31%) in First Nations reserves (Knight, 2020). In 2019, the federal government of Canada introduced 'Canada's Connectivity

²⁰ More detailed information is available in Appendix 1.

²¹ Triple P, Positive Parenting Program, is an evidence-based parenting programs, backed up by more than 35 years of ongoing research and implemented in 25 countries (Triple P, 2020a). Its headquarter is in Australia and has staff based in Canada (Triple P, 2020b).

²² 50 Mbps download/10 Mbps upload, outlined by Canada's Connectivity Strategy



Strategy, High-Speed Access for All' to address the national connectivity gap and announced a \$1.7 billion budget to support access to affordable high-speed internet for all Canadians. Since Canada is a large country with different geographic and topographical challenges, varied technologies, such as wireline, wireless and satellite, are needed to reach universal connectivity and provide access at the target speeds and above to rural and remote Canadians (Innovation, Science and Economic Development Canada, 2019).

Access to technology among foster youth: Some evidence from the US suggests that youth in foster care have lower access to technology. The results of three studies in Los Angeles County found that access to a computer at home is only 5% for rural and 21% for urban foster youth. These rates were much lower than the access rates of 90% for all youth in the US and 79% for low-income youth (Goldbach, 2016). Another study in the US disclosed that about 43% of foster parents of high-risk foster teens believed that access to technology facilitates high-risk behaviours. Therefore, to protect their teens from online and offline risks, they intentionally did not allow them to have or use internet-enabled devices at home (Badillo-Urquiola et al., 2019).

Recently, programs in Canada and the US have been introduced to improve access to digital technologies among foster youth. For example, a pilot program was launched in 2019 in California's foster system offering free cellphones and internet access to youth aged 13-26 who are in foster care or have aged out of care. This initiative aims to help bridge the digital divide between children in foster care and their peers. Moreover, young adults who were

formerly in the foster system experience high levels of unemployment and homelessness. In partnership with the state's welfare departments, this program will also provide digital literacy training through classes for online safety, effective social media use, and how to present professionally for potential employment (Weber, 2019).

In Canada, the TELUS Mobility For Good program by the TELUS company offers a free mobile phone and data plan for two years for 20,000 youth ageing out of foster care. The program helps vulnerable youth to stay connected and gain their independence (TELUS, 2020). By September 2020, across Canada, more than 5400 youth had enrolled in this program (CBC, 2020a).

3.1.2 Inadequate organizational policies and training

One survey among child welfare workers in eight states of the US (Sage et al., 2017) disclosed the insufficiency of clear and practical policies and guidelines as well as the required training for using social media in child social services. The study found that due to the absence of clear guidelines for social media use, child welfare workers often act based on the supervisor's approval. Some participants were uncertain about the appropriate use of social media at work, which led them to take action on their own, resulting in role conflict, overload, burnout, and increased intent to turnover. The study by Sage suggested that child welfare agencies might develop targeted interventions, including training for both workers and supervisors, developing clear agency policies, and workgroups. These interventions may help workers make correct decisions about their work-related social media use.

One literature review by Singer and Brodzinsky (2020) suggested that child welfare workers need new guidelines on how to gauge progress toward the objectives in virtual reunification practices, which is different from face-to-face sessions, to better comprehend the reunification goals. They also should learn how to integrate virtual visits with face-to-face visits as an ongoing part of the reunification process. Other studies also acknowledge the missed opportunities and challenges for child welfare workers in utilizing ICT in their daily work, including inadequate orientation and training for collaboration with IT professionals and problems in navigating the challenges (Bennett E. et al., 2020; Lagsten & Anderson, 2019).

Results of a survey on Canadian and American social workers (not specifically child welfare workers) (Mishna et al., 2019) showed that under one-half of the respondents identified having a workplace policy on informal ICT use²³ (47.4% of the Canadian and 46.4% of the US participants). Among the Canadian participants (n= 2609), about 20% were not aware

²³ The question in this survey was: "Is there a policy related to e-mail, text/instant messaging or social media use with clients in between regular face-to-face service at your workplace?"

of their workplace ICT use policies relevant to their practice. This lack of awareness reached 42% for provincial government and 52% for federal level policies²⁴.

In addition to the need for more training in the use of ICT among child welfare workers, Singer and Brodzinsky (2020) found that training programs for foster parents are also important, not only in decreasing placement disruptions, but also for coordination of their interactions with the child in their care, birth parents and the social welfare system. The researchers concluded that the birth families and foster families' knowledge and access around various visual communication platforms such as FaceTime, Zoom, and Skype for virtual visits should be assessed and provide appropriate training where necessary. Moreover, child welfare workers should train and guide foster parents about their expectations, roles and responsibilities during virtual visits compared to in-person visits²⁵.

3.1.3 Access to a conducive environment

Access to a private and confidential space is important for providing both in-person and virtual child welfare services to families and children such as assessments, home visits, counselling, and mental health support. However, this option is not always available for families, particularly for low-income families with limited physical space. Privacy may be critical for the assessment and identification of child maltreatment and intimate partner violence; yet the presence of other family members at home sometimes means that privacy is not possible. The absence of privacy may prevent maltreatment disclosure (Collin-Vezina et al., 2020 & Golberstein et al., 2020).

One literature review by Racine et al. (2020) underlined inadequate evidence for the safety of online services in clinically unsupervised settings, such as a personal residence, and the need for safety plans and protocols when providing telemental health interventions for children and adolescents (Further discussion on best practices of VC in telemental health services, including important considerations for the appropriate environment, is provided in Section 5.

²⁴ These are the results of answering 'No' to this survey question: "In general, are you aware of policy, privacy laws or regulations related to privacy or confidentiality in the use of e-mail, text/instant messaging or social media relevant to your practice?" and do not include people who answered "Aware, but does not know it".

²⁵ Singer and Brodzinsky (2020) suggested a list of topics for trainings for foster and birth parents including "(a) the benefits of video calls; even with babies; (b) how to determine the best time for virtual visits; (c) how to prepare the child for a virtual visit; (d) how to manage connection problems while maintaining contact between the birth parent and the child; (e) how to engage jointly with each other to support children during a video call; (f) what kinds of props (books, toys, art supplies, snacks) to have available or what activities can be shared; (g) how to engage and maintain the child's attention; (h) how to entice the child back to the call when his or her attention wanders; (i) how to understand the child's behavior when he/she loses interest; (j) how to respond when the child seeks care or comfort from the foster parent; and (k) how to manage differences in expectations or conflicts between the adults that might arise related to scheduling or behavior during the visits."



3.2 Therapeutic limitation

3.2.1 Assessing and treating severe or specific clinical presentations

Some of diverse barriers or challenges for delivering virtual child welfare and telemental health services to children and youth are acknowledged by the below studies, including:

- i) difficulties in sustaining attention to online therapeutic sessions for children with severe attentional difficulties or behavioural outbursts (Racine et al., 2020);
- ii) greater risk for misinterpretation during online treatment or assessment, compared with in-person treatment (Boydell et al., 2014);
- iii) difficulties in identifying and assessing child affect, including dissociation²⁶ when the child is encouraged to encounter negative feelings; as discussing a traumatic experience is a part of a trauma assessment and treatment (Racine, 2020), and
- iv) inability to assess family dynamics and parenting skills compared to in-person visits (Quinn et al., 2015).

²⁶ Dissociation includes separating oneself from reality and is a common symptom in children who have been maltreated (Collin-Vezina & Hebert, 2005).

3.3 Practitioner's abilities to use ICT and conduct the virtual sessions effectively

3.3.1 Clinical knowledge, personal attributes, communication and risk management skills

Conducting successful virtual sessions with clients requires child welfare workers to possess certain personal qualities and skills. Table 1 describes a range of necessary qualities for conducting virtual parenting services that have been identified by both practitioners and managers in an Australian survey by Bennett. et al. (2020).

Table 1: Necessary personal attributes, communication and risk management skills for conducting virtual services

Domain	Attributes
Clinical/practice knowledge and skills	<ul style="list-style-type: none"> • Up-to-date clinical knowledge and skills • Commitment to working in partnership • Experience working in a similar service • Broad knowledge base of topics for working with groups • Contemporaneous documentation
Personal attributes	<ul style="list-style-type: none"> • Problem-solving skills • Flexibility • Ability to work outside the comfort zone • Work under pressure • Awareness of necessary etiquette when conducting group work or client consultations, e.g. tolerating silences during the consultation • Able to multi-skill during consultations, e.g. listen, talk and type to enable documentation of interaction.
Communication skills	<ul style="list-style-type: none"> • Listening skills and empathy • Need to be mindful of the client's environment • Clinician's and client's body language • Communication when working with groups
Risk management	<ul style="list-style-type: none"> • Identify risks for the client (e.g. someone else in the home) • Be able to quickly work out how to manage the risk for the client (e.g. suicidal ideation) • Competence in documenting and reporting the risk

Source: (Bennett E. et al., 2020)

3.3.2 Digital Literacy and Identifying appropriate technology

A child welfare worker or clinician who engages in virtual service delivery also requires various digital knowledge and skills, ranging from basic computer knowledge and interest to learn, to being able to update and use the technologies and solve fundamental technical

problems (Bennett E. et al., 2020). Identifying the best platform for communication depends on knowing various technological parameters, such as the service provider IT infrastructure, clients' access to the internet and devices, caseworkers' experience, the type of information to be communicated in terms of complexity and also privacy restrictions (Waters et al., 2020). If care providers and case managers want to use social media for their work, they should have adequate knowledge and understanding of how social media works in order to have discussions with youth about their social networking and safety online (Hughes, 2018).

3.4 Cultural fit of technologies to work practice

The introduction of new technologies into child welfare agencies has changed the work practice and workplace interactions. For the adoption of ICT in child welfare work to be most effective, there should be a consideration of the cultural context of the work setting and adapt the technology to the work environment and community of practice to ensure cultural fit. (Smith & Eaton, 2014). Bennett E. et al. (2020) conducted a qualitative study on welfare workers and clinicians who engaged in implementing a parenting program in Australia. The study participants referred to some cultural barriers in the use of technology in their work. For instance, some clients and cultural groups may not accept support group programs using technology, and some Indigenous families²⁷ had poor uptake of virtual services, often due to language barriers in using technology for communication.

One review of 31 virtual interventional parenting studies showed that cultural adaptation had not been implemented in most interventions. Moreover, these programs were implemented just based on validated tools for White Americans. This cultural adaptation should go beyond surface-level adaptations, such as hiring diverse actors for videos and develop more culturally appropriate interventions to enhance the services to diverse communities (Corralejo & Rodríguez, 2018).

3.5 Limitations in technological interface design and data quality

Poor user interface design and usability are common problems reported by social workers when using a new information management system, specifically for case management (Ince & Griffith, 2011; Lagsten & Andersson, 2019 and Vogl, 2020-January).

3.6 Ethics in using ICT, privacy, data security and confidentiality

The use of digital technology and social media in child welfare practice raises ethical issues such as privacy, security, and confidentiality. These considerations have been incorporated into the Global Social Work Statement of Ethical Principles, which was developed based on recognizing the inherent dignity of humanity, promoting human rights, social justice and

²⁷ The authors' findings referred to some families such as Torres Strait Islander families or Maori and Pacific families.

other essential values²⁸, and allocates a section for the ethical use of technology in all social work practice and research (International Federation of Social Workers, 2018). Based on these principles, some countries have developed their own national code of ethics. For example, in Canada, the Code of Ethics²⁹ and the Guidelines for Ethical Practice³⁰ were set in 2005 (Canadian Association of Social Workers, 2005), and some provinces, such as Ontario, adopted their own versions. Ontario also developed the Standards of Practice Handbook and briefly acknowledged the importance of information confidentiality in using ICT (The Ontario College of Social Workers and Social Service Workers, 2008). The US developed its own standard in 2017 (National Association of Social Workers et al., 2017).

One study among social workers in Ontario explored the ethical application and adaptation of ICT in traditional clinical social work practice. The researchers found that after three years of using ICT in their work, practitioners were able to "adapt ethical and clinical standards to the new reality and developed their own practice wisdom and deliberate approach" (Mishna et al., 2014).

The Global Social Work Statement of Ethical Principles identified the necessary precautions for potential threats to confidentiality and privacy in the use of ICT. Therefore, special attention is given to the following areas in using technology and conducting virtual sessions: verification of users' identity in online services (e.g. age and location), informed consent for participation in the activities or for posting their photos on social media, and the principle of inclusivity in group-based e-technology (International Federation of Social Workers, 2018). They also underscored the potential drawbacks of asynchronous communication and the unverifiable identities of people who social workers are working with, particularly for some sensitive cases, such as child sexual abuse (Dombo et al., 2014).

The use of emails and text messages also creates some ethical challenges. For example, different corporate service providers usually host emails, such as Gmail, Hotmail, Microsoft Outlook and Apple Mail, or provide services for text messages. Consequently, they are not necessarily a secure or private method of communication (Lustgarten et al., 2020; Breyette & Hill, 2015). Particular concerns are linked to using text messages in child welfare practice, such as confidentiality, counsellor competence, appropriateness of use and misinterpretation of the contents (Breyette & Hill, 2015 and Sude, 2013). There is also a risk of spyware and malware being used to allow access to client's personal health information in email messages (Drummond & Cromarty, 2015). Other ethical considerations in the use of technology in practice include blurred boundaries for workers

²⁸ The right to self-determination and participation, respect for confidentiality and privacy, treating people as whole persons, ethical use of technology and social media, and professional integrity

²⁹ [Code-of-Ethics-and-Standards-of-Practice-September-7-2018.pdf \(ocswssw.org\)](#)

³⁰ [CASW-ACTS Project to Research and Develop a \(casw-acts.ca\)](#)



(i.e. the expectation of being available 24/7³¹), and harassment from clients³² (Breyette & Hill, 2015).

Child welfare agencies are advised to be proactive rather than reactive in developing clear policies and standards for ICT use. These standards should provide clear guidance for social media use in the child welfare setting, as errors may result in profound consequences for children's privacy, confidentiality, or safety (Sage et al., 2017). The confidentiality and privacy of shared information on social media by children-in-care is especially concerning. British Columbia has introduced a social media policy for foster parents to help them ensure the safe use of social media by children in their care. The guide does not recommend the use of social media for children-in-care under 13 years of age. It is also advised that foster parents never use their social media accounts to communicate confidential, sensitive or personal information about a child-in-care (Government of British Columbia, 2018).

³¹ “If I am on vacation or out of the office for personal reasons and I receive a text message, the client expects an immediate response. I respond by saying I am not able to spend time to help them with their concern but provide information about who to contact in the office for immediate assistance” or “The use of personal cell phones for text messaging causes dilemmas to workers. There is no way to block the number. Clients are then able to text anytime of the day, night or weekends. If the worker reads the text, they are in a dilemma if it involves a crisis situation to have to respond during their off hours” (Breyette & Hill, 2015).

³² “... a kid in foster care angry at me, found my son at school using social media and confronted him about me—said some nasty things to him about me. ...” (Breyette & Hill, 2015).

3.7 ICT use and safety

Section 3.1.3 discussed the dearth of evidence on safety concerns about delivering online services in clinically unsupervised settings for children.

Children who use public networks to access social media may unknowingly reveal their address or school name online. For example, some children face safety risks by posting pictures with GPS embedded in them, which potentially exposes their location to online predators, sex traffickers or others who are banned from contact with them, specifically for foster care children (Stott et al., 2017). One literature review by Badillo-Urquiola et al. (2017) also acknowledged inadequate empirical research about adolescent online safety and technology mediation in the home, specifically in the space of foster families. One study of foster parents showed that over half of foster teens reportedly come across high-risk situations involving unsafe people online, sometimes resulting in extreme psychological harm, sex trafficking and rape. These foster parents believed that balancing online safety with technology access for their foster children was a significant challenge (Badillo-Urquiola et al., 2019).

The government of British Columbia's social media policy advised that a child-in-care should be familiar with the safety risks of using social media, including cyberbullying and predatory behaviours and should not post their personal information on social media or interact with unknown people. This policy also advised foster parents on the importance of balancing the child's right to privacy with monitoring their computer or mobile phone use; this monitoring might be adjusted based on the children's age, capacity, and living arrangements (Government of British Columbia, 2018).

3.8 Legal implications of ICT use in child welfare

The increasing use of ICT for service delivery raises significant legal concerns. For instance, one review study underlined the unclear laws governing online practice, such as issues of licensure in providing online social work interventions (Dombo et al., 2014). They found that at the time of the study, only two out of 50 States in the US clearly stated that a social worker must have a license to engage in telehealth. They also found that 35 States required that all supervision be provided face-to-face.

Currently, there is no legislation in Ontario that specifically governs the online delivery of child welfare or social services, generally. However, there are pieces of privacy legislation that apply to these two areas of practice, which can be translated to the provision of services via technology. These pieces of legislation are Part X of the *Child, Youth, and Family Services Act*³³ (CYFSA) and the *Personal Health Information Protection Act*³⁴ ("PHIPA").

One of the stated purposes of the CYFSA is to recognize that sharing information is necessary to plan for and provide services to achieve the best possible outcome for children and

³³ *Child, Youth, and Family Services Act*, SO 2017, c 14, Sched 4 [CYFSA].

³⁴ *Personal Health Information Protection Act*, SO 2004, c 3, Sched A [PHIPA].

families.³⁵ With these considerations in mind, the legal implications of offering ICT services according to the *CYFSA* and *PHIPA* are examined in Appendix 3 and 4.

4.0 Efficacy of ICT Use in Child Welfare

This brief reviewed published peer-reviewed articles between 2010 and 2020 to investigate the efficacy of utilizing digital technology in the provision of child welfare services during the COVID-19 pandemic. This section focuses on published quantitative or mixed-method studies before the pandemic. Table 2 and Appendix 1 present a summary and the detailed findings of the reviewed studies.

Parenting programs: Considering the large number of studies on technology-assisted parenting programs, we included five systematic review³⁶ and meta-analysis³⁷ studies as the most reliable level of evidence (Ingham-Broomfield, 2016). These five studies reviewed 105 primary-level interventional studies, typically clinical trials with a control group, including no-intervention or face-to-face groups.

For almost all the interventions, the researchers provided free access to high quality internet and any other required technologies, such as mobile phones or tablets. Under these controlled conditions, overall results indicate significant feasibility and acceptability of using technology in parenting programs. Furthermore, the researchers observed that technology-assisted parenting interventions are significantly effective for both parents' and children's well-being. One of the reviews (Harris et al., 2020) concluded that for socially disadvantaged families³⁸, interventions were only significantly effective when they included additional direct contact, such as in-person, videoconferencing or phone calls, compared to the other digital interventions³⁹.

Other Technology-assisted interventions: The remaining four studies reviewed were interventional studies on the use of technology for home visiting (2 trials) (Ondersma et al., 2017 and Carta et al., 2013) and trauma-focused CBT (2 trials) (Stewart et al., 2020 and Cohen et al., 2016). All of the studies made interventions on parents, with or without their

³⁵ *CYFSA*, *supra* note 1 at ss 1(2), 7.

³⁶ A systematic review attempts to identify all studies that meet the eligibility criteria based on the study objectives and assess the validity of the findings of the included studies, to minimize bias. Therefore, systematic reviews provide more reliable findings (Haidich, 2010)

³⁷ Meta-analysis is "[t]he statistical analysis of a large collection of analysis results from individual studies for the purpose of integrating the findings". Meta-analysis is a study design used to assess the results of previous research, typically randomized, controlled trials, to derive conclusions about the body of research. Outcomes from a meta-analysis may include a more precise estimate of the effect of treatment or intervention. Identifying sources of variation in responses; that is, examining heterogeneity of a group of studies, and generalizability of responses can lead to more effective intervention or modifications of management (Haidich, 2010).

³⁸ The researchers defined included studies on social disadvantages families with at least one of the following criteria: low socioeconomic status (i.e., low-income, single parenthood, and/or young parenthood (maternal age at birth of target child \leq 25 years).

³⁹ This study does not clearly define the other (non-direct) interventions. However, it is assumed that web-based, online forums, emails or text messages are considered as non-direct.

children except one study (Stewart et al., 2020) that targeted children aged 7-18 who experienced post-trauma stress due to maltreatment. More details of the reviewed studies are summarized in Appendix 1; however, additional research is required to deliver more robust evidence.

This review did not capture any trial to study efficacious use of technology as a part of child maltreatment disclosure.

Table 2: Interventional studies on the efficacy of ICT usage in child welfare services

Intervention	Target Group	Method	Summary of Findings	Reference
Meta-analysis and systematic review studies on virtual parenting programs				
Technology-Assisted Parenting Interventions (meta-analysis of 9 studies)	Families with at least one of the following demographic challenges: low socioeconomic status, single parenthood, and/or young parenthood; 846 participants	Interventions delivered by computer, cell phone, smartphone, and/or tablet	Interventions that did not include direct contact: no effectiveness; Interventions including contact: significantly effective; Parental psychological well-being: near-significant impact ⁴⁰ ; Intervention length: shorter interventions yielded greater improvements in well-being; Overall: Interventions were associated with significant improvement in parenting and child behaviour.	(Harris et al., 2020)
Online parenting interventions (a meta-analysis of 15 studies)	Parents of children and adolescents with behavioural problems (1668 participants)	online, via computer or mobile/tablet app (both self-directed and clinician delivered).	Online parenting interventions effectively reduce children's behavioural problems, improve parenting behaviours, parental distress, parenting efficacy with long term effects for children and parental outcomes (compared to the waitlist control group); no significant difference between online and face-to-face delivery of parenting interventions in reducing children behavioural problems was observed.	Florean et al., (2020)
Online parenting interventions, 31 studies (and a meta-analysis of 28 studies)	Diverse parental groups	Online forum, video-conference, website, email	Effective in improving parenting variables (parental knowledge, behaviour, and self-efficacy).	(Corralejo & Rodríguez, 2018)
Technology-based parenting interventions (a meta-analysis of 22 studies)	Diverse parental groups	Video-conference (88% of studies), podcast, DVD, tablet	Technology-based parenting interventions are feasible and effective for both parents and children in terms of the usefulness and efficacy for psychological and physical health.	Flujas-Contreras; García-Palacios & Gómez, 2019)

⁴⁰ P-value= 0.051

Online Parenting Programs, 28 studies (and a meta-analysis of 22 studies)	Diverse parental groups (3979 participants)	Different technologies (not specified)	Online parenting programs are effective in improving positive parenting behaviours, parent confidence and satisfaction, positive child behaviours and decreasing negative parent-child interactions, negative discipline strategies, parenting conflicts, parental stress and anger, child anxiety, and parental depression.	Spencer et al. (2019)
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Other studies

Trauma-focused cognitive-behavioural Therapy (TF-CBT)	Children (7-18) who experienced Post Trauma Stress (70 children); not appropriate for children 3-5 years.	Videoconference (in community-based locations of either schools or patient homes)	The results confirmed the feasibility and effectiveness of this intervention. The clinically meaningful symptom changes were observed after treatment for both posttraumatic stress disorder symptoms with large effect sizes.	Stewart et al. (2020)
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Trauma-focused cognitive-behavioural Therapy (TF-CBT)	Adjudicated youth in residential treatment facilities (32 cases)	Web-based TF-CBT training	Web-based training plus live workshop and phone consultation was generally superior to just web-based training and consultation in improving trauma-related symptoms (PTSD and depression).	Cohen et al. (2016)
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Mobile app for Early Home Visitation [EHV],	At-risk families for maltreatment (413 cases)	e-Parenting Program (eight 20-min computer-delivered modules) for mothers during EHV, delivered by iPad or computer-based	Good acceptability and feasibility were recorded. The findings did not support the effectiveness of the app tested for this study, as it was deployed, in decreasing maltreatment within EHV.	Ondersma et al. (2017)
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Home visits with texts messages by cell phone	High-risk mothers for child Maltreatment (245 cases)	Cell phone (added to the SafeCare Program)	Mothers who received cell phones and text messages used more parenting strategies and experienced greater reductions in depression and stress in comparison with the mothers who received training without mobile follow up.	Carta et al. (2013)
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5.0 ICT Usage in Mental Health Services: Best Practices for Child Welfare

Mental health services are widely deploying technology, supported by a large body of literature. Telemental health services have been delivered in different settings and programs such as schools (Koren, 2020); home-based for children and families (Comer et al., 2017; Shimshoni & Lebowitz, 2020) and online family check-up as a family-centred intervention to address child and adolescent adjustment problems (Danaher et al., 2018). One group of Canadian researchers from SickKids Hospital in Toronto, Ontario noted the lack of evidence or guidelines available to address children and youth's virtual mental

healthcare (Doan et al., 2020). They developed a six-pillar framework in response to the rapid transition to virtual service delivery after the COVID-19 pandemic, to be used for educational purposes to support clinicians and trainees (Figure 1). This framework encourages the service providers to consider patient, caregiver, and provider factors to optimize virtual mental health for children and youth by asking critical questions, similar to a checklist.

Online videoconferencing is one of the most common examples of using technology in mental health services. Shore et al. (2018) reviewed the best practices in video conference-based telemental health to update and consolidate the previous guidance developed by The American Telemedicine Association (ATA) and The American Psychiatric Association (APA).

This guidance advised providers to develop clear communication policies with patients and standard operating procedures/protocols for videoconferencing. Some of these policies may also be applicable to child welfare services, such as attention to patient-provider identification, technical and clinical competence in the management of emergencies, considerations for using clinically unsupervised settings and provision of videoconferencing platform requirements (including appropriate verification, confidentiality, and security parameters). Table 3 describes some of these administrative and technical considerations.

Studies on the feasibility and effectiveness of ICT use in mental health services are diverse due to the high number of ICT platforms and mental health disorders. Appendix 2 summarizes the results of some meta-analysis studies published from 2015-2020, including 95 interventional studies.

These studies provide evidence of the overall efficacy of videoconferencing interventions compared with face-to-face service provision. Two systematic reviews (Backhaus et al., 2012 & Yellowlees, 2016) provided evidence to support user satisfaction, effectiveness and feasibility for VC telepsychiatry for participants of all age groups. Other studies have found that some clients prefer VC counselling over in-person sessions, for example, in the treatment of eating disorders where there are high levels of shame and guilt⁴¹ (Stubbings et al., 2015).

One systematic review of studies on online CBT (iCBT) for pediatric obsessive-compulsive disorders (OCDs) (Babiano-Espinosa et al., 2019) showed high feasibility and good acceptability. However, the researchers concluded that robust evidence is limited to support efficacy of iCBT for pediatric OCD.

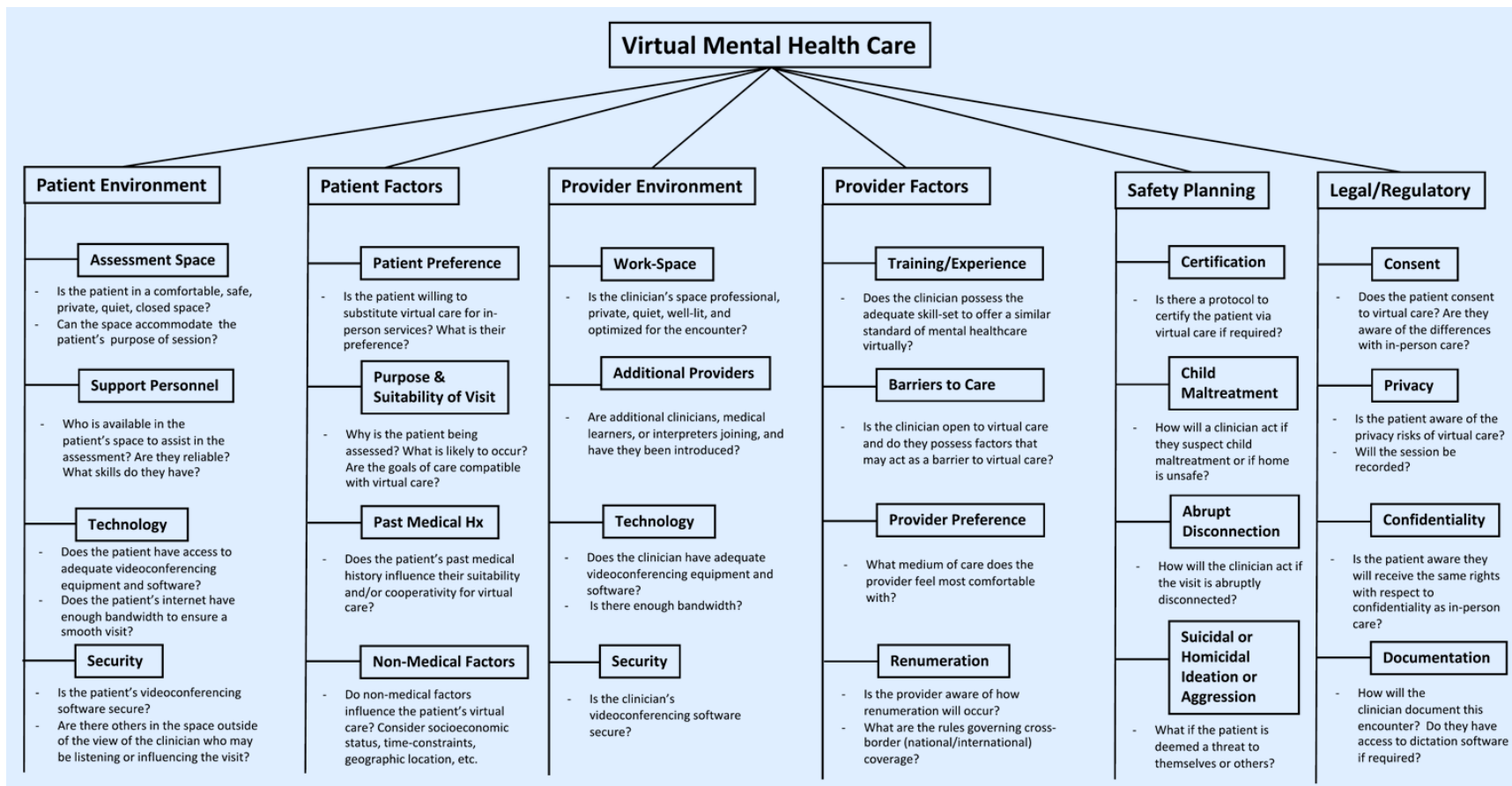
⁴¹ For example, for body shape due to obesity.



One review of the studies on text messaging for mental health purposes showed a positive attitude toward text messaging and enhanced adherence to treatment and symptom surveillance. Other benefits included an increased attendance rate in appointments and

satisfaction with management and health care services (Berrouiguet et al., 2016). One case study on the use of technology to treat OCD found that videoconferencing combined with text messaging facilitated client engagement and disclosures by reducing interpersonal anxiety and that some clients preferred this method over in-person treatment (Stubbings et al., 2015). However, there is marginal evidence for the treatment of clinical depression through text messaging (Senanayake et al., 2019).

Figure 1: A six-pillar framework for providing virtual mental healthcare to children, youth & families



(Source: Doan et al., 2020)

Table 3: Table 3: Some of the Considerations for Videoconferencing-Based Telemental Health

Issue	Considerations
Legal and regulatory issues	Being aware of federal, provincial and local rules and regulations about licensure and malpractice, the scope of practice, prescribing, informed consent, billing and reimbursement
Physical location/room requirements (for adults)	<ul style="list-style-type: none"> • Providers should consider the patient's cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behaviour. • Providers shall consider geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status. • The consent process shall include a discussion of circumstances around session management. If a patient can no longer be safely managed through VC, the patient is aware that services may be discontinued. • Providers should consider whether there are any medical aspects of care that would require in-person examination, including physical examinations. If the provider cannot manage the medical aspects for the patient without being able to conduct initial or recurrent physical examinations, this shall be documented in the record, and arrangements shall be made to perform physical examinations onsite as clinically indicated.
The developmental status of youth	<ul style="list-style-type: none"> • The procedures shall follow the adult's guidelines with modifications to consider the developmental status such as motor functioning, speech and language capabilities, relatedness, and relevant regulatory issues.
The younger children	<ul style="list-style-type: none"> • The environment should facilitate the assessment by providing adequate room size, furniture arrangement, toys, and activities that allow the youth to engage with the accompanying parent, presenter, and provider, and demonstrate age-appropriate skills
Extended participation of family members or other relevant adults	<ul style="list-style-type: none"> • Providers should adhere to usual in-person practices for including relevant adults with appropriate modifications for delivering service through videoconferencing in the context of resources at the patient site. • Extended participation may include a "presenter" who may facilitate sessions (e.g., vital signs, assistance with rating scales, managing active children, and assisting with any urgent interventions).

	<ul style="list-style-type: none"> • Providers should consider how the presenter's involvement can affect service delivery (e.g., social familiarity with the family, perceived confidentiality, and sharing information with other team members).
Service delivery outside of traditional clinic settings (e.g., schools)	<ul style="list-style-type: none"> • Providers should work with staff to ensure safety, privacy, appropriate setting, and accommodations. It is particularly true if multiple staff participate in sessions. • Appropriateness for tele-mental care shall consider the youth's safety, the availability of supportive adults, the mental health status of those adults, and the ability of the site to respond to any urgent or emergent situations.
Forensic and correctional	Providers shall be aware of system issues in working in forensic and correctional settings and follow applicable standard consent around both treatment and evaluation regarding the patient's legal status and rights. Providers shall have clear site-specific protocols for working with patients and staff in forensic and correctional settings

Source: Shore et al. (2018). Best practices in videoconferencing-based telemental health.

6.0 Impact of the COVID-19 Pandemic on children and families

The new public health measures to control the spread of COVID-19 have been implemented since early 2020 and will likely persist into 2021. While these measures (i.e. physical distancing and restrictions on movements) are meant to keep families and children physically safe and healthy during the pandemic, they can also result in multiple sources of stress: closure of schools and businesses, working from home, job losses, social isolation and loneliness, and economic vulnerability (Ghosh et al., 2020; Lawson et al., 2020). COVID-19, similar to some viral infections such as SARS and flu, is associated with a better prognosis and less severity among children compared to adults (Lee et al., 2020). However, the impact of COVID-19 on other dimensions of children's lives may be greater. For example, children who live in abusive homes may face an increased risk of violence and maltreatment during the pandemic. This phenomenon is known as the "pandemic paradox," whereby measures designed to help people stay safe at home may adversely affect children's safety at the same time (Bradbury-Jones & Isham, 2020).

6.1 Impacts of the pandemic on the regular daily life of families

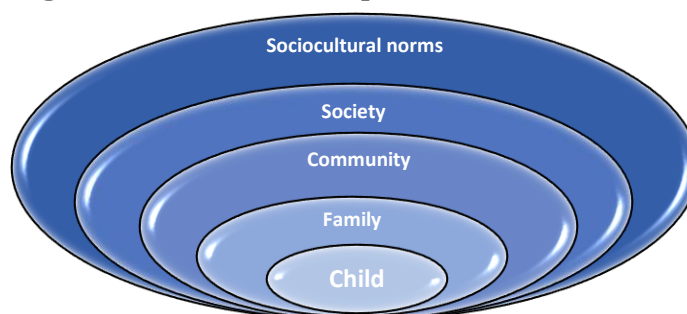
School closures have disrupted children's usual lifestyle and imposed new challenges, including online learning, home-confinement, lack of outdoor activities, changes in dietary and sleeping habits and cancellation of scheduled trips (Ghosh et al., 2020; Gurwitch et al., 2020; Lee et al., 2020; The Alliance 2020a). Schools are children's second home, not just a learning hub; losing the routine practices in school time and remaining at home with stressful parents, puts children in jeopardy (Ghosh et al., 2020). Research suggests that children's reactions to these stressful conditions include challenging behaviours, more



distress, impatience, irritation, disrupted attachment, fear of uncertainty and disorganized interpersonal relations (Ghosh et al., 2020; Gurwitch et al., 2020; Lee et al., 2020; The Alliance 2020a). However, the impact of school closures is not always negative; some parents expressed positive aspects of staying at home with children. For example, survey research from Germany (one conducted online, and the other through a non-representative telephone survey) found at least temporary benefits of staying at home for some families, who were able to experience a more relaxed daily routine and reported that children enjoyed having more time with their parents. However, the families in these studies were more likely to be financially secure and well-educated; thus, their experiences may not be applicable to other families who are less well-off. (Jentsch & Schnock, 2020)⁴².

The Alliance for Child Protection in Humanitarian Action (The Alliance, 2020b) summarized the sociological impact of COVID-19 on children and families in a multi-level model (Figure 2 and Table 4), including the child, family, community, society and sociocultural norms. The model includes factors that place children at a greater risk of violence or maltreatment, as well as protective factors that can reduce or prevent these risks. According to the model, community and society factors and changes in sociocultural norms must be considered to better understand the impact of COVID-19 on children and families. Some examples of community and social risk factors are the breakdown of trust,

⁴² The samples of both surveys were not representative of all population groups. Since both study results presented in the German language, we did not deeply review them, independently.

Figure 2: Socio-ecological model for the impact of COVID-19 on children and family

Adapted from: (The Alliance, 2020b). Technical Note: Protection of Children during the Coronavirus Pandemic (v.2)

Table 4: Socio-ecological impact of COVID-19: Protective and Risk Factors

Level	Risk Factors	Protective Factors
Child	Heightened risk of violence, neglect, exploitation & psychosocial distress; possible developmental delays; discrimination due to gender/disabilities.	Creativity, resilience, personal safety plans, including safe adults; communication with friends and family; feeling loved and valued; knowledge of Covid-19 facts.
Family	Family separation; reduced access to social supports; caregiver distress; heightened risk of violence; disrupted livelihoods; poverty; fear of disease; gender inequality; mental illness; substance use.	Family time & activities; increased time with parents; fathers more involved; social support through ITC; informal support systems with remote access; new rituals/routines established.
Community	Breakdown of trust; competition over resources; limited access for community supports, health care, education, play spaces, child welfare.	Formal support: food banks, cash transfers, virtual support, food programs, health & protection messaging. Informal support: neighbourhood check-ins; community kitchens; production of PPE.
Society	Erosion of social capital; disruption of civil society & access to basic services.	Essential services available through government; support from civil society organizations.
Sociocultural norms	Heightened stigma & discrimination against specific groups, e.g. certain genders; front line workers.	Highlighting heroes such as front-line workers; valuing lives lived; intergenerational respect & care.

Source: (The Alliance, 2020b). Technical Note: Protection of Children during the Coronavirus Pandemic (v.2).

competition over limited resources, limited access to health care and child welfare services, erosion of social capital, heightened stigma and discrimination against specific groups. Section 7.2 explains the factors involved in violence against children during the pandemic based on this model.

6.2 Impacts of the pandemic on children-in-care

Sistovaris et al. (2020) reviewed the available literature on the effects of the COVID-19 pandemic and concluded that children-in-care are at a higher risk of harm because of the pandemic and the restrictions that have been imposed by governments. Wilke et al. (2020) also found that the pandemic has exacerbated pre-existing health and social disparities by increasing vulnerabilities among children and families who are more at risk for separation. Not only have families lost access to material goods and income, but service providers such as NGOs who typically support vulnerable families have also been unable to provide adequate services due to government restrictions and loss of funding.

Another consequence of the pandemic has been that children in residential care have been rapidly returned to their biological families to limit the virus' spread. However, this has often occurred without appropriate preparation or a plan for safe return to care, which can increase the risk of maltreatment (Wilke et al., 2020; The Alliance, 2020c).

The Alliance for Child Protection in Humanitarian Action (2020c) summarized other challenges that children face while living in alternative care during the pandemic:

- i. Children who remain in residential care may also face risks such as a higher likelihood of abuse, neglect, exploitation or being infected by COVID-19. These risks may be even greater for children with disabilities or pre-existing conditions, such as immunodeficiency, who are more likely to be affected by COVID-19.
- ii. Children in independent living arrangements are more at risk of isolation and separation from peers. Also, they may not have access to cash and other supports for their daily needs.
- iii. Kinship caregivers and foster families, specifically older adults, may need to temporarily stop supporting children due to their fear of COVID-19 infection or the pandemic's financial impact, resulting in abandonment of children in foster care.
- iv. Children who are unhappy in their alternative care placement may find an enforced lockdown to be intolerable.

Other environmental conditions may also increase health risks among children in care. For example, children who are separated from parental care often come from families living in poverty, which may lead to malnutrition and poor hygiene. They may also come from overcrowded living spaces that make social distancing and handwashing very difficult, leading to an increased risk of COVID-19 spread (Wilke et al., 2020, The Alliance, 2020c).



6.3 Impacts of the pandemic on vulnerable children

Caregivers' well-being can directly affect children (Goldschmidt, 2020). Reduced access to material goods and the increased need for financial assistance due to lost employment during the pandemic can increase stress, family tension and vulnerability to psychological disorders, which may increase the risk of violence and child maltreatment (Wilke et al., 2020; Marshall et al., 2020; Racine et al., 2020). The disrupted economy and job losses caused by COVID-19 result in more families who are struggling to provide food. Breakfast Club of Canada forecasted an increase from one in four children to more than one in three children who will be going to school without breakfast (Raising Canada, 2020). One study showed that the incidence of child abuse was higher when children spent more time socially isolated, perhaps in the same home with the perpetrators of their physical, emotional, or sexual abuse (Wilke et al., 2020). Another study showed that adolescents with a history of childhood maltreatment face more substantial negative mental health impacts while struggling with COVID-19 challenges (Guo et al., 2020). In Canada, Kids Help Phone has reported a rise in discussions about physical, sexual and emotional abuse

(Children First Canada, 2020). Limitations in appropriate and on time response to children's prior mental health problems is another challenge for some vulnerable children: before the pandemic, waiting lists for child mental health services were already growing and had reached up to 2.5 years for some children. The disruption of services and the stress of the pandemic has now exacerbated the problem even further (McGrath et al., 2020).

The Alliance for Child Protection in Humanitarian Action technical note (2020a), which was informed by global field reports, disclosed an increase in gender-based violence against children during the pandemic. Examples included increased household chores and care for females, commercial sexual exploitation and forced early marriage. Worldwide, school closures and family income reduction have resulted in more prevalent child labour and potentially increased health and development risks for children (The Alliance, 2020a). In Canada, online sexual exploitation of children has soared during the COVID-19 pandemic as reported by the RCMP's National Child Exploitation Crime Centre and the Canadian Centre for Child Protection (Raising Canada, 2020), perhaps associated with more time spent online by children and lack of access to schools and other supporting services.

Global experience also shows that social stigmatization and racial discrimination against some individuals or ethnic groups are other sources of risk for children and families during the pandemic. The impact of racial discrimination and stigmatization may disproportionately affect marginalized and disadvantaged groups, including children living or working on the streets. Furthermore, limitations in access to basic social and supportive services among disadvantaged groups deepens this problem (Alliance, 2020b).

7.0 The COVID-19 Pandemic and Changes in Child Welfare Services

During the COVID-19 pandemic, the health system has been required to transition from face-to-face to remote service delivery through ICT (Fisk et al., 2020). This change was accompanied by several administrative, technological, training, and clinical challenges (Sharma et al., 2020). However, in some countries such as the U.S., the U.K. and Australia, the transition to telehealth services was smoother because they had already established appropriate remote services infrastructure (Jaffe et al., 2020 and Fisk et al., 2020). In the U.S., an 845% rise in telehealth service usage was recorded during the first month of the pandemic, in comparison with the same period in the previous year (Jaffe et al., 2020), and 80% of mental health appointments were delivered through telemental health services in March 2020 (Reilly, 2020). These figures represent changes in health services overall and are not specific to child welfare services.

7.1 Changes in the child maltreatment reporting

An increase in child abuse and neglect is a predictable consequence of natural disasters and pandemics. However, the reported rate of violence is less than the actual rate in natural disasters and conflicts, according to the finding of a systematic review (Seddighi et al.,

2019). Some of the reasons for this under-reporting are absence of required infrastructure and reporting mechanisms, stigma, and the fact that perpetrators are parents or relatives of the children in many cases.

The evidence thus far on the impact of the COVID-19 pandemic on rates of child abuse and neglect is mixed. While some reports show increasing demands and calls to child distress hotlines in the early months of the pandemic in 2020 (Levy, 2020; Walker et al., 2020; Children First Canada, 2020), other evidence shows a decrease in calls to child abuse hotlines and reporting (Quander, 2020; Dowd, 2020; Schultz, 2020; Baginsky & Manthorpe, 2020). In one study during the school closure in March and April 2020 in Florida, Baron et al. (2020) compared the actual and expected child maltreatment allegations. They found that the number of reported cases for those two months, in a conservative estimate, was approximately 15,000 lower (27 percent) than expectations. However, they believe that this decrease does not mean that the children are safer. An alternative explanation for the decrease could be that the drastic reduction of social interaction has limited the child's exposure to various potential and mandated reporters, such as teachers and school personnel, child daycare providers, law enforcement personnel, pediatricians, and extended family members (Baron et al., 2020). Based on the Child Maltreatment report 2018 in the U.S., schools submitted 20.5 percent of child maltreatment reports, the highest rank among all reporters (Administration for Children and Families, 2020). This pandemic underlined the importance of childcare facilities for reporting allegations and their continuous cooperation with child protection workers (Jentsch & Schnock, 2020).

7.2 Factors involved in violence against children

The socio-ecological model for the impact of COVID-19 (Figure 2 and Table 4) helps to understand the role of different factors in explaining the increased violence between parents and children, as described below:

Child factors: The decrease in children's mobility, missing classmates and friends, and increased contact with parents may increase interpersonal tensions. The consequent aggressive behaviours and disobedience among children and adolescents may result in more episodes of violence against them. Pre-existing mental health conditions among maltreated children could be another facilitating factor for increasing conflict and decreasing the capacity to cope during the pandemic (Guo et al., 2020 & Marques et al., 2020).

Family/parental factors: Marques et al. (2020) summarized some of the negative consequences of the pandemic on parents, such as: "increased stress due to fear of falling ill, uncertainty about the future, the impossibility of social contact, the imminent threat of reduced income (especially in the underprivileged classes, where a large proportion make their living from informal labour)." Furthermore, parents of younger children felt higher stress levels due to changing family dynamics that place more demands on their time, such as: reconciling challenges of working from home, increased load of housework, and care for

the children who are always at home. Moreover, schools often act as daycare facilities for many parents when they worked; during the school closure, these parents face a trade-off between work and adequate childcare (Baron et al., 2020).

Community factors: Barboza et al. (2020) analyzed child abuse and neglect incident data among children under 18, reported to the Los Angeles Police Department from July 24, 2019 to July 19, 2020. The investigators used additional datasets to provide an innovative analysis to explore the dual trajectories of COVID-19 and child maltreatment. They first mapped the hot and cold spot patterns of child abuse and neglect. After further spatiotemporal analysis, they found a significant association between the pattern of hot spots of child maltreatment and neglect with neighbourhood structural factors, for example, school absenteeism, poverty, labour force participation, housing insecurity, and the number of assets children have at birth. This study helps to better understand how the COVID-19 pandemic has impacted different communities and would help policymakers more effectively target and distribute social and economic resources across communities in greater need (Barboza et al., 2020).

Research shows that natural disasters and pandemics can impact the capacity of child welfare agencies to ensure continuity of care and services (Sistovaris et al., 2020). Competition for limited resources, such as child welfare support, and reduced partial functioning of many services to defend children's rights are also known risk factors for child maltreatment (Marques et al., 2020). Changing priorities within the health system during the pandemic may also have an impact. For example, the health system has prioritized caring for patients with respiratory symptoms of COVID-19 and postponed responding to non-urgent cases such as families' stress and mental health problems, which might result in increased mental health disorders and consequent conflict and violence (Marques et al., 2020).

Society factors: The suspension or reduction of some activities in local places, such as churches, daycare centers and schools, may worsen pre-existing effects of the pandemic through erosion of social support and decreased social cohesion. Higher levels of fear and uncertainty about the future may also be a risk factor (The Alliance, 2020a and Marques et al., 2020).

Stigma & discrimination: Some groups have faced discrimination as a result of the pandemic, including frontline health workers, who have been stigmatized by their landlords due to the risk of spreading the virus, forcing them to evict their rented houses (Villa et al., 2020; CBC, 2020b; Ghosh et al., 2020); as well as Chinese families; leading to more stress for both parents and their children (National Collaborating Centre for Determinants of Health, 2020 and Villa et al., 2020). The findings of one study in the US on Chinese American families showed that nearly half of parents and youth reported that they

were directly targeted by COVID-19 racial discrimination online and/or in person. They also found that higher levels of perceived racism and racial discrimination for parents and youth were associated with poorer mental health⁴³ (Cheah et al., 2020). Raising Canada (2020) also summarized similar findings for Canadian adults of Chinese ethnicity after the pandemic began⁴⁴.

7.3 Children with special needs

A review of recently published studies showed that pre-existing conditions such as mental health or psychiatric problems and medical comorbidities among children or their parents/caregivers raised the impact of COVID-19 on children's mental health resulting from higher levels of distress. The negative impact could be greater for more vulnerable children, including children with disabilities, marginalized families and those living in crowded spaces (Ontario Centre of Excellence for Child and Youth Mental Health & Children's Mental Health Ontario, 2020).

Special care should be given to children living in institutions: if they are still living in an operating institution, public health guidelines should be carefully implemented. New approaches should be developed with some measures for needs assessments, monitoring placements and risk appraisal if they have left the facility. Development of a care plan for children and families, if relevant, could be followed up after lifting the public health measures (Goldman et al. 2020).

Other vulnerable groups include children who have lost their parents because of COVID-19 and children whose parents are frontline health workers, who may be under more stress due to fear of the higher risk of contracting the virus for parents and family members (Ghosh et al., 2020).

7.4 Digital divide and the COVID-19 pandemic

About one in ten Canadian households have no internet connection, and the pandemic has intensified the connectivity gap between rural and urban areas (the 'digital divide', as described in Section 3.1.1), with internet speeds becoming faster in cities but plateauing in remote areas (Stewart, B., 2020).

⁴³ The sample included 543 Chinese American parents (mean [SD] age, 43.44 [6.47] years and their children (N = 230; mean [SD] age, 13.83 [2.53] years. For both parents and children, psychological well-being was negatively associated with online direct discrimination; anxiety and depressive symptoms were positively associated with all types of racial discrimination and Sinophobia (a fear or dislike of China, or Chinese people, their language or culture).

⁴⁴ "Half (50%) report being called names or insulted as a direct result of the COVID-19 outbreak, and 43% say they have been threatened or intimidated. Six out of 10 (61%) say they have adjusted their routines in order to avoid run-ins or otherwise unpleasant encounters since the COVID-19 outbreak began".



One study examining the transition to working remotely for child social care workers in the UK highlighted their concerns with parents' problems in access to new technologies. For example, some parents did not have the necessary technology or skills to join virtual sessions and needed extra support. Some parents did not join multi-agency child protection conferences by phone to avoid being targeted as disadvantaged and 'the only one who dialled in on a telephone,' while the others joined through video calls by their smartphones (Baginsky & Manthorpe, 2020).

An analysis of a large sample of US adults ($n= 11,614$) with healthcare claims made during March 2020 confirmed not only increased usage of telehealth service but also the presence of inequalities in telehealth usage by several factors, including age (less likely to be used by older age groups), marital status (less likely to be used by married people), prior mental health problems (more likely for people with a previous diagnosis of anxiety or depression), region (more likely for urban areas), geographical area (based on the prevalence of COVID-19 and restriction policies in different states), race (less likely for Asians) and employment status (less likely for employed people) (Jaffe et al., 2020). Although similar data on inequities in the delivery of child social services is not available

for Canada, more research is required to investigate inequalities in the digital divide after COVID-19.

7.5 Virtual child welfare services during the pandemic

Shifting from face-to-face to virtual service delivery under the new COVID-19 restrictions meant child welfare agencies became responsible for providing further services or an alternative method for the previous services to maintain service delivery to children and their families (IASSW, ICSW, IFSW, 2020). The ability to continue to provide regular services during this time was a challenge for child protection workers as their work highly relies on face-to-face contact with children as a fundamental approach (Schwab-Reese et al., 2020). Child welfare workers have found that balancing between infection protection and child protection is very challenging. In addition, in many countries, the necessary infrastructure was not readily available for transitioning from the usual work process to online services at this large-scale after such an unprecedented disruption (Jentsch & Schnock, 2020⁴⁵; Schwab-Reese et al., 2020). Even under the COVID-19 restriction measures, 67 percent of respondents to a survey in Germany⁴⁶ who had managerial positions in the child welfare system revealed that their staff continued to face-to-face contact with families, specifically for home visiting (Jentsch & Schnock, 2020). One study on a random sample of 169 social workers in Switzerland was conducted from mid-March to mid-April 2020, during the lockdown (Lätsch et al., 2020). This study showed that only 45% of the respondents reported restrictions in their ability to provide child protection services; they reported that most home visits were no longer carried out in person and are limited to phone conversations with parents. However, some of the concerns mentioned by participants were that “it is difficult to judge how things normally go, parents are very challenged right now and do not have the poise to talk about their situation.” We did not find any study comparing the short and medium-term pros and cons of continuation or ending the service delivery during COVID-19.

Germany is one of the countries that was affected widely by COVID-19. In response to the pandemic, German child welfare workers and agencies have developed a range of strategies to adapt to changing circumstances. For instance, they expanded online counselling services and also used an app to make their services available on mobile devices. They also involved the broader public in identifying and reaching families in need of services by distributing information to various groups on how to access help⁴⁷.

⁴⁵ This valuable review unsurprisingly used many references in the German language. Therefore, it was not feasible for investigators to review each reference independently, and therefore, the original review study is referenced more frequently.

⁴⁶ A part of the DJI-Jugendhilfeb@rometer Survey

⁴⁷ For instance, the Federal Ministry of Family Affairs published on its website a list of support services for families, and the National Centre for Early Prevention, provided a list of online and telephone counselling services for pregnant women and parents with children up to three years of age. In order to expand the target groups for information sharing from individuals to groups, they sent the information to “targeted neighbourhoods, relatives and acquaintances of families, as well as health professionals, advising these groups on

Counselling portals targeting migrant youth and homeless young people were also expanded because of their increased demands. The researchers pointed to some of the reasons for the increased demand for counselling, such as “young people’s fears of the future, loneliness, and family conflicts”. Conducting research studies to analyze the current situation⁴⁸ was another initiative among child welfare agencies (Jentsch & Schnock, 2020).

The experience from Germany also underpinned the problem in access to technology. Results of another survey⁴⁹ showed only one-fourth of public youth and child welfare services used VC to provide services, for several reasons, including a lack of technical equipment and internet access, data protection concerns, and inadequate experience in working with VC for communication among both professionals and families (Jentsch & Schnock, 2020).

Although many counselling services shifted to online delivery after the pandemic began, it is difficult to achieve the same level of contact and engagement compared with face-to-face encounters. Child protection workers have reported that it is harder to comply with professional standards using exclusively digital means. Also, VC is not very suitable for children and parents with reduced intelligence and attention deficit (Jentsch & Schnock, 2020). Results of an evaluation of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative in Florida after the COVID-19 pandemic disclosed the most common barriers for a virtual home visit as: “being unable to observe parent-child relationship due to lack of video, difficulty familiarizing clients to virtual software, and lack of efficient internet service” (Marshall et al., 2020).

Another challenge with implementing virtual child welfare services is privacy. Public health measures, including school closures, have increased the likelihood of other family members being present in the home, which decreases the opportunity for a private space at home to conduct virtual sessions with children. The lack of privacy may be an even greater issue for low-income families with smaller spaces. These conditions increase the importance of client confidentiality as one of the only opportunities for a child to disclose maltreatment and intervention (Collin-V’ezina et al., 2020 & Golberstein et al., 2020).

Sections 2 and 3 discussed the benefits and challenges of ICT use in child welfare practice. However, one recent study in England on child and family social workers provides further insight into their experiences with transitioning to virtual services. This study was conducted immediately before and after the lockdown announcement, from 19th March to 13th June 2020 (Cook & Zschomier, 2020a and 2020b). Immediately after lockdown, social

how to support families looking for help and how to proceed if concerns arose about the protection of a child. An example of this is the appeal of the Commissioner for Child Sexual Abuse ... as part of the campaign ‘Leaving no child alone’.

⁴⁸ An online survey ‘The impact of Covid-19 on violence against women and children in Germany’, an ad-hoc qualitative study by the National Center for Early Intervention and the survey of youth welfare agencies

⁴⁹ Allgemeiner sozialer Dienst (ASD)

workers developed a risk assessment strategy to prioritize visits and decide how to contact children and families, using the RAG⁵⁰:

- 'red' (high risk) for essential face-to-face visits and/or frequent virtual visits;
- 'amber' (medium) or 'green' (low) risk were visited less frequently, typically virtual.

Table 5: Virtual engagement experience with children and families during COVID-19 lockdown

Area	Experience
Methods used during virtual visits with children	<ul style="list-style-type: none"> • Instigating basic games over a video call, for example, nougats and crosses • Asking children to use their mobile phones to take them on a tour of the house • Engaging children in imaginative play games. 'Imagine you are in a spaceship; can you show me around?' • Sending hard copies of worksheets, genogram templates, and other resources in the post to be completed with the social worker during a later video call • Using backgrounds and emojis available on video call services to initiate interaction with the child • Using their own children's toys, such as dolls and tea sets, to engage play 'through the screen'. • Singing nursery rhymes with young children • "Using a 'show and tell' approach to initiate interaction - inviting children to bring toys/objects to show the worker • Starting a video call with the parent or carer who could help/encourage the child to participate. The child could then take over when they felt comfortable."
Benefits	<ul style="list-style-type: none"> • The 'little and often' approach was welcomed, and developing closer relationships with families and becoming more familiar with their everyday lives during lockdown were some of the benefits • More responsiveness: a quick video call in response to a text was more convenient than scheduling a visit and travelling to the family home • Young people/adolescents felt more comfortable with messaging and video calls • The preferred way of sharing information about difficult topics to talk about in person was text/instant messaging rather than VC. "This was surprising to many workers, who initially regarded text messages as a less appropriate form of contact with families." • Many workers felt more energized and focused on their interactions by saving time and could support a more significant number of service users

⁵⁰ RAG: Red, Amber, Green risk-ratings

Risks and Limitations	<ul style="list-style-type: none"> • Digital exclusion: not all families had access to the internet at home or could afford the data costs of video calls • Without a prior relationship with the child, parent or carer, "virtual engagement was far less effective". • "Virtual home visits had significant limitations for initial assessments and high-risk cases where there were child welfare concerns." • Difficulties of understanding body language and social cues, the home's sensory experience, the atmospheres and emotions were partial. • "Difficulties in virtual visiting a family could make it more to assess the home environment and to pick up on important cues and sensory information." • Detecting 'hidden risks' during virtual home visits were difficult, and the judgments about child safety were 'less robust' and were concerned to be blamed for difficult decisions they had made • Confidentiality and safety concerns: no way of knowing who might be listening to the call specifically when talking to children at risk of abuse/neglect and parents experiencing domestic abuse • "Virtual communication could be inappropriate for sensitive topics – particularly in the context of new relationships," and they "could not convey empathy and reassurance." <p>Technology failures such as low signal quality and calls' dropping out.'</p>
Recommendations and Lessons Learned	<ul style="list-style-type: none"> • Research into children and families' perspectives on virtual social work and their views on how this can work more effectively • "Virtual home visiting can work well in some circumstances but cannot adequately replace face-to-face home visits. Social workers still need to conduct home visits in urgent cases concerning child protection and initiate new relationships. Local authorities, therefore, need to continue to provide PPE to minimize the risk for social workers and families as much as possible." • "For some young people, virtual contact may be the preferred form of communication with their social worker rather than an option borne of necessity <p>Social workers should consider text messaging alongside other modes of communication in their work with families as it can provide a helpful way into sensitive topics</p> <ul style="list-style-type: none"> • Social workers need to check where the child or parent is, who is with them and whether it is safe to talk, remaining mindful of the risks to the child/parent of being overheard • Emojis, basic games, and engaging backgrounds can aid virtual engagement with children – designing age and social work appropriate add-ins to existing platforms is an essential area for innovation • Pre-posted physical resource packs may act as a link between the child and their social worker. Consideration should be given to the design of engaging, impressive posted materials for children."

Source: Cook & Zschomier, 2020a, 2020b

On a case-by-case basis, social work teams weighed infection risks for both social workers and families against the visit's necessity. They noticed a dramatic drop in referrals to Children's Services, concurrent with "an increase in referrals from neighbours around domestic abuse and mental health issues among children and young people." Table 5 summarizes this experience of virtual engagement with children and families, including home visits.

Cook and Zschohier (2020a) also shared the British experience of conducting children's reviews, fostering and adoption meetings, panels and child protection conferences virtually, summarized in Table 6.

Table 6: Experience of virtual family participation in meetings, panels and reviews

Area	Experience
Benefits	<ul style="list-style-type: none"> • Families felt more relaxed and confident • Greater sense of autonomy for some family members: parents/ carers and youth on different devices in different rooms • Enhanced young peoples' participation in meetings and reviews and sharing their views, while some of them had never previously felt comfortable with professionals; WhatsApp or FaceTime seems more comfortable and less 'professionalized' space for young people to share their views; also, "young children and less confident young people could 'listen in' to the meeting via a parent or carer's device and join later if/when they felt comfortable." • "Young people often became the 'tech experts,' helping foster carers, parents and professionals to manage the technology during meetings. This [interaction] altered the power dynamic within the meetings, helping to build their confidence and increase their involvement."
Risks and Limitations	<ul style="list-style-type: none"> • Digital exclusion: no access to a reliable internet connection, unaffordable costs of video calls or struggling with the required technology • Language barrier: if families need a translator • Appropriate platform: Most families preferred FaceTime, WhatsApp or Zoom, while the organizer used Microsoft Teams as a 'business as usual' for professionals. Some social workers expressed confusion about the safety and confidentiality of the meetings and security concerns around Zoom • Difficulties in follow up with each family in a meeting: to see when people were upset or distressed or why they left the call- they were upset, or it was a technological problem
Recommendations and Lessons Learned	<ul style="list-style-type: none"> • "When inviting families to participate in reviews and meetings, professionals need to consider the four barriers to digital inclusion (access, skills, confidence and motivation) and how these might be overcome on a case-by-case basis."

	<ul style="list-style-type: none"> • Replacing travel grants to attend meetings, with subsidies for WiFi/additional data by local authorities • Pre-meeting check-ins with families to ensure their ability to participate, to reassure about what will happen and to address their worries or concerns • “Professionals chairing meetings need to regularly check-in with families during meetings.” • Chairs may consider alternatives to Microsoft Teams if it is a barrier for families to participate • Local authorities may provide clear guidance on secure platforms • Professionals should encourage family participation during meetings throughout the video call • Children, young people, parents and carers should be consulted about their perspectives on virtual meetings
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Source: Cook & Zschemier, 2020a and 2020b

With the closure of schools, one of the recommendations for mitigating the impact of the pandemic on child maltreatment is raising awareness about different technological channels for reporting child maltreatment, among potential reporters such as primary health care workers and pharmacies, police officers, faith-based organizations and the public (Wong et al., 2020 & Jentsch & Schnock, 2020).

7.6 Virtual or in-person family visits?

Restricting or banning family visits during the COVID-19 pandemic is one of the unprecedented challenges facing children and families in the child welfare system. In Ontario, Children’s Aid Societies (CAS)⁵¹ cancelled in-person access visits⁵². Zwibel (2020), on behalf of the Canadian Civil Liberties Association (CCLA), raised concerns “about the treatment of families involved in child protection proceedings during the COVID-19 pandemic”. In Ontario, some families are more affected by restrictions, including those whose access visits took place at CAS offices and access centres with supervision, and also families where children are in kin placements (Canadian Civil Liberties Association, 2020). CCLA requested more guidance and direction to “ensure that rights of access for parents and children are being respected and facilitated in accordance with the law” (Zwibel, 2020)⁵³.

⁵¹ “Children’s aid societies are organizations governed by locally-elected boards of directors, Indigenous societies and Band Councils. Societies are responsible for the delivery of child protection services, in accordance with legislation, regulations, and ministry policy and standards.” (Source: <https://ccla.org/children-covid/>)

⁵² Access is defined as, “court ordered visitation between non-custodial parents and their children” (Morrison et al.,2011)

⁵³ So far, “[t]he parents took the matter to Court and the Court decided that access could be suspended, despite the absence of any compelling medical evidence indicating that the child was at increased risk of infection and even though the parents and grandparents were all in favour of the parents having access.

The American Academy of Pediatrics (2020) developed a guide for children and families involved with the child welfare system during the COVID-19 pandemic in response to the uncertainties. With attention to the guiding values of child welfare services, including safety, permanency, and well-being, the guidance recommends in-person visitation whenever possible, for both family visitations and visits between children and child welfare professionals. Further details on these visitation principles and guidance are provided in Appendix 5.

One study on family reunification services during the COVID-19 pandemic concluded that given the uniqueness of every child welfare case, the alternative reunification strategies should be defined and evaluated on a case by case basis (Singer & Brodzinsky, 2020). According to the authors, "[b]irth parents must be given reasonable time and support to meet established reunification goals, without undue pressure from statutory timeframes that are no longer realistic because of the inability to provide appropriate supports. At the same time, children's well-being must also be assessed in terms of the likelihood that reunification remains a realistic goal." However, the authors are concerned that it is still unclear how children and their birth parents cope with having only virtual visits without direct interaction and recommended more research in this area.

7.7 The COVID-19 Pandemic and child protection workers

Public health restrictions present different challenges to social workers in terms of their working environment and interactions. Some social workers reported insufficient office space to continue their job remotely and maintain social distancing measures, whereas others in the lockdown areas who worked from home did not have access to a quiet and private space (Baginsky & Manthorpe, 2020). In the initial weeks of the pandemic, some workers experienced less established teams, different connectedness problems with their teams and the loss of collegial discussions. The shift to remote work was more challenging for newer team members, many of whom felt marginalized in virtual interactions and deprived of quick advice from more experienced team members (Cook et al., 2020). The social workers also pointed to their concerns regarding the transition to virtual home visiting, including greater anxiety and uncertainty (Marshall et al., 2020). However, after the initial adjustment period, many social workers surveyed in England "described how their teams were able to successfully function as a secure base... create virtual spaces signalling availability, sensitivity, acceptance, cooperation and a sense of belonging, ... [and] being more able to manage the emotional demands of virtual practice" (Cook et al., 2020). Positive organizational culture and high organizational engagement resulted in improved

The parents have appealed the decision and CCLA is intervening out of a concern for the due process rights of families implicated in child protection proceedings and to ensure that courts require parties to take into consideration meaningful evidence of risks even in our current context of a global pandemic." (Source: <https://ccla.org/children-covid/>)

staff resilience, an intense commitment to and willingness to adapt to the COVID-related transition (Schwab-Reese et al., 2020).

Many child welfare workers who continued working with children-in-care worried about their own health. Although studies have shown that young children who acquired COVID-19 in child care settings can transmit the virus to their household members, one large survey of the U.S. childcare providers (N= 57,335) published in October 2020 did not find any association between exposure to childcare and COVID-19 infection (Gilliam et al., 2020).

Training of new and existing child protection caseworkers remains an essential component of providing effective services. However, under the COVID-19 restrictions, the delivery of training has had to shift to virtual methods. One study (Schwab-Reese et al., 2020) found no differences in training outcomes between pre- and post-COVID learning. Another study (Kobulsky et al., 2020) found that virtual coaching training was more effective than online training without coaching in terms of completed training modules and improvements in knowledge and practice. These results suggested that the transition to a virtual learning environment does not negatively impact the training process; however, some trainees need coaching for better improvement.

8.0 Conclusions

8.1 Findings

The purpose of this policy brief was to explore evidence regarding utilizing information communication technology (ICT) to deliver child welfare services during the COVID-19 pandemic. Results showed there is a dearth of evidence to support the efficacy of technology use in both child welfare and mental health service provision during the pandemic. The research findings are limited to a few reports presenting the experience of ICT use during the pandemic, specifically after lockdown, including new initiatives, challenges, recommendations, and lessons learned.

The relevant interventional efficacy studies were conducted before the pandemic. A review of studies on technology-assisted parenting services showed that robust evidence supports the feasibility, acceptability and efficacy of these services, given the availability of technological requirements. Evidence on the other technology-mediated interventions, such as home visiting or services for foster children and parents, is limited and inconsistent.

The pandemic highlighted a need for updated evidence-based policies, guidelines and training for technology use in child welfare service provision and enhanced digital literacy for service providers and clients. COVID-19 underlines the emerging need for improving the digital infrastructure for more vulnerable communities. The literature review also exposed the inadequate child maltreatment standard reporting channels during school closures.



8.2 Limitations of this research

This study reviewed English language publications and did not cover reports and publications in languages other than English. In addition, since this brief was not a systematic review, there may be additional studies that were not included. Most of the efficacy studies before the pandemic were conducted in the US; while findings on the direct experience of challenges during the pandemic mostly came from European countries. The earlier onset of the epidemic and national lockdown strategies in European countries might explain this difference.

The World Health Organization declared COVID-19 as a pandemic on 11 March 2020. Given the recency of the pandemic and its impact on child welfare services, additional methodical publications and reports from different countries' experiences in using technology for child welfare services are expected in the coming months.

Most post-pandemic literature is extracted from qualitative studies, reviews and non-representative surveys. In addition, most efficacy studies were conducted using free and standardized technological devices, internet and full support services that were available to rectify any problem. These conditions are different from real-life experience, specifically for families in remote areas or lower socioeconomic situations. Furthermore, access to the internet and a smartphone per se does not guarantee the desired quality for delivering all services such as videoconferencing. Accessibility of one electronic device such as a tablet or cell phone in a family does not warrant full access, security and privacy for all family members.

Some of the efficacy studies used social determinates in their statistical analysis, such as parents' educational level (Florea *et al.*, 2020). However, providing a desirable and free electronic device and internet access for study participants restricted the generalizability of the study results and the ability to measure any association between families' financial situation and study outcomes.

8.3 Future research

Further research is essential to measure the efficacious ICT use during the COVID-19 pandemic. The available literature suffered from inadequate attention to the increased inequity and digital divide in delivering child welfare services, specifically among minorities such as Indigenous communities. More studies are needed on the short, medium and long-term pros and cons of physical distancing measures on children-in-care, including the limitation of access visits. Future research should also examine the impact of the pandemic and its restrictive measures on more vulnerable groups, including visible minorities and First Nations. Epidemiological studies to find the spatiotemporal patterns of child welfare outcomes are needed to identify more vulnerable neighbourhoods and the associated contextual factors to mitigate the impact of COVID-19.

Finally, more research is required to explore the impact of interventions to help reduce the impact of COVID-19 on children and families and their effectiveness. For example, the mixed findings thus far on changes in the number of reports of child maltreatment and the number of calls or text messages to helplines or crisis lines suggests the need for further research or alternative measurement variables for these outcomes.

9.0 Implications for Policy and Practice

The imbalance between the increased need for supports for children and decreased access to social services due to the restrictive measures for controlling the spread of COVID-19 is a challenge for the child welfare system. Milner and Kelly (2020), the top Child Welfare officials of the US federal government, stated that: "We ... cannot allow our structural, functional and funding limitations to be used against families down the line. Time is a child welfare system's biggest challenge". However, from a more optimistic perspective, the impact of COVID-19 on the child welfare system may also be understood as a catalyst for expediting the development of evidence-based efficacious technology-assisted services, as a complement to existing face-to-face services.

Based on the reviewed evidence, four core recommendations are proposed for medium and long-term perspectives, described in sections 9.1 to 9.4.

9.1 Scale up the child welfare system based on the emerging needs

The COVID-19 pandemic crisis highlighted the emerging adaptive changes in the child welfare system. Even after the end of the pandemic, the economic recession will continue

to impact the well-being, mental health, and consequent trauma from domestic violence to women and children. These changes necessitate a long-term response for evolution of child welfare services with increased use of technology-assisted services. This transition could occur through a wide range of policies and strategies, including:

- i) continue to improve virtual services for appropriate cases;
- ii) prioritize communities, families or individuals to target resource allocation. These resources will support improving infrastructural and technological requirements to deliver better virtual services for mitigating the medium and long-term impacts of the COVID-19 pandemic (Barboza et al., 2020 & Cook & Zschomier, 2020a) and
- iii) upgrade the research agenda and information provision to recognize the existing barriers and provide responsive services. Future research can investigate disparities in access to the required child welfare services and the associated risk factors (section 8.3).

Greater access to more reliable information and data sources will help to better identify problems and produce more reliable information to monitor the optimal response (UNSDG, 2020).

9.2 Develop required guidelines to support digital technology in child welfare services

- i) Technology-assisted services are not equally appropriate for all. Section 3.1.2 underlined the importance of developing clear and evidence-based guidelines for child welfare workers. These guidelines should provide clear directions about the appropriateness of the digital service delivery, and answer the questions about 'for whom, when and under what circumstance' (Comer & Myers, 2016). These comprehensive tools and guidelines will support child welfare workers to appropriately triage the cases for online or in-person visiting and service delivery. Also, new measures for quality of virtual care should be developed to support child welfare services (section 3.1.2).
- ii) In the child welfare setting, errors in working with ICT may profoundly affect the clients' privacy, confidentiality or safety (section 3.7 and 3.8). Child welfare agencies should choose a proactive rather than reactive approach to standardize the current practices. New guidelines with safety plans for online services in clinically unsupervised settings, such as a personal residence, are crucial.

9.3 Build capacity among social workers for technology use

Social workers need to receive specific training to perform their work in a digital society, use available applications, develop online programs and analyze online opinions (section 3.1.2 and 3.3.2). The curriculum of social work students could also be updated to include this training (López Peláez, 2018) to prepare them for future work. Child welfare workers need to know more about being mindful of the client's environment, body language, listening skills, and identifying and managing risks during virtual services. This knowledge



will help to increase engagement among clients and decrease potential harms. Child welfare workers also need to know how to gauge progress toward the new objectives in providing online services and using different online platforms, such as social media, appropriately and overcome the related challenges. Conducting reorientation sessions would be useful to continuously update child welfare workers' knowledge about the available federal and provincial policies.

Engaging every layer of management and staff in the change process for implementing new technologies, and attention to leading with the culture⁵⁴ (section 3.4 and 3.5), would ensure the sustainability of technological change in current child welfare services.

9.4 Enhance intersectoral collaboration

This brief highlights the importance of collaboration between child welfare services with other sectors to improve technology-mediated services.

- i) Intersectoral collaboration at the federal and provincial levels is needed to help bridge the digital gap – which remains a significant challenge in the uptake of ICT in child welfare services (section 3.1 and 7.4). Many high-risk families who need online child welfare services to improve their parenting skills do not have

⁵⁴ Lead with the culture, involve every layer and engagement are some of the principles of change management (Aguirre & Alpern, 2014)

adequate digital literacy or access to the internet and fit-to-purpose devices. Reducing this barrier in access will not be achievable except through effective partnerships with the federal or provincial governments, businesses⁵⁵, charities and educational systems to reduce the cost of the internet, provide enough devices and improve digital literacy. The expansion of virtual services necessitates shifting the subsidies to the new targets at all levels. For example, in the welfare system, this could mean shifting the travel costs for face-to-face visits to technology costs.

- ii) Establishing a continuum of virtual care requires the Federal, Provincial and Territorial Governments to collaborate to ensure that systems, including technology fundamentals, records, professional licensure (section 3.9 and Table 3) and funding are adequate to support appropriate care for children⁵⁶.
- iii) Social workers must collaborate with computer science engineers and IT specialists throughout the process of developing and implementing new technologies in their area of work to leverage the usability and performance of technological applications. A resilient and adaptable system should support this multi-agency work (López Peláez, 2018).
- iv) Improving alternative child maltreatment reporting channels beyond the school setting is one lesson learned from the lockdown during this pandemic. Raising awareness about different technological channels for reporting child maltreatment is essential among other potential reporters, which may require collaboration between primary health care providers and pharmacies, police officers, faith-based organizations and the public for mitigating the impacts of the pandemic on child maltreatment⁵⁷.

The challenges experienced during the COVID-19 pandemic provide different countries with a unique opportunity to re-think the strengths and weaknesses of current child welfare systems and practices and look for new opportunities to improve their systems, including through effective use of digital technology. Attention to the experiences from local initiatives demonstrates the need to develop long-term plans to build a more responsive child welfare system. However, regardless of when the pandemic ends,

⁵⁵ For example, Siemens Canada has donated laptops for underserved communities, since 2010 (Siemens, 2018), [Siemens Canada donates almost 300 refurbished laptops to Canadian charities - Ontario Central East Division \(salvationarmy.ca\)](#); [News Coverage | CFCC \(c4cc.ca\)](#); and [FNTI Receives Generous Computer Donation](#)

⁵⁶ Adapted from recommendation 11 by the Royal Society of Canada for to support the mental health of the people of Canada (McGrath et al., 2020)

⁵⁷ Cooperating with judicial system to use ICT to prevent child removal from families (Spinak, 2020 & Milner, 2020) is another strategy. The letter from Associate Commissioner of the US Children's Bureau, Administration on Children, Youth and Families in Washington to Child Welfare Legal and Judicial Leaders, provides a list of valuable suggestions for technology use in the legal system to improve child protection, which is out of the scope of this brief.

restructuring the child welfare system is at the core, and the importance of technological infrastructure for child welfare agencies has been highlighted now more than ever.

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Appendix 1: Results of Literature Scan

Table A: Harris *et al.*, 2020

Author(s)(Date). Study Title	Harris, M., Andrews, K., Gonzalez, A., Prime, H., & Atkinson, L. (2020). Technology-Assisted Parenting Interventions for Families Experiencing Social Disadvantage: a Meta-Analysis. <i>Prevention Science: the Official Journal of the Society for Prevention Research</i> .
Study Characteristics	A meta-analysis of 9 studies ($N^{58}= 864$) from 2007 to 2019 on evaluating a parenting intervention for families with at least one of the following demographic challenges, low socioeconomic status, single parenthood, and/or young parenthood. Interventions (or a component of the intervention): by computer, cell phone, smartphone, and/or tablet
Findings	Parental psychological well-being: near-significant impact $g^{59}= .35$, 95% CI^{60} [-0.001-0.69] $p^{61} = .051$; Interventions that did not include direct contact: no evidence of effectiveness $g = -.02$ 95% CI [-0.23-0.18] $p < .05$; Interventions included contact: significantly effective $g= .68$, 95% CI [0.08–1.28]. Intervention length: shorter interventions yielded greater improvements in well-being; $\beta = -0.067$, 95% CI [- .14, .001], $p = .055$. Interventions were associated with significant improvements in parenting ($N= 592$), $g= 0.38$, 95% CI [0.21–0.54], $p<.001$; and child behaviour ($N= 547$) $g= 0.39$, 95% CI [0.09–0.69].
Conclusions	The results show that technology-assisted interventions effectively enhance parental psychological well-being, parenting, and child behaviour in families experiencing social disadvantage. “From a cost-benefit perspective, technology-assisted interventions may need not be as effective as traditional interventions to be considered meaningful.” In other words, the resource advantages of digital delivery, such as increased accessibility and reduced costs of development and implementation, should be considered when we interpret effectiveness for policymaking.
Limitations	Missing data in the primary-level studies; including both RCTs and pre-post study designs; the authors did not deliver forest plots for all reviewed variables.

⁵⁸ N : number of participants; n : number of studies

⁵⁹ g : Hedge’s g test; it is an effect size summary measure that controls for bias in small studies, for which it overestimates the effect. Hedges’ g is commonly used in meta-analysis (

⁶⁰ CI : coefficient interval

⁶¹ P : P -value

Table B: Florean *et al.*, 2020

Author(s)(Date). Study Title	Florean, I. S., Dobrean, A., Păsărelu, C. R., Georgescu, R. D., & Milea, I. (2020). The Efficacy of Internet-Based Parenting Programs for Children and Adolescents with Behavior Problems: A Meta-Analysis of Randomized Clinical Trials.
Study Characteristics	A meta-analysis of 15 RCTs with waitlist control groups (2012-2019) ($N=1668$), examined the effectiveness of online parenting interventions in reducing children and adolescent's behavioural problems (primary outcome) and improving parenting behaviour, parent distress and parenting efficacy (secondary outcomes). Twelve studies had also follow-up measures.
Findings	<p>Online parenting interventions are effective in reducing children behaviour problems (small effect size) compared to waitlist ($n=9$), ($g=0.4$; 95% CI [0.19 to 0.60], $p<0.001$); but not significant compared to non-internet-based intervention ($n=7$), ($g=-0.07$; 95% CI [-0.22 to 0.09], $p=0.411$)</p> <p>Effective in improving parenting outcomes (compared to waitlist control group), ($n=9$), $g=0.32$; 95% CI [0.2 to 0.44], $p<0.001$.</p> <p>Effective in improving parenting behaviour compared to waitlist ($n=8$), $g=0.34$; 95% CI [0.17 to 0.51], $p<0.001$.</p> <p>Effective in decreasing parenting distress compared to waitlist control ($n=6$), $g=0.3$; 95% CI [0.14 to 0.46], $p<0.001$.</p> <p>Effective in improving parenting efficacy compared to waitlist control ($n=5$), $g=0.4$; 95% CI [0.17 to 0.64], $p=0.001$.</p> <p>At follow-up, overall, the intervention group was significantly superior to the waitlist, ($n=4$), ($g=-0.47$; 95% CI [0.2 to 0.74]. The number of sessions positively predicts a reduction of children's behaviour problems ($p<0.001$).</p> <p>The percentage of parents with a university degree predicted the effectiveness of self-directed programs in reducing children's behaviour problems.</p>
Conclusions	Online parenting interventions are effective in reducing children's behaviour problem and parental outcomes, compared to a control group (i.e., waitlist), seem to have the same effectiveness as other non-Internet-based interventions only for children's behaviour. The number of sessions and parents' educational level seems to play a role in the effectiveness of the interventions on children's behaviour. Online parenting interventions appear to have long-term effects on both children and parent outcomes.
Limitations	The small number of eligible studies, no RCTs with pre-registered protocols, and the outcomes measurement based on parental reports

Table C: Corralejo & Rodríguez, 2018

Author(s)(Date). Study Title	Corralejo, S. M., & Rodríguez, M. M. D. (2018). Technology in parenting programs: a systematic review of existing interventions.
Study Characteristics	A systematic review of 31 studies (19 experimental, 3 quasi-experimental, and 3 pre-post designs), to identify the populations targeted in technology-based parenting interventions and the effectiveness of these interventions. Common outcome measures: child behaviour, parent behaviour, self-efficacy, and satisfaction with the intervention.
Findings	The results are presented as absolute efficacy (i.e., treatment compared to control) and relative efficacy (i.e., treatment compared to alternative treatment) in the tables; Effective in improving parenting variables such as parent knowledge, behaviour, and self-efficacy; For parent outcomes (19 studies): 47% showed statistical significance results and 42% mixed results. For child outcomes (17 studies): 35% had statistically significant positive results, 41% mixed results, and 24% reported non-significant findings. For parent outcomes, 8 studies reported large effect sizes, 12 reported moderate effect sizes, and 8 reported small effect sizes; For child outcomes, 8 studies reported large effect sizes, 7 reported moderate effect sizes, and 4 reported small effect sizes. Parent outcomes were clinically significant for 4 out of the 5 studies, and for 5 out of 7 studies for child outcomes; Of those 24 studies that reported participant ethnicity, only three interventions that had diverse samples included cultural adaptations, including diverse actors in video models, using goals informed by parents' values and traditions, and using measures validated with the target population.
Conclusions	Technology-based parenting interventions improved parenting variables (e.g. parent knowledge, behaviour, and self-efficacy) and child variables, while the overall size effects were higher for parental variables. Technology-based interventions should implement cultural adaptations for minorities beyond just hiring diverse actors to enhance services to diverse communities.
Limitations	Eleven of the 25 studies did not report any effect size—no conclusion about absolute and relative efficacy.

Table D: Fluja-Contreras; García-Palacios & Gómez, 2019

Author(s)(Date). Study Title	Flujas-Contreras, J. M., García-Palacios, A., & Gómez, I. (2019). Technology-based parenting interventions for children's physical and psychological health: a systematic review and meta-analysis.
Study Characteristics	A meta-analysis of 24 studies with the control groups (up to August 2017), to provide evidence for the efficacy of preventive and treatment parenting interventions using technology for parents to promote children's physical or psychological health. Interventions: PCIT, CBT, psychoeducation & Triple P. Treatment format: 88% online; podcast, DVD & tablet 12%).
Findings	The CBT studies ($n^{62}=5$): an overall small to moderate effect sizes with statistically significant differences $g=0.49$; 95% <i>CI</i> [0.32, 0.670]. The PCIT ⁶³ studies ($n=3$): large effect size, 2 studies showed significant positive results; $g= 0.94$; 95% <i>CI</i> [0.52–1.36] Triple P-CBT studies ($n=8$): small effect size, statistically significant differences, 5 studies showed positive results; $g= 0.4$; 95% <i>CI</i> [0.27, 0.53]. Psychoeducative studies ($n= 8$): small effect size; $g= 0.2$; 95% <i>CI</i> [0.05, 0.35]. Overall meta-analysis ($n=24$); $g= 0.55$; 95% <i>CI</i> [0.27, 0.82]. Based on the outcomes, the highest size effect belongs to parental knowledge improvement, followed by self-efficacy.
Conclusions	The technology-based parenting interventions can be beneficial to both parents and children in terms of the usefulness and efficacy for psychological and physical health in childhood and adolescence's well-being.
Limitations	The big effect sizes were usually captured when intervention compared with waitlist controls whereas, in comparison with active control (e.g. another treatment) the effect sizes were small. The long-term effects were not measured.

⁶² *n*: number of studies⁶³ PCIT: Parent-child interaction therapy

Table E: Spencer, Topham & King, 2019

Author(s)(Date). Study Title	Spencer, C. M., Topham, G. L., & King, E. L. (2019). Do online parenting programs create change?: A meta-analysis.																																																																
Study Characteristics	A meta-analysis of 28 studies ($N=3,979$), 2008- 2018, to examine the effectiveness of online parenting studies. Interventions: InTERACT ($n=4$), Infant-Net ($n=1$), Triple P ($n=7$), Strongest Families Smart Website ($n=2$), Parenting Toolkit ($n=2$), Rational Positive Parenting Program, Parent Management Training, Understanding Your Child, Integrated Bipolar Parenting Intervention, Internet Newborn Care Education Programme, KidzGrow Online, 1-2-3 Magic, Partners in Parenting, KopOpOuders (Chin UP, Parents)																																																																
Findings	<p>Twelve of the online parenting programs were clinically supported, and 16 were not. The online parenting programs showed significant effects on improving encouragement by parents, positive parenting behaviours, parent confidence and satisfaction, and positive child behaviour. These programs resulted in a significant decrease in “negative parent-child interactions, child problem behaviours, negative discipline strategies, parenting conflicts, parent stress, child anxiety, parent anger, and parent depression.”</p> <p>This study did not show any significant difference between clinically supported online programs with non-clinically supported ones.</p> <table border="1"> <thead> <tr> <th>Outcome measure</th> <th>N of effect sizes</th> <th>Cohen's <i>d</i></th> <th>95% <i>CI</i></th> </tr> </thead> <tbody> <tr> <td>Encouragement by parents</td> <td>6</td> <td>1.13</td> <td>[.70, 1.56]</td> </tr> <tr> <td>Positive parenting behaviors</td> <td>6</td> <td>1.00</td> <td>[.24, 1.76]</td> </tr> <tr> <td>Negative parent-child interactions</td> <td>6</td> <td>.97</td> <td>[-.47, -1.47]</td> </tr> <tr> <td>Child problem behavior</td> <td>19</td> <td>.58</td> <td>[-.31, -.86]</td> </tr> <tr> <td>Parent confidence</td> <td>15</td> <td>.35</td> <td>[.21, .48]</td> </tr> <tr> <td>Negative discipline strategies</td> <td>16</td> <td>.32</td> <td>[-.24, -.39]</td> </tr> <tr> <td>Positive child behavior</td> <td>6</td> <td>.31</td> <td>[.10, .51]</td> </tr> <tr> <td>Parenting conflicts</td> <td>5</td> <td>.31</td> <td>[-.17, -.46]</td> </tr> <tr> <td>Parent stress</td> <td>12</td> <td>.31</td> <td>[-.18, -.44]</td> </tr> <tr> <td>Child anxiety</td> <td>4</td> <td>.31</td> <td>[-.08, -.55]</td> </tr> <tr> <td>Parent anger</td> <td>5</td> <td>.30</td> <td>[-.15, -.45]</td> </tr> <tr> <td>Parent depression</td> <td>11</td> <td>.26</td> <td>[-.08, -.44]</td> </tr> <tr> <td>Parenting satisfaction</td> <td>3</td> <td>.15</td> <td>[.03, .27]</td> </tr> <tr> <td>Parent relationship satisfaction</td> <td>4</td> <td>.14</td> <td>[-.01, .28]</td> </tr> <tr> <td>Parent anxiety</td> <td>9</td> <td>.11</td> <td>[-.02, -.19]</td> </tr> </tbody> </table>	Outcome measure	N of effect sizes	Cohen's <i>d</i>	95% <i>CI</i>	Encouragement by parents	6	1.13	[.70, 1.56]	Positive parenting behaviors	6	1.00	[.24, 1.76]	Negative parent-child interactions	6	.97	[-.47, -1.47]	Child problem behavior	19	.58	[-.31, -.86]	Parent confidence	15	.35	[.21, .48]	Negative discipline strategies	16	.32	[-.24, -.39]	Positive child behavior	6	.31	[.10, .51]	Parenting conflicts	5	.31	[-.17, -.46]	Parent stress	12	.31	[-.18, -.44]	Child anxiety	4	.31	[-.08, -.55]	Parent anger	5	.30	[-.15, -.45]	Parent depression	11	.26	[-.08, -.44]	Parenting satisfaction	3	.15	[.03, .27]	Parent relationship satisfaction	4	.14	[-.01, .28]	Parent anxiety	9	.11	[-.02, -.19]
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Conclusions	Online parenting programs, with or without clinical support, are effective. Future research is suggested to compare online and in-person parenting programs' effects on outcome variables and including the long-term data to investigate the sustainability of the results.																																																																
Limitations	Under publication of the studies with non-significant results; the researchers did not include follow-up data in the meta-analysis or compare online with in-person studies.																																																																

Table F: Stewart et al., 2020

Author(s)(Date). Study Title	Stewart, R. W., Orengo-Aguayo, R., Young, J., Wallace, M. M., Cohen, J. A., Mannarino, A. P., & de Arellano, M. A. (2020). Feasibility and effectiveness of a telehealth service delivery model for treating childhood posttraumatic stress: A community-based, open pilot trial of trauma-focused cognitive-behavioral therapy.
Study Characteristics	A trial study (70 children 7-17) that examined the feasibility and effectiveness of trauma-focused cognitive-behavioural therapy (TF-CBT). It was delivered via tele-psychotherapy (videoconference) in the community-based locations of either schools or patient homes.
Findings	The results showed clinically meaningful symptom change posttreatment, with large effect sizes for both youth and caregiver-reported reduction in posttraumatic stress disorder symptoms. Comparing baseline to posttreatment UCLA-PTSD-RI ⁶⁴ scores: DSM-IV ⁶⁵ , (40) = 14.12; $p < .0001$; $d = 2.42$ and DSM-5 ⁶⁶ versions, $t^{67}(17) = 8.90$; $p < .0001$; $d = 2.04$. Comparing parent-reported data was similar, DSM-IV, $t(36) = 9.19$; $p < .0001$; $d = 1.68$; DSM-5, $t(16) = 6.09$; $p < .0001$; $d = 1.50$. The reported SMFQ ⁶⁸ for children: $t(57) = 9.27$; $p < .0001$; $d = 1.24$, and for parents, $t(51) = 6.34$; $p < .0001$; $d = 1.21$. The results confirmed the feasibility and effectiveness of this novel treatment format.
Conclusions/Policy Implications	The findings supported the potentials for providing effective and accessible intervention through tele-psychotherapy during a different crisis. "Future work to develop new clinical and technical infrastructures, public policies, and methods of reimbursement is imperative to ensuring that this crisis results in an opportunity to improve service delivery to those in need."
Limitations	Some difficulties with logging into the videoconferencing software, small sample size and primarily female sample, no randomization, no assessment of fidelity with an active control (e.g. another treatment) the effect sizes were small. The long-term effects were not measured.

⁶⁴ UCLA-PTSD-RI: University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index

⁶⁵ DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (fourth edition);

⁶⁶ DSM-5: Diagnostic and Statistical Manual of Mental Disorders (fifth edition);

⁶⁷ t : t value in t -test

⁶⁸ SMFQ: Short Mood Feeling Questionnaire

Table G: Cohen *et al.* (2016)

Author(s)(Date). Study Title	Cohen, J. A., Mannarino, A. P., Jankowski, K., Rosenberg, S., Kodya, S., & Wolford, G. L. (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential treatment facilities.
Study Characteristics	This RCT targeted 18 adjudicated youth in residential treatment facilities (RTFs) to evaluate 2 strategies for implementing technology-based TF-CBT: 1) web-based training plus 2-day live workshop and twice monthly phone consultation (W+L) vs. just web-based training and consultation (W).
Findings	The W+L condition resulted in significantly more therapists conducting trauma screening, completing treatment, and completing TF-CBT with fidelity than the W condition. Adjudicated RTF youth receiving TF-CBT across conditions experienced statistically and clinically significant improvement in PTSD ⁶⁹ [$t(32)=5.16$; $p=0.001$]and depressive symptoms ⁷⁰ [$t(32)= 2.65$, $p=0.18$].
Conclusions	TF-CBT is effective for improving trauma-related symptoms in adjudicated RTF youth. The W + L condition is generally superior to W for implementing TF-CBT in RTF. “These experiences strongly underscore the critical importance of organizational readiness when undertaking implementation of evidence-based trauma treatment, particularly when working with systems that traditionally do not focus on trauma, such as the juvenile justice system in which these RTF programs functioned.”
Limitations	The inability to assess youth externalizing behaviour problems; the failure to collect data about changes in knowledge, skills, and attitudes following the trauma-informed care curriculum training, relying solely on therapists’ self-report for fidelity.

⁶⁹ Based on the University of California at Los Angeles post-traumatic stress disorder Reaction Index

⁷⁰ Based on the Mood and Feelings Questionnaire-Short Version

Table H: Ondersma *et al.*, 2017

Author(s)(Date). Study Title	Ondersma, S. J., Martin, J., Fortson, B., Whitaker, D. J., Self-Brown, S., Beatty, J., ... & Chaffin, M. (2017). Technology to augment early home visitation for child maltreatment prevention: A pragmatic randomized trial.
Study Characteristics	A randomized trial with $N=413$ cases to test the effectiveness of a multicomponent computer-based supplement, the e-Parenting Program (ePP), that “designed to augment the ability of ongoing EHV to prevent child maltreatment directly either via effects on risk factors for child maltreatment (e.g., substance abuse) or via increased retention in EHV” to prevent maltreatment. The target group was at-risk families ⁷¹ who were not yet part of the child welfare system in Indiana. The participants were assigned to 3 groups: home visiting plus software supplementation to home visiting (ePP; software + Healthy Families) ($N=142$), services as usual (SAU or standard Healthy Families), and to a community referral control condition ($N=412$). They were evaluated at baseline, 6- and 12-months post-baseline. The intervention included eight 20-min computer-delivered modules for use by mothers during EHV.
Findings	All conditions reported significantly higher mean levels of harsh parenting over time. “The reduction in depression scores ($g = 0.22, p < 0.01$) and self-reported drug use (absolute risk reduction = $0.05, p = 0.03$) was significant from baseline to the 6-month follow-up for the ePP condition but not for SAU or control, and change in depression between 6 and 12 months showed a significant advantage for the ePP condition versus control ($p = 0.01$).” These results showed that the EHV model deployed in this study did not result in a significant reduction in child maltreatment, measured by major maltreatment risk factors and self-reported harsh parenting. Good acceptability and feasibility were recorded;
Conclusions	The computerized technology and app tested in this study as it was deployed was not an efficacious method to ongoing, intensive, and multifocal EHV.
Limitations	Some problems with software, reliance on maternal self-report of harsh parenting, the outcome selection were limited & didn’t include neglect.

⁷¹ The parents needed to be women scoring between 25 and 85 on the Kempe Family Stress Checklist a measure of overall maltreatment risk that evaluates factors such as substance abuse, prior maltreatment, and IPV.

Table I: *Carta et al., 2017*

Author(s)(Date). Study Title	Carta, J. J., Lefever, J. B., Bigelow, K., Borkowski, J., & Warren, S. F. (2013). Randomized trial of a cellular phone-enhanced home visitation parenting intervention.
Study Characteristics	A randomized experimental design with control group ($N=371$) mother-child dyads from low-income families, to evaluate the efficacy of the 2 parenting interventions; The mothers had 3.5- to 5.5-year-old children and at least 1 of the following child maltreatment risk factors: age <18 years at first child's birth, having less than a high school diploma or equivalent, receiving financial assistance, or meeting the income eligibility requirement for Head Start or the Special Supplemental Nutrition Program for Women, Infants, and Children. Mothers randomly assigned to 1 of the 3 groups: Planned Activities Training (PAT ⁷²) ($N=142$), PAT supplemented with cellular phones and text messaging (CPAT ⁷³) ($N=113$) and wait-list control (WLC) ($N=116$). The assessments were done at pre-test, post-intervention, and 6 months post-intervention.
Findings	Children of mothers in both intervention groups exhibited more positive engagement than the WLC group: small effect size ($d = 0.29$) for PAT versus WLC and moderate for CPAT versus WLC ($d = 0.43$). Mothers receiving cell phones (CPAT) used more parenting strategies and experienced greater reductions in depression and stress in comparison with the PAT mothers and control group.
Conclusions/Policy Implications	The addition of cellular phones to a home visiting training program enhanced maternal responsivity and reduced depression and stress.
Limitations	The research team provided a cell phone and the service for participants The study results did not provide the readers with p -values for all comparison measures.

⁷² PAT: "a manualized component of the SafeCare parent training model, aims at preventing challenging child behaviour and improving parent-child interactions by focusing on teaching specific parenting strategies. The 10 specific strategies taught in PAT included planning activities in advance, explaining activities, establishing rules and consequences, giving choices, talking about what you are doing, using positive interaction skills, ignoring minor misbehavior, giving feedback, and providing rewards or consequences." (Carta et al., 2017)

⁷³ CPAT: "The cellular phone enhancement consisted of text messages and phone calls that occurred between mothers and Family Coaches between PAT sessions. Text messages were sent twice per day, with 1 message prompting mothers to use a specific PAT strategy or to engage in positive interactions with their child, and a second text inquiring about mothers' use of PAT, their implementation of a planned activity or interactions with their child, or their child's behavior. Text message content was individualized for each mother and related to the focus of recent intervention visits." (Carta et al., 2017)

Appendix 2: The results of meta-analysis studies on ICT use in mental health Services

Objective	Number of included studies	Results and conclusion	Reference
Determine the evidence supporting the effectiveness of videoconference-delivered treatment for anxiety disorders	20 studies: PTSD (N = 10), OCDs, mixed anxiety and depression, panic disorder, and social phobia No study on generalized anxiety disorders (GAD).	Delivered therapy through VC for anxiety disorders is supported by evidence of effectiveness. These results are comparable with in-person treatment.	Rees & Maclaine, (2015). A systematic review of videoconference-delivered psychological treatment for anxiety disorders.
Determine non-inferiority of remote psychiatric counseling, including both assessment and treatment, compared to face-to-face intervention	26 RCTs, focused on the general psychiatric approach, including pharmacotherapy, counseling, and some psychotherapeutic techniques (listening, reformulation and clarification among others).	High levels of consistency between remote and face-to-face psychiatric assessment is reported. The efficacy of remote psychiatric counseling was shown to be not inferior compared to in vivo settings.	Drago et al. (2016). Videoconferencing in psychiatry, a meta-analysis of assessment and treatment.
Compare the efficacy of ICBT as to face-to-face CBT.	20 RCTs (social anxiety disorder, panic disorder, depressive symptoms, body dissatisfaction, tinnitus,	The ICBT and face-to-face treatment yielded equivalent overall effects and study quality did not influence study outcomes.	Carlbring et al. (2018). Internet-based vs. face-to-face cognitive behaviour therapy for psychiatric and somatic disorders: an updated systematic review and meta-analysis
To assess the current knowledge of treating Maternal depression (MD) through CBT, behavioural activation and other psychoeducation	10 trials on MD represent 1138 women, using traditional telephone calls, email, smartphone applications, and most studies utilised websites as a means of delivering interventions via prestructured sessions.	Therapeutic strategies involved CBT, behavioural activation and other psychoeducation. 8 trials reported significant improvement in depression scores post-intervention; 4 studies that conducted post-intervention follow-up found that these improvements continued. Limited evidence to support the delivery of CBT for the treatment of MD and anxiety by telemedicine.	Nair, et al., (2018). The effectiveness of telemedicine interventions to address maternal depression: a systematic review and meta-analysis.

<p>Compare the effectiveness of online vs. face-to-face of psychological interventions on perfectionism</p>	<p>10 RCTs that investigated the effectiveness of interventions for perfectionism and associated symptoms of depression and anxiety</p>	<p>The online psychological interventions are effective in reducing perfectionism, comparable to face-to-face. "Incorporating online interventions into clinical practice should be done with prudence and simply substituting face-to-face interventions with online interventions is not recommended."</p>	<p>Suh, et al. (2019). A Review and Meta-Analysis of Perfectionism Interventions: Comparing Face-to-Face With Online Modalities</p>
<p>Effectiveness of text messages for patients with clinical major depression</p>	<p>9 RCTs (764 adults and 181 adolescents); 5 studies used it as the only intervention and 4 studies combined it with behavioural activation or CBT</p>	<p>There is marginal evidence supporting text messaging interventions as an effective treatment for depression. However, because of its versatility, easy to use, non-invasive and increasing usage, it is promising where the routine telehealth modalities cannot be used (Internet, email, mobile apps).</p>	<p>Senanayake et al. (2019). Effectiveness of text messaging interventions for the management of depression: A systematic review and meta-analysis.</p>

Appendix 3: Some pieces of legislation from Part X of the Child, Youth, and Family Services Act (“CYFSA”) and the Personal Health Information Protection Act (“PHIPA”).

Part X of the CYFSA: The Collection, Use, and Disclosure of Personal Information

(a) Overview

On January 1, 2020, Part X of the *CYFSA* came into effect. This part of the *CYFSA* governs the collection, use, and disclosure of personal information by the Minister of Community and Social Services (“the Minister”) and service providers (including Children’s Aid Societies). Personal information is defined as “recorded information about an identifiable individual”.⁷⁴ Prior to the enactment of this section of the legislation, there was a legislative gap present within the sphere of privacy legislation. The predecessor to the *CYFSA*, the *Child and Family Services Act* (“*CFSA*”), did not provide rules regarding the use of personal information within child protection, and child protection agencies are not included in other existing pieces of privacy legislation.⁷⁵ This legislative gap meant that agency policies surrounding privacy requirements could vary across the province, with potentially problematic inconsistencies.

Part X applies the same privacy standards to all Children’s Aid Societies and imposes a significant change in perspective for agencies. Part X reinforces the preamble to the *CYFSA*, which focuses on respecting the voice of the child, including their views and preferences. Whereas it was previously assumed that personal information records belonged to societies who had custody and control of them, Part X clearly states that such records belong to the individual. There is therefore a shift from paternalism to individualism, with greater respect for the rights of privacy for children.

Given that privacy rights have been deemed to “foste[r] respect for dignity, personal integrity, and autonomy of the young person”⁷⁶, these new legislative provisions mark an important development in the privacy rights of children and youth in Ontario. The new legislative provisions also assist in bringing Ontario law in line with Canada’s international commitments. Canada is a signatory to the *United Nations Convention on the Rights of the Child* (“*UNCRC*”),⁷⁷ whose Article 16 specifically addresses a child’s right to freedom from interference with their privacy.⁷⁸

(b) Rights of Communication of the Child

Before discussing the provisions of the *CYFSA* that address personal information held by service providers, it is important to outline the rights of the child in terms of their own communications. Section 10(1)(c) provides that a child in care has a right to send and receive written communications that are not read, examined, or censored by another person. This rule is subject to certain exceptions, where service providers are permitted to open communications in the child’s presence (see Appendix 3).⁷⁹

⁷⁴ *CYFSA*, *supra* note 1 at s 2(1) states that “personal information has the same meaning as in the *Freedom of Information and Protection of Privacy Act*”. In the *Freedom of Information and Protection of Privacy Act*, RSO 1990, c F 31 at s 2(1), it provides the definition as quoted above [*FIPPA*].

⁷⁵ Child protection agencies are not included within the list of institutions covered by the *FIPPA* or the *Municipal Freedom of Information and Protection of Privacy Act*, RSO 1990, c M 56 [*MFIPPA*]. Further, the *Personal Information Protection and Electronic Documents Act*, SC 2000, c 5 only applies to private sector businesses engaged in commercial activities [*PIPEDA*].

⁷⁶ *Toronto Star Newspaper Ltd. v R*, 2012 ONCJ 27 at para 44.

⁷⁷ UN General Assembly, *Convention on the Rights of the Child* (20 November 1989), UNTS vol 1577 at 3 [*UNCRC*].

⁷⁸ *Ibid* at art 16(1).

⁷⁹ *CYFSA*, *supra* note 1 at s 10(3).

(c) The Scope of Part X: Defining “Service Providers” and “Services”

As discussed above, Part X of the *CYFSA* applies to the Minister and to “service providers”. As per the definition provided in the *CYFSA*, a “service provider” includes licensees (i.e. foster homes), people or entities providing services funded by the *CYFSA* (i.e. Children’s Aid Societies), and anyone else so prescribed. Foster parents are explicitly excluded from this definition of “service providers”. Services offered by these providers that are covered by the *CYFSA* include: those offered to children with developmental or physical disabilities and children in need of protection; mental health services; services related to adoption; and services that are preventative in nature.⁸⁰ For a full list of services, please see Appendix 3.

(d) The Collection of Personal Information

Under Part X, service providers are only permitted to collect as much information as is “reasonably necessary to provide the service” being offered.⁸¹ This constitutes another marked departure from previous practices of child protection agencies. Many service providers may have previously collected additional information to ensure comprehensive records in case of inquests into injuries or deaths of youth in care. However, such practices are now precluded under Part X, and could lead to individuals requesting corrections to over-inclusive records.⁸²

(e) The Requirement of Informed Consent

Consent is of central importance within Part X of the *CYFSA*. A service provider is not permitted to collect personal information unless they have the consent of the individual under the *CYFSA* and the collection, use, or disclosure is necessary for a lawful purpose or disclosure without consent is permitted by the *CYFSA*.⁸³ The consent must be informed, and this is made clear by two indicators from Part X. Firstly, s. 290 requires that service providers inform the individual that the personal information they are collecting may be used or disclosed under the *Act*.⁸⁴ Secondly, s. 296(1) provides the four essential elements to consent to the collection, use, or disclosure of personal information by a service provider. The consent:

- (a) must be a consent of the individual;
- (b) must be *knowledgeable* [emphasis added];
- (c) must relate to the information; and
- (d) must not be obtained through deception or coercion.⁸⁵

The requirement of “knowledgeable” consent is further elaborated to mean that an individual knows the purposes of the collection, use, or disclosure of the information and that they know they have the right to give, withhold, or withdraw consent.⁸⁶

Under the *Act*, individuals are presumed to be capable of giving consent unless a service provider has reasonable grounds to believe otherwise.⁸⁷ Consent and capacity to consent are therefore highly contextual, as opposed to being dependent on the age of the individual. When an individual is found not to be capable of

⁸⁰ *Ibid* at s 2(1).

⁸¹ *Ibid* at s 287(2).

⁸² *Ibid* at s 315(2), where the provision provides that individuals who have been granted access to a record may request a correction of inaccurate or incomplete information. Under s 315((9), service providers who receive such a request have a duty to complete the correction.

⁸³ *Ibid* at s 286.

⁸⁴ *Ibid* at s 290.

⁸⁵ *Ibid* at s 295(1).

⁸⁶ *Ibid* at s 295(4).

⁸⁷ *Ibid* at s 299.

providing consent, a parent may act as a substitute decision-maker.⁸⁸ In such scenarios, there is no requirement under Part X that a child be consulted.

The use of age and the determination of a child's ability to make decisions in the *CYFSA* varies. Section 23(1) provides that a child 12 or older may be provided counselling by a service provider with strictly the child's consent.⁸⁹ Section 301 of the *CYFSA* states that youth ages 16 and 17 must consent to service provision.⁹⁰ This variation in decision-making capabilities based on age has established a grey area for service providers when it comes to privacy rights. It is unknown if there is an obligation to consult children under the age of 16 who are unable to consent. Given the focus of the *CYFSA* generally on respecting the voice of the child, it may be prudent, subject to the age of the child, for service providers to still engage in consultation when the parent is the one providing consent.

(f) Exceptions to the Consent Requirement

(i) Collection of Personal Information

There are different exceptions to the requirement for consent when collecting information directly or indirectly. When collecting personal information directly, consent is not required when:

- (a) the collection is reasonably necessary for the provision of a service and it is not reasonably possible to obtain consent in a timely manner;
- (b) the collection is reasonably necessary to assess, reduce or eliminate a risk of serious harm to a person or group of persons; or
- (c) the service provider is a society and the information is reasonably necessary to assess, reduce or eliminate a risk of harm to a child.⁹¹

When the collection of personal information is being done indirectly, consent is not required if: collecting information without consent is permitted or required by law; the information is reasonably necessary to provide a service or to assess, reduce, or eliminate a risk of serious harm and it is not possible to collect personal information directly that can be relied on as accurate and complete, or in a timely manner; a Children's Aid Society can collect personal information from another Society if it is reasonably necessary to assess, reduce, or eliminate a risk of harm to a child.⁹² Service providers can indirectly collect personal information if indirect collection is specifically authorized by the OPC.⁹³

(ii) Disclosure of Personal Information by Service Providers

There are separate exceptions for consent when disclosing personal information that has been collected by a service provider. These exceptions allow a service provider to disclose an individual's personal information to certain entities for the purpose of providing a service. These can include: a Canadian law enforcement agency to aid in or commence an investigation; a proposed or existing litigation guardian or legal representative; or if there is a belief on reasonable grounds that disclosure is necessary to assess, reduce, or eliminate a serious risk of harm.⁹⁴ For a full list of personal information disclosure exceptions, please refer to Appendix 3.

The obligations of third parties upon disclosure of personal information by a service provider are unclear under the *CYFSA*. Under *PHIPA* (discussed below), the recipient rule holds that individuals that receive information

⁸⁸ *Ibid* at s 301(2).

⁸⁹ *Ibid* at s 23(1).

⁹⁰ *Ibid* at s 77.

⁹¹ *Ibid* at s 289.

⁹² *Ibid* at s 288(2).

⁹³ *Ibid* s 288(2)(c).

⁹⁴ *Ibid* at 292(1).

from a health information custodian (“HIC”) are subject to restrictions of use.⁹⁵ These include using information only for the purpose of which it was disclosed, or to carry out a statutory or legal duty. These exceptions do not apply if the organization is a municipal or provincial institution, or if the individual gave consent for the use of the information.⁹⁶

While the *CYFSA* recognizes an obligation of service providers to protect the privacy of youth,⁹⁷ it does not mirror the restrictions established in *PHIPA*. The *CYFSA* provides that information can be disclosed to a “successor”,⁹⁸ for the purpose of assessing and evaluating the operations of the service provider, if the successor enters into an agreement to maintain confidentiality and to not retain information longer than necessary for the purpose of the assessment or evaluation.⁹⁹ The requirement that successors agree to confidentiality and maintain security of personal information are minimal requirements, and the lack of specific restrictions under the *CYFSA* leaves a discretionary gap.

(g) Protection of Personal Information: Unique Challenges of Technology

Part X of the *CYFSA* contains provisions regarding maintaining the security of personal information that has been collected. Section 308(1) provides that:

A service provider shall take reasonable steps to ensure that personal information that has been collected for the purpose of providing a service and that is in the service provider’s custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal.¹⁰⁰

Online delivery of child welfare and social services poses unique challenges in meeting the above requirement. The legislation does not provide a definition of what “reasonable steps” entail, relying on a case-by-case analysis of the steps taken by the service provider should there be a breach in security.

Further, it may be argued that in order for consent to be “knowledgeable”, individuals should be informed of the inherent risks of utilizing technology. Information disclosed and collected over the internet can never be described as fully secure, and a discussion of this limit should be an integral part of the service provider obtaining informed consent.¹⁰¹

(h) The Right to Access Records

An individual has a right under Part X of the *CYFSA* to access their records of personal information that are in the custody or control of a service provider and that relate to the provision of a service (for a list of exceptions, see Appendix 3).¹⁰² If the record is not “dedicated primarily to the provision of a service”, the individual may only access their own personal information that can be reasonably severed from the remainder of the record.

⁹⁵ *PHIPA*, *supra* note 2 at s 49.

⁹⁶ *Ibid*.

⁹⁷ *CYFSA*, *supra* note 1 at s 87.

⁹⁸ *Ibid* at s 310(3), where “potential successor” and “successor” mean a potential successor or a successor that is a service provider or that will be a service provider if it becomes a successor.

⁹⁹ *Ibid* at s 310(1).

¹⁰⁰ *Ibid* at s 308(1).

¹⁰¹ See also Ontario College of Social Workers and Social Service Workers, *The Code of Ethics and Standards of Practice Handbook* (2008, 2nd ed), “Principle V: Confidentiality” at 5.4, where it states clients should be informed “early in their relationship of the limits of confidentiality of information.”

¹⁰² *CYFSA*, *supra* note 1 at s 312.

Service providers must respond to a request for access within 30 days and cannot charge any fees for such requests.¹⁰³

There are no decisions of the Information and Privacy Commissioner (“IPC”) interpreting the various provisions of Part X of the *CYFSA*, as this part has just recently come into effect. However, the *CYFSA*’s provisions regarding access to records mirror those in *PHIPA*, and those decisions can be used to assist in interpreting Part X. Under both pieces of legislation, an individual is only entitled to access the full record in question if it is “dedicated primarily” to the provision of a service (health care under *PHIPA* and various services under *CYFSA*).¹⁰⁴ In the IPC’s oft-cited decision interpreting the meaning of a record being “dedicated primarily” to service provision, the adjudicator found that a qualitative approach is appropriate.¹⁰⁵ This means that inquiries should not focus on how much of a record is dedicated to personal information about an individual, but on the characteristics of the record. Such qualitative considerations include the following:

- the quantity of personal [health] information of the requester in the record;
- whether there is personal [health] information of individuals other than the requester in the record;
- the purpose of the personal [health] information in the record;
- the reason for creation of the record;
- whether the personal [health] information of the requester is central to the purpose for which the record exists; and
- whether the record would exist “but for” the personal [health information] of the requester in it.¹⁰⁶

The impact of this requirement will differ between *PHIPA* and *CYFSA*. Under *PHIPA*, records will generally be centered on an individual and the provision of health care to that individual. This means that patients will often be able to access entire records or, if this is not possible, have their personal health information easily severed from a more complex record. On the other hand, records created under the *CYFSA* will almost always concern an individual (the child) and at least one other person (their caregiver). It may therefore be more difficult for an individual to argue that a record is “dedicated primarily” to their service provision, where it is co-mingled with information about others. This will make severing individual personal information from such a complex record more challenging. As was discussed, the information must be “reasonably severable”. The IPC has interpreted this requirement under *PHIPA* to mean that the severance must result in more than “disconnected and meaningless snippets” of information.¹⁰⁷

An additional concern regarding access to records is determining who has custody and control over the documents being requested. Decisions of the IPC released prior to Part X coming into force demonstrate that there have been discrepancies concerning who has control over documents involving children that have been

¹⁰³ *Ibid* at ss 314(3), (10).

¹⁰⁴ *Ibid* at s 312(3); *PHIPA*, *supra* note 2 at s 52(3).

¹⁰⁵ *PHIPA* Decision 17 (10 November 2015), online: Information and Privacy Commissioner <<https://decisions.ipc.on.ca/ipc-cipvp/hipa/en/item/134860/index.do>> at para 95 [*PHIPA* Decision 17].

¹⁰⁶ *PHIPA* Decision 73 (28 May 2018), online: Information and Privacy Commissioner <<https://decisions.ipc.on.ca/ipc-cipvp/hipa/en/item/311106/index.do>> at para 47, summarizing para 95 of *PHIPA* Decision 17.

¹⁰⁷ *PHIPA* Decision 17, *supra* note 30 at para 133.

in extended society care.¹⁰⁸ The analyses of adjudicators in decisions released from May 2018 onwards delineate the gap in legislation for the privacy considerations of children and the enforcement of the right to access personal information.

(i) Remedies for Breach of Privacy

If an individual has reasonable grounds to believe that someone has breached the “personal information” provisions of the *CYFSA*, the individual may make a written complaint to the IPC.¹⁰⁹ The IPC provides oversight of Part X of the *CYFSA*, and investigates privacy complaints and the application of privacy legislation in Ontario. After a complaint, the IPC will attempt to reach a settlement between the service provider and the complainant.¹¹⁰ If no settlement is reached, the IPC may conduct its own review and provide an order to the service provider to have them comply with the provisions of the *CYFSA*.¹¹¹

The PHIPA: Social Workers as Health Information Custodians and Agents

(a) Overview

PHIPA is a piece of provincial legislation that sets out the privacy rules for personal health information. It is possible for an organization to be subject to both Part X of the *CYFSA* and to *PHIPA*, depending on the role of its employees and the information they are collecting. For instance, a Children’s Aid Society is a service provider under the *CYFSA*, but certain employees may be in receipt of personal health information (i.e. counsellors) and would be subject to *PHIPA*.

PHIPA applies to “health care practitioners”, which include members of the Ontario College of Social Workers and Social Service Workers who provide health care.¹¹² Health care is defined as follows:

“health care” means any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and that,

(a) is carried out or provided to diagnose, treat or maintain an individual’s physical or mental condition,

(b) is carried out or provided to prevent disease or injury or to promote health, or

(c) is carried out or provided as part of palliative care.¹¹³

Many social workers in Ontario are governed by *PHIPA*, as the promotion of mental and physical health is a common function served by the profession.¹¹⁴ The applicable provisions of *PHIPA* differ depending on how a social worker is classified: as a health information custodian (“HIC”) or an agent of a HIC. These roles will be discussed below.

(b) Defining Health Information Custodians, Agents, and their Responsibilities

The most relevant scenarios in which social workers are considered to be “health information custodians” are:

¹⁰⁸ PHIPA Order PO – 3036 (26 January 2012), online: Information and Privacy Commissioner < <https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/133796/index.do?q=3036>>; PHIPA Order PO – 3995 (30 September 2019), online: Information and Privacy Commissioner < <https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/423348/index.do?q=PO++3995>>; PHIPA Order PO – 3864 (16 July 2018) online: Information and Privacy Commissioner <<https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/316769/index.do?q=PO++3864>>.

¹⁰⁹ *Ibid* at s 316(1).

¹¹⁰ *Ibid* at s 317(1).

¹¹¹ *Ibid* at s 317(3), 321(1).

¹¹² *PHIPA*, *supra* note 2 at s 2.

¹¹³ *Ibid*.

¹¹⁴ *Ibid*.

- (i) when they are employed in an independent practice;
- (ii) when they are part of a group practice providing health care;
- (iii) when they provide health care as part of an organization that is not itself considered a “health information custodian”.¹¹⁵

This means that social workers who have a private practice or a group practice with other social workers or health care professionals qualify as HICs. It also means that social workers employed outside of traditional health care settings (i.e. hospitals) can be HICs. This may include social workers providing counselling services through a Children’s Aid Society. A HIC may collect, use, and disclose information, subject to the consent rules discussed below.

Agents of HICs are social workers employed in traditional health care settings, like hospitals and walk-in clinics.¹¹⁶ There are further provisions governing how agents may collect, use, and disclose information. They may only do so with permission of a HIC if it is necessary for their work,¹¹⁷ and they may be subject to certain conditions imposed by the HIC when using the personal health information.¹¹⁸

(c) The Requirement of Informed Consent

The four required elements for consent are the same under the *CYFSA* and the *PHIPA*,¹¹⁹ as is the definition for knowledgeable¹²⁰ and the presumption of capacity.¹²¹ The main difference between the two pieces of legislation is that *PHIPA* provides a more specific understanding of capacity:

An individual is capable of consenting to the collection, use or disclosure of personal health information if the individual is able,

- (a) to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure, as the case may be; and
- (b) to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent.¹²²

This requirement of needing to understand “the reasonably foreseeable consequences” of consent may establish a more explicit need for social workers to discuss the risks of online service delivery. As has been discussed, it is impossible for the exchange of information over the internet to be entirely risk-free, and this would need to be made clear to clients before they can be deemed to have the capacity to consent.

(d) Exceptions to the Consent Requirement

Informed consent is not required for the use, collection, or disclosure of personal health information where “the information is reasonably necessary for the provision of health care and it is not reasonably possible to obtain consent in a timely manner.”¹²³ The caveat to this rule is that if the individual has “expressly” instructed

¹¹⁵ *Ibid*; See also Ontario College of Social Workers and Social Service Workers, “Privacy Toolkit for Social Workers and Social Service Workers”: Guide to the Personal Health Information Protection Act, 2004 (PHIPA)”, online: <https://www.ocswssw.org/wp-content/uploads/2018/11/OCSWSSW-PHIPA-Toolkit-ENG_FINAL.pdf>.

¹¹⁶ *PHIPA*, *supra* note 2 at s 2.

¹¹⁷ *Ibid* at s 17(1).

¹¹⁸ *Ibid* at s 17(4)(a).

¹¹⁹ *Ibid* at s 18(1).

¹²⁰ *Ibid* at s 18(5).

¹²¹ *Ibid* at s 21(4).

¹²² *Ibid* at s 21(1).

¹²³ *Ibid* at s 36(1), 38(1)(a).

that their personal health information is not to be used, collected, or disclosed for a certain purpose, the HIC or agent cannot proceed.¹²⁴

(e) Practices to Protect Personal Health Information

Unlike Part X of the *CYFSA*, the *PHIPA* contains specific provisions regarding the electronic use, collection, and disclosure of personal information, and best practices surrounding technology and privacy. While this section is not yet in force, it may serve as a guide for social workers providing services through technology. Under s 10(3), a HIC that uses electronic means to collect, use, modify, disclose, retain, or dispose of personal health information must comply with any prescribed requirement.¹²⁵ When these provisions regarding use of technology come into force, one such prescribed requirement will be the maintenance of an electronic audit log.¹²⁶ This electronic log must follow the statutory regulations listed in *PHIPA* (see Appendix 4)¹²⁷ These regulations appear to take into account the increased accessibility of electronic records and the need to closely monitor who is accessing sensitive information.

(f) Access to Records

Mirroring the *CYFSA*, individuals have a right to access their personal health information in the custody or under the control of a HIC, subject to exceptions (see Appendix 4).¹²⁸ Additionally, individuals share the right to request corrections to their personal health information in the care of the HIC.¹²⁹ Requests regarding the issue of access to personal health information and a denied request by an HIC are dealt with by the IPC. A recent IPC decision considered whether a non-custodial parent had the right to access their child's personal counselling appointment information.¹³⁰ The adjudicator found that while the custodian may rightfully decide that a parent or guardian has no right of access to a child's health information, a HIC may still have a duty to consider whether *PHIPA* access permits it to disclose the information requested. The adjudicator found that the service provider had breached its duty under *PHIPA* to properly consider the complainant's request. If the individual believes that a custodian has neglected to comply with a legal requirement to disclose information, they can seek enforcement through the courts. However, it is important to recognize that an IPC can only order proper consideration for the disclosure of personal health information and cannot order the release of the information itself.¹³¹

(g) Remedies for Breach of Privacy

The same remedies for breach of privacy as provided by the *CYFSA* (through filing a written complaint to the IPC) are available under the *PHIPA*.¹³² The considerations for taking reasonable steps to ensure the security of information are also the same. For example, in *PHIPA* Decision 64, a hospital staff member viewed over 100 patient documents without permission, resulting in a breach of privacy.¹³³ The IPC reviewed the breach and the steps taken by the hospital to mitigate the risk of such a breach, and found that although the use of personal health information was unauthorized, the hospital had taken reasonable steps to protect the information, including reporting the incident and actively responding to the investigation.

¹²⁴ *Ibid* at s 37(1)(a), 38(1)(a).

¹²⁵ *Ibid* at s 10(3).

¹²⁶ *Ibid* at s 10.1(1).

¹²⁷ *Ibid* at s 10.1(4).

¹²⁸ *Ibid* at s 52(1).

¹²⁹ *Ibid* at s 55(1).

¹³⁰ *PHIPA* Decision 96 (30 July 2019) online: Information and Privacy Commissioner <<https://decisions.ipc.on.ca/ipc-cipvp/hipa/en/item/421609/index.do?q=Decision+96+>>.

¹³¹ *Ibid* at para 94.

¹³² *PHIPA*, *supra* note 2 at s 56(1).

¹³³ *PHIPA* Decision 64 (18 December 2017), online: Information and Privacy Commissioner <<https://decisions.ipc.on.ca/ipc-cipvp/hipa/en/item/304619/index.do?q=Decision+64+>>.

Existing Gaps and Limitations

Due to the lack of specific provisions within the *CYFSA* regarding online service delivery, and the fairly broad provisions on electronic privacy concerns set to come into force under the *PHIPA*, the appropriate standards in this area are unclear. For instance, an individual who consented to the collection, use, or disclosure of personal or personal health information in-person would likely need to provide additional consent should their service delivery be moved online. However, this is not made explicit within the available legislation. An additional concern relates to providers of electronic formats for service delivery (i.e. Zoom, Skype). Though the not-yet-in-force provisions of *PHIPA* regarding electronic use do state that such providers are governed by it¹³⁴, there is a lack of specificity in terms of their responsibilities and obligations.

Additional Resources:

Information and Privacy Commissioner - Mini-Guide: <https://www.ipc.on.ca/wp-content/uploads/resources/provincial%20guide-e.pdf>

Information and Privacy Commissioner - Privacy and the *Child, Youth, and Family Services Act*: <https://www.ipc.on.ca/wp-content/uploads/2017/10/2017-10-19-pres-occas.pdf>

Part X of the *Child, Youth and Family Services Act*: A Guide to Access and Privacy for Service Providers: <https://www.ipc.on.ca/wp-content/uploads/2019/05/part-x-guide-e.pdf>

Guidelines for Obtaining Meaningful Consent: https://www.priv.gc.ca/en/privacy-topics/collecting-personal-information/consent/gl_omc_201805/

¹³⁴ *PHIPA*, *supra* note 2 at s 10(4).

Appendix 4: The statutory legislation listed in PHIPA

Relevant sections of the *United Nations Convention on the Rights of the Child*:

Article 16: No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.¹³⁵

Relevant sections of the *Child, Youth and Family Services Act*:

Definitions

S 2(1) In this Act,

“service” includes,

- (i) a service for a child with a developmental or physical disability or the child’s family,
- (ii) a mental health service for a child or the child’s family,
- (iii) a service related to residential care for a child,
- (iv) a service for a child who is or may be in need of protection or the child’s family,
- (v) a service related to adoption for a child, the child’s family or others,
- (vi) counselling for a child or the child’s family,
- (vii) a service for a child or the child’s family that is in the nature of support or prevention and that is provided in the community,
- (viii) a service or program for or on behalf of a young person for the purposes of the *Youth Criminal Justice Act* (Canada) or the *Provincial Offences Act*, or
- (ix) a prescribed service.

Rights of communication, etc.

S 10(1) A child in care has a right,

(c) to send and receive written communications that are not read, examined or censored by another person, subject to subsections (3) and (4).

(3) Subject to subsection (4), written communications to a child in care

- (a) may be opened by the service provider or a member of the service provider’s staff in the child’s or young person’s presence and may be inspected for articles prohibited by the service provider;
- (b) subject to clause (c), may be examined or read by the service provider or a member of the service provider’s staff in the child’s or young person’s presence, where the service provider believes on reasonable grounds that the contents of the written communication may cause the child or young person physical or emotional harm;
- (c) shall not be examined or read by the service provider or a member of the service provider’s staff if it is to or from a person described in subclause (1) (b) (i), (ii), (iii) or (iv) [their lawyer; another person representing them; the Ombudsman; and a member of the Legislative Assembly of Ontario or of the Parliament of Canada]; and

¹³⁵ *UNCRC*, *supra* note 13 at art 16(1).

(d) shall not be censored or withheld from the child or young person, except that articles prohibited by the service provider may be removed from the written communication and withheld from the child or young person.

(4) Written communications to and from a young person who is detained in a place of temporary detention or held in a place of secure custody or of open custody,

(a) may be opened by the service provider or a member of the service provider's staff in the young person's presence and may be inspected for articles prohibited by the service provider;

(b) may be examined or read by the service provider or a member of the service provider's staff and may be withheld from the recipient in whole or in part where the service provider or the member of their staff believes on reasonable grounds that the contents of the written communications,

(i) may be prejudicial to the best interests of the young person, the public safety or the safety or security of the place of detention or custody, or

(ii) may contain communications that are prohibited under the *Youth Criminal Justice Act* (Canada) or by court order;

(c) shall not be examined or read under clause (b) if it is to or from the young person's lawyer; and

(d) shall not be opened and inspected under clause (a) or examined or read under clause (b) if it is to or from a person described in subclause (1) (b) (ii), (iii) or (iv).

Collection, use and disclosure of personal information – requirement for consent

S 286 A service provider shall not collect personal information about an individual for the purpose of providing a service or use or disclose that information unless,

(a) the service provider has the individual's consent under this Act and the collection, use or disclosure, to the best of the service provider's knowledge, is necessary for a lawful purpose; or

(b) the collection use or disclosure without the individual's consent is permitted or required by this Act.

Indirect collection of personal information

S 288(1) A service provider may collect personal information indirectly for the purpose of providing a service if the individual to whom the information relates consents to the collection being made indirectly.

(2) A service provider may collect personal information indirectly for the purpose of providing a service and without the consent of the individual to whom the information relates if,

a) the information to be collected is reasonably necessary to provide a service or to assess, reduce or eliminate a risk of serious harm to a person or group of persons and it is not reasonably possible to collect personal information directly from the individual,

(i) that can reasonably be relied on as accurate and complete, or

(ii) in a timely manner;

b) the information is to be collected by a society from another society or from a child welfare authority outside of Ontario and the information is reasonably necessary to assess, reduce or eliminate a risk of harm to a child;

- c) the information is to be collected by a society and the information is reasonably necessary for a prescribed purpose related to a society's functions under subsection 35 (1);
- d) the indirect collection of information is authorized by the Commissioner; or
- e) subject to the requirements and restrictions, if any, that are prescribed, the indirect collection of information is permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada.

Disclosure without consent

S 292 (1) A service provider may, without the consent of the individual, disclose personal information about an individual that has been collected for the purpose of providing a service,

- (a) to a law enforcement agency in Canada to aid an investigation undertaken with a view to a law enforcement proceeding or to allow the agency to determine whether to undertake such an investigation;
- (b) to a proposed litigation guardian or legal representative of the individual for the purpose of having the person appointed as such;
- (c) to a litigation guardian or legal representative who is authorized under the Rules of Civil Procedure, or by a court order, to commence, defend or continue a proceeding on behalf of the individual or to represent the individual in a proceeding;
- (d) for the purpose of contacting a relative, member of the extended family, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or otherwise not capable;
- (e) for the purpose of contacting a relative, member of the extended family or friend of the individual if the individual is deceased;
- (f) subject to section 294, for the purpose of complying with,
 - (i) a summons, order or similar requirement issued in a proceeding by a person having jurisdiction to compel the production of information, or
 - (ii) a procedural rule that relates to the production of information in a proceeding;
- (g) if the service provider believes on reasonable grounds that the disclosure is necessary to assess, reduce or eliminate a risk of serious harm to a person or group of persons; or
- (h) if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada, subject to the requirements and restrictions, if any, that are prescribed.

Elements of consent for collection, use and disclosure of personal information

S 295(1) If this Act or any other Act requires the consent of an individual to the collection, use or disclosure of personal information by a service provider, the consent,

- (a) must be a consent of the individual;
- (b) must be *knowledgeable* [emphasis added];
- (c) must relate to the information; and
- (d) must not be obtained through deception or coercion.

Individual's right of access

S 312(1) An individual has a right under Part X of the *CYFSA* to access their records of personal information, subject to the following exceptions:

- (a) the record or the information in the record is subject to a legal privilege that restricts its disclosure to the individual;
- (b) another Act, an Act of Canada or a court order prohibits its disclosure to the individual;
- (c) the information in the record was collected or created primarily in anticipation of or for use in a proceeding, and the proceeding, together with all appeals or processes resulting from it, has not been concluded; or
- (d) granting the access could reasonably be expected to,
 - (i) result in a risk of serious harm to the individual or another individual,
 - (ii) lead to the identification of an individual who was required by law to provide information in the record to the service provider, or
 - (iii) lead to the identification of an individual who provided information in the record to the service provider explicitly or implicitly in confidence if the service provider considers it appropriate in the circumstances that the identity of the individual be kept confidential.

Relevant sections of the *Personal Health Information Protection Act*:**Definitions**

S 2 In this Act,

“health care” means any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and that,

- (a) is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition,
- (b) is carried out or provided to prevent disease or injury or to promote health, or
- (c) is carried out or provided as part of palliative care

and includes,

- (d) the compounding, dispensing or selling of a drug, a device, equipment or any other item to an individual, or for the use of an individual, pursuant to a prescription, and
- (e) a community service that is described in subsection 2 (3) of the *Home Care and Community Services Act, 1994* and provided by a service provider within the meaning of that Act.

Health information custodian

S 3 (1) In this Act,

“health information custodian”, subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:

1. A health care practitioner or a person who operates a group practice of health care practitioners.

2. A service provider within the meaning of the *Home Care and Community Services Act, 1994* who provides a community service within the meaning of that Act. A service provider is a health information custodian in connection with the provision of any community service within the meaning of *Home Care and Community Services Act, 1994*, regardless of whether a particular community service is publicly funded.
3. Repealed: 2016, c. 30, s. 43 (1).
4. A person who operates one of the following facilities, programs or services:
 - i. A hospital within the meaning of the *Public Hospitals Act*, a private hospital within the meaning of the *Private Hospitals Act*, a psychiatric facility within the meaning of the *Mental Health Act* or an independent health facility within the meaning of the *Independent Health Facilities Act*.
 - ii. A long-term care home within the meaning of the *Long-Term Care Homes Act, 2007*, a placement co-ordinator described in subsection 40 (1) of that Act, or a care home within the meaning of the *Residential Tenancies Act, 2006*.
 - ii.1 a retirement home within the meaning of the *Retirement Homes Act, 2010*.
 - iii. A pharmacy within the meaning of Part VI of the *Drug and Pharmacies Regulation Act*.
 - iv. A laboratory or a specimen collection centre as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*.
 - v. An ambulance service within the meaning of the *Ambulance Act*.
 - vi. A home for special care within the meaning of the *Homes for Special Care Act*.
 - vii. A centre, program or service for community health or mental health whose primary purpose is the provision of health care.
5. An evaluator within the meaning of the *Health Care Consent Act, 1996* or an assessor within the meaning of the *Substitute Decisions Act, 1992*.
6. A medical officer of health of a board of health within the meaning of the *Health Protection and Promotion Act*.
7. The Minister, together with the Ministry of the Minister if the context so requires.
8. Any other person prescribed as a health information custodian if the person has custody or control of personal health information as a result of or in connection with performing prescribed powers, duties or work or any prescribed class of such persons.

Use of electronic means

S 10 (3) A health information custodian that uses electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any.

Electronic audit log [not yet in force]

S 10.1 (1) Subject to any prescribed exceptions, a health information custodian that uses electronic means to collect, use, disclose, modify, retain or dispose of personal health information shall,

- (a) maintain, or require the maintenance of, an electronic audit log described in subsection (4);

- (b) audit and monitor the electronic audit log as often as is required by the regulations; and
- (c) comply with any requirements that may be prescribed.

(4) The electronic audit log must include, for every instance in which a record or part of a record of personal health information that is accessible by electronic means is viewed, handled, modified or otherwise dealt with,

- (a) the type of information that was viewed, handled, modified or otherwise dealt with;
- (b) the date and time on which the information was viewed, handled, modified or otherwise dealt with;
- (c) the identity of all persons who viewed, handled, modified or otherwise dealt with the personal health information;
- (d) the identity of the individual to whom the personal health information relates; and
- (e) any other information that may be prescribed.

Restrictions on recipients

S 49 (1) Except as permitted or required by law and subject to the exceptions and additional requirements, if any, that are prescribed, a person who is not a health information custodian and to whom a health information custodian discloses personal health information, shall not use or disclose the information for any purpose other than,

- (a) the purpose for which the custodian was authorized to disclose the information under this Act; or
- (b) the purpose of carrying out a statutory or legal duty.

Extent of use or disclosure

(2) Subject to the exceptions and additional requirements, if any, that are prescribed, a person who is not a health information custodian, and to whom a health information custodian discloses personal health information, shall not use or disclose more of the information than is reasonably necessary to meet the purpose of the use or disclosure, as the case may be, unless the use or disclosure is required by law.

Employee or agent information

(3) Except as permitted or required by law and subject to the exceptions and additional requirements, if any, that are prescribed, if a health information custodian discloses information to another health information custodian and the information is identifying information of the type described in subsection 4 (4) in the custody or under the control of the receiving custodian, the receiving custodian shall not,

- (a) use or disclose the information for any purpose other than,
 - (i) the purpose for which the disclosing custodian was authorized to disclose the information under this Act, or
 - (ii) the purpose of carrying out a statutory or legal duty; or
- (b) use or disclose more of the information than is reasonably necessary to meet the purpose of the use or disclosure, as the case may be.

Same

(4) The restrictions set out in clauses (3) (a) and (b) apply to a health information custodian that receives the identifying information described in subsection (3) even if the custodian receives the information before the day that subsection comes into force.

Freedom of information legislation

(5) Except as prescribed, subsections (1) to (4) do not apply to an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* that is not a health information custodian or to a person employed by or acting for such an institution when the person is acting in that capacity.

Same

(6) Where this Act permits or requires a health information custodian to disclose personal health information to an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* that is not a health information custodian, the institution may collect the information from the custodian.

Individual's right of access

S 52 (1) Subject to this Part, an individual has a right of access to a record of personal health information about the individual that is in the custody or under the control of a health information custodian unless,

- (a) the record or the information in the record is subject to a legal privilege that restricts disclosure of the record or the information, as the case may be, to the individual;
- (b) another Act, an Act of Canada or a court order prohibits disclosure to the individual of the record or the information in the record in the circumstances;
- (c) the information in the record was collected or created primarily in anticipation of or for use in a proceeding, and the proceeding, together with all appeals or processes resulting from it, have not been concluded;
- (d) the following conditions are met:
 - (i) the information was collected or created in the course of an inspection, investigation or similar procedure authorized by law, or undertaken for the purpose of the detection, monitoring or prevention of a person's receiving or attempting to receive a service or benefit, to which the person is not entitled under an Act or a program operated by the Minister, or a payment for such a service or benefit, and
 - (ii) the inspection, investigation, or similar procedure, together with all proceedings, appeals or processes resulting from them, have not been concluded;
- (e) granting the access could reasonably be expected to,
 - (i) result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person,
 - (ii) lead to the identification of a person who was required by law to provide information in the record to the custodian, or

- (iii) lead to the identification of a person who provided information in the record to the custodian explicitly or implicitly in confidence if the custodian considers it appropriate in the circumstances that the identity of the person be kept confidential; or
- (f) the following conditions are met:
 - (i) the custodian is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or is acting as part of such an institution, and
 - (ii) the custodian would refuse to grant access to the part of the record,
 - (A) under clause 49 (a), (c) or (e) of the *Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record, or
 - (B) under clause 38 (a) or (c) of the *Municipal Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record.

Appendix 5: Guidance for Children and Families Involved with the Child Welfare System During the COVID-19 Pandemic (by The American Academy of Pediatrics)

Visitation Principles

- Whenever possible, in-person visitation is preferable. This refers to family visitations as well as visits between child welfare professionals and children.
- Agencies should prioritize obtaining regular feedback from birth families and caregivers regarding visitations so that adjustments can be made to best promote connection and secure attachment between the child and family members.
- A combination of in-person and virtual visits can be considered to increase the frequency of parent-child and sibling interactions. It may be especially useful to use virtual visits to prepare a child for an in-person visit (for example, a parent's appearance may have changed, helping children become familiar with wearing masks, and discussion of what to do for fun at the visit), to follow-up on an in-person visit (address sadness or acting-out behaviors), or as a substitute for a planned in-person visit if it must be postponed because of COVID risks.
- Everyone involved in the visits should adhere to the same guidelines, for the purpose of risk reduction.

Visitation Guidance

- Everyone (child, caregiver and household members, birth family, and child welfare professionals) should be screened for COVID-19 exposure or symptoms the day before the planned in-person visit. A nonurgent in-person visit should not take place if anyone involved answers "yes" to these screening questions:
 - Are you COVID-19 positive or have you been exposed to someone with COVID-19?
 - Do you have any of the following symptoms of COVID-19: fever (100.4°F or higher) or chills, fatigue, nasal congestion, cough, shortness of breath, sore throat, muscle aches, headache, a new loss of taste or smell, vomiting, or diarrhea?
- Although not an absolute contraindication, consideration should be given to avoiding in-person visits with individuals considered by the Centers for Disease Control and Prevention (CDC) to be high-risk, including those 65 years of age or older or people who are immune suppressed, have certain chronic illnesses, or are obese. [Children with medically complex conditions](#), children who have neurologic, developmental, genetic, or metabolic conditions, and children who have congenital heart disease are at higher risk for severe illness than other children (visit the [CDC website](#) for a full list). Extra precautions such as meeting outdoors or in large, well-ventilated indoor spaces, and even more stringent attention to physical distancing, cloth face coverings, and sanitizing should be taken when such individuals are involved. More frequent virtual visits in these circumstances may also be a good option.
- All vehicles used to [transport](#) children should be cleaned before and after a visit. Children should sit in the back seat with ideally no more than two children in a vehicle. Keep windows open as appropriate.
- The best location for a visit is outside whenever possible.

- When a visit is held indoors, all surfaces (handles, doorknobs, toys, electronics, etc) should be thoroughly cleaned before and after the visit.
- All participants in the visit should wear cloth or disposable [face coverings](#), except for children <2 years old. In very rare cases, a child may not be able to wear a cloth or disposable face covering. Visits should not be canceled because of inability to wear a cloth face covering.
- Hand hygiene should be implemented for every participant frequently before, during, and after the visit, using soap and water or hand sanitizer.
 - Gloves are not required except for when changing diapers. Gloves should be discarded and hands washed in soap and water or hand sanitizer once the diaper change is completed.
 - Gowns and goggles are not necessary in this setting.
- Although physical distancing is strongly recommended, this may be difficult to enforce throughout the visit, recognizing the desire of parents and children to comfort and show affection for each other.
 - In the interest of risk reduction, try to use safer ways to physically connect. Strategies for physical contact that may be less risky include hugging with faces in the opposite direction and leg/waist hugs with children (as suggested in a [NYTimes article](#)). Try to avoid kissing on the face or hands and cheek-to-cheek or face-to-face contact.
- Maintain a log of everyone present at the visit, with contact information. If anyone who was present develops symptoms of COVID-19 within 2 weeks of the visit, he or she should contact the child welfare professional, who should in turn notify local public health authorities.
 - The individual with symptoms should also contact his or her primary care provider, who can direct their health care related to COVID-19.
- When in-person visits cannot safely occur, attention is needed to ensure that virtual visits are accessible and developmentally appropriate for the child(ren) involved.
 - Child welfare professionals should ensure that all people involved have access to and understanding of the necessary technology.
 - Visits should be developmentally appropriate for the child(ren) involved.
 - Shorter, more frequent visits will likely work better than single longer virtual visits, particularly for younger children or those with developmental delays.
 - Having games or activities planned for the visit can make it more successful and fun.
 - Having a facilitator can be helpful, both to engage all participants and to provide technological support

Retrieved from: [Guidance for Children and Families Involved with the Child Welfare System During the COVID-19 Pandemic \(aap.org\)](#)